Issue Brief: Potential Components of ACA Repeal & Replace Legislation

Nov. 10, 2016

EXECUTIVE SUMMARY

This Issue Brief examines the most credible evidence we have to date regarding what path congressional Republicans and President-elect Trump will pursue next year to repeal the Affordable Care Act (ACA) and replace its policies with new or differentiated strategies for expanding coverage and reforming our healthcare system.

These key indicators include the congressional Republican reconciliation bill that was vetoed by President Obama last year, Speaker Paul Ryan and other congressional Republicans' proposal to replace the ACA, and additional repeal and replace plans offered by congressional Republicans and right-leaning think tanks. Mr. Trump's campaign platform largely drew from the main themes of these proposals,[1] the key provisions of which are outlined in detail below.

We believe it is most likely that congressional Republicans will use the budget reconciliation process to advance an ACA repeal and replace bill to President-elect Trump's desk because Democratic support, otherwise necessary in the Senate, is extremely unlikely. Therefore, an important consideration in examining how this ACA repeal and replace campaign will take shape is which policies qualify for the budget reconciliation process.

In brief, policies that have a substantial impact on the budget qualify for reconciliation. Policies that either do not impact the budget or have only a tangential impact on the budget do not qualify. Thus, changes to the tax code, Medicare funding and reimbursement, and Medicaid financing generally qualify. Commercial insurance reforms, Exchange policies, and consumer protections generally do not. A more extensive overview of the budget reconciliation process, drawn from a congressional staff overview, is provided at the end of this memo. Throughout, we have attempted to distinguish policies that we believe likely qualify from those that do not.

Finally, there are other must-pass healthcare policies on the docket for next year, most notably extension of Children's Health Insurance Program (CHIP) funding and key Medicare policies. We believe that, to the degree possible, these policies may get "rolled in" to the ACA repeal and replace reconciliation package, because pursuing these items on a bipartisan basis, while a highly partisan battle over the ACA rages, seems fairly unlikely. Our previously circulated chart outlining the likely components of the CHIP and Medicare extenders package is appended to this memo.

2015 RECONCILIATION BILL

Last year, congressional Republicans passed, and President Obama vetoed, a budget reconciliation bill that repealed key aspects of the ACA.[2] This legislation provides the clearest view of what Republicans are likely to pursue in this regard next year.

[1] https://www.donaldjtrump.com/positions/healthcare-reform.
[2] For a staff-prepared summary and full text, see here: http://rsc.flores.house.gov/files/2016LB/RSC_Legislative_Bulletin_HR_3762.pdf.

In their analysis of the budgetary impacts of the legislation,[3] the Congressional Budget Office (CBO) and Joint Committee on Taxation (JCT) said the Senate-passed bill would reduce deficits by about $282 billion from fiscal 2016 through 2025, with an additional $193 billion in deficit reduction coming from broader macroeconomic effects. This is based on approximately $1.35 trillion in aggregate spending reductions and $870 billion in decreased revenue collections (i.e., taxes). The key provisions of the bill are provided here.

COVERAGE PROVISIONS

The Senate-passed measure would repeal the penalties used to enforce the individual and employer mandates, while leaving the coverage requirements intact. It also would repeal tax credits and other programs intended to increase the coverage of individuals under the law. The ACA imposed the mandates to help offset the risk and costs to insurance companies of covering sick individuals, particularly given that the law prohibits dropping coverage, imposing lifetime limits, or forgoing coverage of pre-existing conditions.

- **Individual Mandate –** Individuals who don't comply with the mandate or qualify for an exemption are subject to penalties consisting of a percentage of income or a flat per-person fee, in the case of family coverage. Those penalties would be eliminated, retroactive to the beginning of 2015.

- **Employer Mandate –** The employer mandate requires employers with 50 or more full-time employees, or equivalents, to provide health insurance or pay a per-employee fine. The law defined a full-time employee as one who averages 30 hours per week or more for the purposes of the mandate, also referred to as "employer shared responsibility." The measure would eliminate the penalties, retroactive to the beginning of 2015.

- **Premium Subsidies –** The ACA created premium tax credits to help individuals purchase health insurance coverage. The measure would repeal those credits after 2017, as well as cost-sharing subsidies. The credits are provided in advance, with end-of-the year reconciling to ensure that individuals or families don't receive more than they're allowed. The measure would invalidate for the 2016 and 2017 tax years a rule that limits the recapture of overpaid amounts from families with incomes of less than 400 percent of the federal poverty line. The recapture provisions would reduce mandatory spending by about $6.1 billion from fiscal 2016 through 2025, according to CBO and JCT, and increase revenue by $2.6 billion. Those effects are separate from the combined estimate of the bill's coverage provisions.

