



Summary of House Republicans' Latest Obamacare Legislation

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Executive Summary

The U.S. House of Representatives released its long-anticipated Obamacare repeal and replace legislation the evening of March 6, 2017. The bill falls far short of making good on the promise to fully repeal Obamacare and fails to fundamentally change federal control over supply and demand of healthcare.

- This plan fails to repeal most of the costly mandates and insurance regulations driving up premiums and deductibles
- This plan replaces Obamacare's subsidy scheme with a new costly federal entitlement in the form of a refundable tax credit
- This plan leaves significant portions of the flawed and costly Medicaid expansion intact by delaying the freeze on Medicaid enrollment, maintaining the expansion of the program to the able-bodied, and providing a pathway for non-expansion states to accept enhanced federal dollars.

Congress should be focused on policy solutions that respect states, patients, doctors, and families by lowering costs, increasing quality of care, and providing greater choice and competition in healthcare while empowering states. This plan does not live up to those benchmarks and continues many of the flawed solutions first promulgated under Obamacare.

Full Analysis

On the evening of March 6, 2017, House leadership released a revised draft of their Obamacare "repeal-and-replace" bill—the Energy and Commerce title is [here](#), and the Ways and Means title is [here](#).

A detailed summary of the bill is below, along with possible conservative concerns where applicable. Changes with the original [leaked discussion draft](#) (dated February 10) are noted where applicable. Where provisions in the bill were also included in the reconciliation bill passed by Congress early in 2016 (H.R. 3762, text available [here](#)), differences between the two versions, if any, are noted.

Of particular note: It is unclear whether this legislative language has been vetted with the Senate Parliamentarian. When the Senate considers budget reconciliation legislation—as it plans to do with the Obamacare "repeal-and-replace" bill—the Parliamentarian plays a key role in

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determining whether provisions are budgetary in nature and can be included in the bill (which can pass with a 51-vote simple majority), and which provisions are not budgetary in nature and must be considered separately (i.e., require 60 votes to pass).

In the absence of a fully drafted bill and complete CBO score, it is entirely possible the Parliamentarian has not vetted this draft—which means provisions could change substantially, or even get stricken from the bill, due to procedural concerns as the process moves forward.

Title I—Energy and Commerce

Essential Health Benefits: *Repeals Obamacare's actuarial value requirements, beginning on December 31, 2019, an addition compared to the leaked discussion draft. Removes language in the leaked discussion draft permitting states to develop essential health benefits—which include cost-sharing requirements—for insurance for all years after December 31, 2019.*

Prevention and Public Health Fund: Eliminates funding for the Obamacare prevention “slush fund,” and rescinds all unobligated balances. *This language is substantially similar to Section 101 of the 2015/2016 reconciliation bill.*

Community Health Centers: Increases funding for community health centers by \$422 million for Fiscal Year 2018—money intended to offset reductions in spending on Planned Parenthood affiliates (see “Federal Payments to States” below). *The spending amount exceeds the \$285 million provided in the leaked discussion draft. However, the section does NOT include language adding Hyde amendment protections—which would ensure that this stream of mandatory funding occurring outside the usual discretionary appropriations process, does not result in taxpayer funding of abortions—despite a parenthetical note indicating intent to do so in the leaked discussion draft. Language regarding community health centers was included in Section 102 of the 2015/2016 reconciliation bill.*

Federal Payments to States: Imposes a one-year ban on federal funds flowing to certain entities. This provision would have the effect of preventing Medicaid funding of certain medical providers, including Planned Parenthood, so long as Planned Parenthood provides for abortions (except in cases of rape, incest, or to save the life of the mother). *This language is virtually identical to Section 206 of the 2015/2016 reconciliation bill.*

Medicaid: *The discussion draft varies significantly from the repeal of Medicaid expansion included in Section 207 of the 2015/2016 reconciliation bill. The 2015/2016 reconciliation bill repealed both elements of the Medicaid expansion—the change in eligibility allowing able-bodied adults to join the program, and the enhanced (90-100%) federal match that states received for covering them.*

By contrast, the House discussion draft retains eligibility for the able-bodied adult population—making this population optional for states to cover, rather than mandatory. (The Supreme Court's 2012 ruling in [*NFIB v. Sebelius*](#) made Medicaid expansion optional for states.) Some conservatives may be concerned that this change represents a marked weakening of the

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2015/2016 reconciliation bill language, one that will entrench a [massive expansion of Medicaid](#) beyond its original focus on the most vulnerable in society.

With respect to the Medicaid match rate, the discussion draft reduces the enhanced federal match to states, effective December 31, 2019. The bill provides that states receiving the enhanced match for individuals enrolled by December 31, 2019 will continue to receive that enhanced federal match, provided they do not have a break in Medicaid coverage of longer than one month. (In the case of states that already expanded Medicaid to able-bodied adults prior to Obamacare's enactment, the bill provides for an 80 percent federal match for 2017 and all subsequent years.)

Some conservatives may be concerned that—rather than representing a true “freeze” that [was advertised](#), one that would take effect immediately upon enactment—the language in this bill would give states a strong incentive to sign up many more individuals for Medicaid over the next three years, so they can qualify for the higher federal match as long as those individuals remain in the program.

Finally, the bill repeals the requirement that Medicaid “benchmark” plans comply with Obamacare's essential health benefits, also