- **Small-Business Tax Credit –** The bill also would repeal, effective after 2017, a tax credit created to help smaller employers with no more than 25 full-time equivalent employees afford health coverage for their employees.

- **Medicaid Expansion –** The legislation would roll back ACA provisions that supported state expansion of Medicaid. Under the ACA, states are allowed to expand the eligibility of their Medicaid programs to cover single adults with income below 133 percent of the federal poverty line. To facilitate the expansion, the federal government pays 100 percent of the cost of covering newly enrolled individuals. That payment rate is scheduled to be reduced to 95 percent in 2017 and will eventually reach 90 percent after 2019. Currently, 30 states and the

[3] https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/costestimate/hr3762senatepassed.pdf.

District of Columbia have expanded their Medicaid programs, while four states are in discussions. The remaining 16 states haven't taken action to modify their programs under the ACA.

- **Risk Corridor Program –** The bill would bar the Health and Human Services Department from collecting fees or making payments under the risk corridor program, effective Jan. 1. The omnibus spending measure bars the use of funds for the program, which expires at the end of 2016. The ACA set up the program to stabilize the insurance market by preventing significant changes in premium rates in the early years of the insurance Exchanges. The program provides payments to insurance companies whose premiums are exceeded by consumers' medical costs. Conversely, insurers whose premiums exceed costs pay into the system and those funds are used to provide payments to other insurers. According to the Centers for Medicare and Medicaid Services, eligible insurers will receive about 12.6 percent of the requested $2.87 billion in risk corridor payments for the 2014 benefit year, and no funds are expected to be available for the 2015 benefit year.

- **Aid to Territories –** The measure also would end federal assistance to territories for their Exchanges, effective Jan. 1, 2018. The change would reduce mandatory spending by $0.2 billion, which would be separate from the effects of the coverage provisions.

- **Reinstatement of Medicaid Disproportionate-Share Hospital Funding –** The legislation also would repeal reductions in Medicaid allotments for disproportionate-share hospitals (DSH), which would increase mandatory spending by $37.5 billion through fiscal 2025. Hospitals with a large number of low-income patients are eligible for additional payments to cover the cost of lower reimbursements for services provided to those patients. Hospitals are entitled to further payments if they provide a significant amount of uncompensated care. Starting in fiscal 2014, the ACA has phased in reductions to DSH payments to account for increased coverage rates through the Medicaid expansion and individual coverage requirements.

TAXES AND FINANCING

Several of the taxes, fees and legal changes that the ACA created to help pay for the expansion of coverage would be repealed under the Senate-passed bill.

- **Medical Device Tax Repeal** – The measure would eliminate the 2.3 percent tax on medical devices sold to hospitals, reducing revenue by $20 billion from fiscal 2016 through 2025, according to CBO and JCT. The medical device tax took effect January 1, 2013, and applies to the sale of any medical device by a manufacturer, producer, or importer. There is a retail exemption for items typically purchased by the general public, such as hearing aids and contact lenses. The omnibus spending bill suspended the tax for 2016 and 2017. The House passed a stand-alone bill (H.R. 160) by a vote of 280-140 on June 18, when 46 Democrats joined 234 Republicans voting in favor of the bill (no Republican voted against it).

- **Pharmaceutical Tax Repeal –** The measure also would sunset an annual fee imposed on the makers and importers of branded prescription drugs, reducing revenue by $29.6 billion through fiscal 2025. The ACA provision set aggregate amounts of fees that must be collected each year. Those amounts are allocated to individual companies. The fees are imposed on drug companies with more than $5 million in aggregated branded prescription drug sales to federal health programs. The aggregate fee amount for 2016 is $3 billion, according to the

Internal Revenue Service. That amount is scheduled to rise to $4.1 billion in 2018 and then decline to $2.8 billion in 2019 and subsequent years.

- **Insurer Tax Repeal –** The ACA's tax on insurers would also be repealed, decreasing revenue by $142.2 billion over 10 years. The omnibus spending bill suspended the tax for one year.

- **'Cadillac' Tax Repeal –** The so-called "Cadillac" tax on high-cost insurance plans would also be repealed. The tax was scheduled to take effect in 2018, but was delayed for two years by the omnibus spending bill. If it takes effect, it will apply to employer-based health plans that cost more than $10,200 a year for individuals and $27,500 for families. The rate will be 40 percent of costs that exceed those thresholds, which will be adjusted annually for inflation. CBO and JCT didn't provide an estimate for the section, instead including it in their analysis of the coverage provisions. The omnibus spending bill delayed the tax until 2020.

- **Health Savings & Flexible Spending Accounts –** The measure would reverse changes to health savings accounts (HSAs) and flexible spending arrangements (FSAs) made by the ACA. The tax on HSA distributions that aren't used for qualified medical expenses would be reduced to 10 percent from 20 percent. A similar tax on distributions from Archer Medical Savings Accounts (MSAs)—typically used by small-business employees or self-employed individuals—would be reduced to 15 percent from 20 percent. The measure would repeal the limit on contributions to FSAs, which was $2,550 for 2015. The change would reduce revenue by $32 billion through fiscal 2025. The bill would repeal provisions on over-the-counter medicines for HSAs and FSAs, which would reduce revenue by $6.7 billion. For example, it would eliminate language that prevents the use of FSAs to pay for items other than a prescribed drug (whether or not a prescription is needed) or for insulin.

- **Payroll Tax –** A 0.9 percent increase in Medicare payroll taxes would be repealed for wages that exceed $200,000 for single filers, $250,000 for joint returns and $125,000 for married people filing separately. The provisions would reduce revenue by $123 billion through fiscal 2025.

- **Net Investment Tax –** The ACA imposed a 3.8 percent tax on the net investment income of individuals, estates and trusts that exceeded certain dollar amounts, including $250,000 for couples filing jointly, $200,000 for single people and heads of households, and $125,000 for married people filing separately. The tax, which took effect in 2013, would be repealed by the measure. CBO and JCT estimated the change would reduce revenue by $222.8 billion through fiscal 2025.

- **Deductions for Medicare Part D –** The ACA barred companies from deducting expenses that could be allocated to subsidies under Medicare Part D prescription drug coverage. The measure would repeal that rule, effective in tax years beginning after December 31, 2016, at a cost of $1.8 billion over 10 years.

- **Economic Substance Doctrine –** The measure would repeal an "economic substance doctrine" that the ACA codified and associated penalties, which would reduce revenue by $5.8 billion through fiscal 2025. The doctrine prohibits tax benefits for tax-motivated transactions that otherwise don't have economic substance or that lack a business purpose.

- **Tanning Tax –** The ACA's 10 percent excise tax on indoor tanning services also would be repealed, effective in 2016, reducing revenue by $0.8 billion.

- **Health Insurer Remuneration –** The measure would repeal a $500,000 limitation on the amount a health-insurance provider can deduct for employee compensation, or remuneration. A $1 million limit that applies more generally to executives of public companies wouldn't be affected by the bill. The provisions would be effective after 2015 and would reduce revenue by $0.6 billion through fiscal 2025.

- **Deductions for Medical Expenses –** The measure would prevent an adjustment for the threshold used to determine if medical care can be deducted for tax purposes. Under the ACA, a deduction will only be allowed in tax years after 2016 if medical care for a taxpayer, his or her spouse and his or her dependents exceeds 10 percent of adjustable gross income. A temporary 7.5 percent threshold was used from 2013 through 2016 and would be made permanent under the bill. CBO and JCT estimate the change would reduce revenue by $40 billion through fiscal 2025.

ADDITIONAL POLICIES

- **Planned Parenthood** – The measure would essentially block the use of federal mandatory funds for the Planned Parenthood Federation of America Inc. for one year. While the measure doesn't specify the organization, the ban would apply to a 501(c)(3) organization that provides abortions in cases other than rape, incest, or when the mother's life is endangered, and that received more than $350 million in federal and state Medicaid funding in fiscal 2014. The bill also would increase the amount provided for the Community Health Center program, which CBO and JCT said would increase mandatory spending by about $500 million. Planned Parenthood operates through a national office and 59 affiliates, which provide services through approximately 700 local health centers.

- **Prevention Fund –** The bill would also eliminate the Prevention and Public Health Fund, which provides financial support to preventive activities to improve public health. Funded activities include clinical prevention initiatives research, public health infrastructure development, immunizations and screenings, tobacco use prevention, and health workforce training. The fund has been used as an offset for other legislation, such as measures postponing cuts to Medicare reimbursement rates.
    - The following amounts are scheduled to be provided under current law:
        - $1 billion annually through fiscal 2017;
        - $1.25 billion annually in fiscal 2018 and 2019;
        - $1.5 billion per year in fiscal 2020 and 2021; and
        - $2 billion per year from fiscal 2022 onward.
    - The law originally provided for the annual rate to increase to $2 billion in fiscal 2015 and for mandatory appropriations totaling $18.75 billion from fiscal 2010 through fiscal 2020. Eliminating the fund would reduce mandatory spending by about $12.7 billion from fiscal 2016 through 2025.

- **Substance Abuse and Mental Health** – The measure would appropriate $1.5 billion—$750 million annually each for fiscal 2016 and 2017—for HHS grants to states "to address the substance abuse public health crisis or to respond to urgent mental health needs." Funds could be used for improving drug-mentoring programs, implementing substance abuse

prevention activities, training health care practitioners, and supporting access to federally supported opioid treatment programs.

- **Medicare Funding** – The legislation would transfer $379.3 billion to the Federal Hospital Insurance Trust Fund to extend Medicare solvency, reflecting the estimated "on budget" savings from the measure.

CONGRESSIONAL REPUBLICAN REPLACEMENT PLAN

On June 22, House Speaker Paul Ryan unveiled a Republican-developed plan to replace the ACA.[4] The plan proposes sweeping reforms to many ACA policies as well as to Medicare and Medicaid, presenting a broad outline of what the GOP may include in ACA repeal legislation as a replacement for some of the coverage that would otherwise be lost. No coverage or cost estimates have been provided for this plan, however, in part because it has not yet been unveiled in legislative form.

Notably, as with the ACA repeal reconciliation bill, the plan would repeal the ACA's individual mandate but continue to prohibit insurance companies from denying patients coverage or charging them more based on pre-existing conditions so long as they keep continuous insurance coverage. The plan would also transition Medicare into a premium support program, an idea floated by Speaker Ryan when he was the House Budget Committee chairman. For Medicaid, States would get per-capita allotments to administer the program, with per-person spending caps and special considerations for high-needs patients. Further detail on the specific policies follows.

Coverage Policies

While eschewing the individual mandate, the plan lays out a range of options to promote portable and consumer-driven healthcare options. Those that could likely qualify for reconciliation include:

- Expanding choice through consumer-driven healthcare, including through eliminating ACA restrictions on Health Savings Accounts (HSAs); allowing spouses to make catch-up contributions to the same HSA account, allowing qualified medical expenses incurred before HSA-qualified coverage begins to be reimbursed from an HSA account as long as the account is established within 60 days; setting the maximum HSA contribution at the combined allowed annual deductible and out-of-pocket expense limits; and expanding HSA access for certain groups, such as TRICARE and IHS members;
- Facilitating private exchanges and defined contribution methods, such as Health Reimbursement Arrangements through which some employers may reimburse employees for premiums for individual market coverage;
- Promoting the portability of coverage via a universal, advance-able, age-adjusted, and refundable tax credit for those without Medicare, Medicaid, or employer coverage, with the difference deposited in an HSA if selected coverage is less than the credit (note this is loosely analogous to the ACA's advance-able premium subsidy tax credits); and
- Capping the tax exclusion for employer-sponsored health insurance at "at level that would ensure job-based coverage continues unchanged for the vast majority of health insurance plans" (note this is loosely analogous to the Cadillac tax otherwise repealed).

[4] http://abetterway.speaker.gov/. Brief summary here: http://abetterway.speaker.gov/_assets/pdf/ABetterWay-HealthCare-Snapshot.pdf.

Components of the plan in this section that likely would not qualify for reconciliation include:

- Enabling the purchase of insurance across state lines and facilitating interstate compacts;
- Allowing Association Health Plans (AHPs) for small employers as well as individual health pools (IHPs) for individual pooling;
- Clarifying the permissibility of employer wellness programs;
- Maintaining the current definition of self-insurance and stop-loss insurance, citing concerns that stop-loss could be redefined as group insurance;
- Advancing medical liability reform, including caps non non-economic damages and encouragement of state innovation; and
- Recommending a Government Accountability Office study of "the advantages and disadvantages of removing [the] limited McCarran-Ferguson anti-trust exemption" as it relates to insurance markets.

Insurance Market Reforms

The plan seeks to reform insurance markets, notably by removing the individual mandate, and seeks to provide states with flexibility to pursue alternative solutions. These policies would not likely qualify for reconciliation, though many are addressed by the ACA so some of those policies may be simply left un-repealed.

- Pre-existing conditions protections;
- Removal of lifetime coverage limits;
- Protections against insurance policy rescissions;
- Continuous coverage protections in the individual market;
- Returning the age-rating ratio for premiums to five-to-one (with states having flexibility to narrow or expand);
- Innovation grants to states for designing premium-reduction programs that support wellness and offer innovative plan designs;
- At least $25 billion in federal funding for high risk pools and a one-time open enrollment period for uninsured individuals to join the healthcare market; and
- Limitations on abortion funding by permanently enacting and expanding the Weldon Amendment and ensuring that the Hyde Amendment is applied.

Healthcare Innovations

The plan seeks to accelerate the discovery, development, and delivery of new treatments and cures for patients. The plan identifies reforms included in the 21st Century Cures Act and seeks to add to it. Specific policies in this category, which generally would not qualify for reconciliation, include:

- Increasing research collaboration, while protecting patient privacy;
- Incorporating the patient perspective into the FDA's drug development review process;
- Using personalized medicine and developing new drug development tools;
- Modernizing clinical trials;
- Removing regulatory uncertainty for new technology;
- Providing new incentives for repurposing drugs for patients with rare diseases; and
- Reforming rules for electronic health records and meaningful use.

Medicaid Reform

The plan voices concern about Medicaid's significant share of federal and state budgets and designation as a high-risk program by the GAO, citing select findings on program integrity, timely access to care, and physician participation. It notes that the ACA match for the expansion population compared with previously covered populations "creates gross inequity under federal law," adding "this is particularly troubling since it creates an incentive for states that face pressure to make cuts to their programs result of Obamacare for the traditional Medicaid population," among other concerns. As noted above, structural changes to Medicaid likely qualify for budget reconciliation. Key reform proposals outlined by Speaker Ryan include:

- Giving states per capita allotments as a default approach, with the option of electing block grants. Details on the per-capita allotment approach and accompanying reforms are below.
    - The plan notes that a per capita allotment "achieves three inter-related aims: reforming Medicaid's financing, restoring Medicaid's focus on the most vulnerable, and restoring federalism by empowering states with new freedoms and flexibilities to run their Medicaid programs." The policy would begin in 2019, with a total federal Medicaid allotment available for each state based on its federal matching rate and 2016 used as the base year. The allotment would be indexed to grow at a rate slower than is set in current law. Under the policy, states that have not participated in ACA-authorized Medicaid as of Jan. 1, 2016, would not be able to do so.
    - The plan notes that "[t]o prioritize the most vulnerable in Medicaid, starting in 2019, the enhanced FMAP for the expansion adult population in Medicaid would be slowly phased down each year until it reached a state's normal FMAP level."
    - Per capita allotments would be accompanied by new statutory flexibilities to adopt work requirements for able-bodied adults or require participation in education, training, or approved community program. The plan also would allow states to set "reasonable, enforceable premiums" for adults who are not disabled and enable states to require premium assistance if it was cost effective "without all of the existing requirements for the provision of wrap-around services." Other options include waiting lists and enrollment caps for non-mandatory populations to "prevent crowd-out of private coverage," the plan notes. Additionally, the proposal makes certain reforms to the waiver process while grandfathering managed care waivers if already renewed twice or if they meet fast-track parameters. As noted, "[m]oving forward, the proposal would do away with the requirement in current law that states obtain a waiver for enrolling some populations in managed care."
- Returning Children's Health Insurance Program (CHIP) funding to a "historical" level of funding that does not include the ACA's 23-percent enhanced match. The plan does not note an effective date for the policy. It also promotes reforms that "prevent crowd-out of other private coverage and refocus CHIP resources to better serve eligible children in working families, rather than over subsidizing high-income families."

Medicare Reforms

Noting Medicare's "unsustainable" cost trajectory and Obamacare's "raid and ration" approach to the program, the proposal takes a three-step approach to reforming Medicare. First, the proposal repeals the "most damaging" Medicare provisions contained in Obamacare. Second, the plan makes structural reforms to the program that the authors say "make Medicare more responsive to patients' needs, while at same time updating the payment systems that are outdated and inefficient." Third, the plan proposes a premium support model for Medicare that would utilize a newly-created Medicare Exchange. Highlights from the three components of the plan, most of which would qualify for reconciliation, are provided here.

- Repealing ACA Medicare Reforms in the following ways:
    - Repealing Medicare Advantage (MA) benchmark caps;
    - Removing the Administration's ability to negatively adjust MA payments based on coding;
    - Reinstituting an open enrollment period for MA plans.
    - Repealing the Independent Payment Advisory Board (IPAB).
    - Repealing the Center for Medicare and Medicaid Innovation (CMMI) beginning January 1, 2020;
    - Lifting the ban on physician-owned hospitals to "make markets more competitive"; and
    - Repealing ACA changes to wage index calculations.
- Making structural reforms to Medicare, such as:
    - Giving plans more flexibility to design benefits (apparently eliminating requirements that plans have to offer the same benefits to all beneficiaries);
    - Starting in fiscal 2020, placing restrictions on Medigap plans to 1) prevent covering cost sharing below a certain amount and 2) prevent plans from paying more than half of the cost sharing between the deductible and the out-of-pocket (OOP) cap.
    - Starting in 2020, combining Parts A and B, with a "unified deductible" for both. The plan would also institute an OOP cap for FFS and would institute 20 percent cost sharing for all services.
    - Developing a "personalized care demonstration program" that would give beneficiaries and health care professionals the ability to voluntarily enter into an arrangement for items and services outside of the Medicare system;
    - Repealing the fiscal 2018 and 2019 Medicare DSH cuts and the fiscal 2018 through 2020 Medicaid DSH cuts. Beginning with fiscal 2021 and thereafter, the Secretary would be required to create one combined national pool of uncompensated care (UCC) funds distributed via S-10 data.
    - Beginning a new Medicare Compare web site, comparing MA and traditional fee-for-service FFS for each Metropolitan Statistical Area (MSA) on a core set of quality measures.
- Transforming the Medicare benefit into a premium support model starting in 2024. The plan notes that "beneficiaries would be given a choice of private plans competing alongside the traditional FFS Medicare program on a newly created Medicare Exchange." The plan adds that the premium support model "would operate in a manner similar to the Federal Employees Health Benefits (FEHB) program, where plans compete for individuals' choice based upon premium amount and a certain percentage – or a defined contribution – is offset by the government to lower the cost of coverage."
- Raising the Medicare eligibility age beginning in 2020 to gradually correspond with the Social Security eligibility age (Social Security eligibility age is gradually increasing to age 67 for those born after 1959).

Note that there are no references to amending or repealing the ACA's establishment of the Center for Medicare and Medicaid Innovation or the Medicare Access and Chip Reauthorization Act (MACRA), which established a new value-based payment regime for physicians in Medicare.

ADDITIONAL ACA ALTERNATIVES

Republican lawmakers and conservative think tanks have also proposed alternatives to the ACA. Most plans propose a full ACA repeal, while a few of them would repeal major reforms like insurance market regulations or newer Medicare policies, leaving other aspects of the law in place. A main theme running through these plans is their intent to deregulate many of the consumer protections established under the ACA, such as guaranteed issue and the ban on pre-existing condition exclusions. Furthermore, many of the proposals seek to eliminate the individual and employer mandates.

For additional insight into the policies Republicans may include in an ACA Repeal & Replace package next year, we briefly outline some of these key proposals here.

The Patient CARE Act[5]

- Repeals all ACA provisions except Medicare changes (including cuts);
- Offers premium assistance through fixed tax credits for up to 300 percent FPL adjusted based on age and income (e.g., at 200 percent FPL, $4,290 for families ages 18-34 and $11,110 for families ages 50-64);
- Caps the ESI tax exemption at $12,000 for an individual and $30,000 for a family;
- Enacts a 5:1 ratio for premium age bands;
- Includes guaranteed issue and community rating if the individual maintains continuous coverage;
- Sustains dependent coverage up to age 26; and
- Block grants certain Medicaid services allowing eligible patients to opt out and use a tax credit to buy private coverage.

Health Care Choice Act[6]

- Removes state boundaries from insurance markets; and
- Repeals Title I of the ACA.

Empowering Patients First Act[7]

- Creates individual health pools, expands HSAs, offers premium assistance through tax credits, and advances medical malpractice reform; and
- Allows for opt-out of Medicare and Medicaid; can receive tax credits instead.

[5] Introduced by Sens. Richard Burr (R-NC) and Orrin Hatch (R-UT) and Rep. Fred Upton (R-MI). Full text available at: http://www.finance.senate.gov/download/?id=11CE2E81-031F-4559-9FF3-C54BD52A2EAF.
[6] Introduced by Sens. Ted Cruz (R-TX), John Barrasso (R-WY), Mike Crapo (R-ID), Marco Rubio (R-FL) and David Vitter (R-LA). Full text available at: http://www.cruz.senate.gov/files/documents/Bills/20150302_Healthcare_Choice.pdf. Press release available at http://www.cruz.senate.gov/?p=press_release&id=2251.
[7] Introduced by Rep. Tom Price (R-GA). Full text available at: http://tomprice.house.gov/sites/tomprice.house.gov/files/HR%202300%20Empowering%20Patients%20First%20Act%202015.pdf.

American Health Care Reform Act[8]

- Provides standard individual and family deduction for specified percentage of health insurance costs regardless of itemization;
- Allows use of HSA funds for HSA-qualified insurance and LTC insurance premiums;
- Allows for guaranteed issue only for continuous coverage;
- Provides $25 billion in funding for state-run high-risk pools (plan does not provide for community rating);
- Premiums are limited to 200 percent of state average premium; and
- Allows individuals to contribute tax deductible funds to a Medicare Medical Savings Account (MSA).

The Universal Exchange Plan[9]

- Keeps basic structure of ACA individual market reforms, with some changes to eligibility thresholds and assistance amounts;
- Repeals individual and employer mandates, medical loss ratio and other ACA taxes (except Cadillac tax); and
- Phases out Medicare fee-for-service to have seniors eventually enrolled in reformed exchanges with federal means-tested premium assistance, with a similar reform for Medicaid.

A Winning Alternative to Obamacare[10]

- Provides fixed tax credits that increase on an annual basis;
- Provides guaranteed issue and community rating for those who maintain continuous coverage;
- Allocates $7.5 billion per year for high risk pools for states to administer;
- Caps individual premiums at 150-250 percent of market rate; and
- Allows Medicaid beneficiaries to opt for a tax credit for private coverage.

When Obamacare Fails[11]

- Provides fixed risk-adjusted tax credits for everyone under 65;
- Allows guaranteed issue and community rating only for those who maintain continuous coverage;
- Provides capped appropriations to states to fund high risk pools, with potential future transfer of financial responsibility to state;
- Converts Medicare to a premium support ("voucher") system; and
- For Medicaid, converts the program to a defined contribution state block grant for non-disabled individuals.

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[8] Introduced by Rep. Phil Roe (R-TN) et al. Full text available at: http://rsc.flores.house.gov/files/Initiatives/roe_007_xml.pdf. A press release may be found at: http://scalise.house.gov/bill/american-health-care-reform-act.

[9] Introduced by Avik Roy, The Manhattan Institute. Available at: http://www.manhattan-institute.org/pdf/mpr_17.pdf.

[10] Introduced by James Capretta, 2017 Project. Available at: http://2017project.org/2014/01/paving-way-full-repeal/#.VdK9fruFOW8.

[11] Introduced by Thomas P.Miller, American Enterprise Institute. See full text at: http://www.aei.org/wp-content/uploads/2012/12/-when-obamacare-fails-the-playbook-for-marketbased-reform_140559609210.pdf.

OVERVIEW OF THE BUDGET RECONCILIATION PROCESS[12]

The Budget Act of 1974 includes a special expedited procedure for consideration of certain legislation intended to reduce the budget deficit known as reconciliation. To initiate this process, a concurrent resolution on the budget may include reconciliation instructions to committees of the House and Senate to recommend changes in programs within their jurisdictions that would reduce the deficit by at least the amount specified by the budget.

The chief procedural benefits of a budget reconciliation process are that it is protected from filibuster in the Senate, limits amendments, and reduces the margin for final passage to a simple majority (51 votes). Reconciliation limits debate on a bill to 20 hours in the Senate and amendments must be germane. Beyond the procedural benefits, reconciliation also allows the Congress to highlight and consolidate major budgetary legislation into one bill.

Budget reconciliation may be used to make changes to mandatory spending programs and revenues except for changes related to Social Security. Committees can fulfill their spending reconciliation targets with a mix of policies that increase and decrease spending within their jurisdiction, but the net budgetary effect of all policies must meet or exceed the numerical instructions.

In the Senate, the Budget Act provides a procedure, known as the "Byrd Rule," to strike extraneous provisions from reconciliation bills. The definition of "extraneous" is complex. As a general matter, it applies to provisions that do not have a budgetary impact, provisions that increase the deficit and the relevant committee failed to meet its instructions, or provisions that increase the deficit in the year beyond the traditional 10-year budget scoring window. A Senator must raise a point of order against the offending provision. If sustained, the provision violating the Byrd Rule is removed from the underlying bill. The Byrd Rule is a powerful mechanism because it takes 60 votes to waive in the Senate. The Byrd Rule does not apply in the House.

CONCLUSION

This memorandum has aimed for inclusivity to ensure, to the degree possible, that all potential components of an ACA Repeal & Replace bill are addressed. We cannot emphasize enough, however, that the painstaking process of finalizing the details of this package have not yet begun in earnest, and new considerations – most especially that fact that whatever is included is likely to truly become the law of the land – must be taken into account.

With those caveats in mind, we hope this is a helpful step for your organization toward understanding the complex and robust set of issues that are "on the table" for next year. We look forward to working with you to better understand these policies and follow key developments in close detail as the next Congress unfolds.

[12] Copied in full from: http://rsc.flores.house.gov/files/2016LB/RSC_Legislative_Bulletin_HR_3762.pdf.

APPENDIX: LIKELY COMPONENTS OF THE CHIP AND MEDICARE EXTENDERS PACKAGE

Policy	Description	Expiration	Estimated Cost of Two-Year Extension
Medicare			
Work Geographic Practice Cost Index ("GPCI") Floor	The "physician work" component of the physician fee schedule is raised in areas where labor cost is lower than the national average. The physician work cost index has a floor of 1.0.	December 31, 2017	$1.1 billion/10 years
Therapy Cap Exceptions Process	In 2006, Congress created an exceptions process that allows patients to exceed the annual per-patient therapy cap, based on medical necessity.	December 31, 2017	$1.9b
Ambulance Add-Ons	Add-on payment for ground ambulance services, including in super-rural areas.	December 31, 2017	$400m
Medicare Low-Volume Hospital Add-On Payments	Additional payment to hospitals to offset the higher costs associated with operating a hospital with a low volume of discharges.	September 30, 2017	$1.1b
Medicare-Dependent Hospital ("MDH") Program	Rural hospitals with no more than 100 beds that serve a high percentage of Medicare beneficiaries are paid based on a blend of current prospective payment system rates and costs.	September 30, 2017	$400m
Medicare Advantage ("MA") Plans for Special Needs Individuals	Extends authority for MA special needs plans ("SNPs"), which may limit enrollment to certain populations.	December 31, 2018	$600m
Funding for Quality Measure Endorsement, Input and Selection	Funding for National Quality Forum ("NQF") review, endorsement and maintenance of quality and resource use measures and pre-rulemaking process and measure dissemination and review activities.	September 30, 2017	$100m

Funding for Outreach and Assistance for Low-Income Programs	Additional funding for outreach and education activities for Medicare beneficiaries, including State Health Insurance Programs, Area Agencies on Aging, Aging and Disability Centers and the National Center for Benefits Outreach and Enrollment.	September 30, 2017	$100m
Medicare Home Health Rural Add-On	Extends a three percent add-on for payments made for home health services provided to patients in rural areas.	December 31, 2017	$200m
		Medicare Subtotal:	**$5.9b**
Medicaid & CHIP			
Children's Health Insurance Program ("CHIP") Funding	CHIP covers children and pregnant women in families that earn income above Medicaid eligibility levels. The program is authorized through 2019 but needs to be funded.	September 30, 2017	$7.0b
Delay in Effective Date for Medicaid Amendments Relating to Beneficiary Liability Settlements	Delays for another year a provision relating to Medicaid estate recovery.	September 30, 2017	$100m
		Medicaid & CHIP Subtotal:	**$7.1b**
Other			
Funding for Community Health Centers, National Health Service Corps, and Teaching Health Centers	Funding for CHCs is supplemental to standard appropriation. NHSC provides scholarships and loan repayment to healthcare professionals who practice in underserved areas. The Teaching Health Center program provides funds to expand residency training to community based settings.	September 30, 2017	$8.0b
Special Diabetes Programs	Type I diabetes and Type II Indian Health Service programs.	September 30, 2017	$600m
Abstinence Education	Abstinence only programs and associated funding.	September 30, 2017	$100m
Personal Responsibility	PREP provides states and other groups with grants to implement evidence-based	September 30, 2017	$100m

Education Program ("PREP")	strategies for teen pregnancy and HIV/STD prevention, youth development, and adult preparation.		
Family-to-Family Health Information Centers	Program provides grants to support family-staffed organizations in each state to assist families of children with disabilities or special needs.	September 30, 2017	<$50m
Health Workforce Demonstration Project for Low-Income Individuals	Funding to help low-income individuals obtain education and training in high-demand, well-paid health care jobs.	September 30, 2017	$200m
Maternal, Infant and Early Childhood Home Visiting Programs	Provides states, territories and tribes with grants to support evidence-based in-home visiting programs for at-risk families.	September 30, 2017	$700m
		Other Healthcare Provisions Subtotal:	**$9.75b**
		Estimated Total for Entire Package:	**$22.75b**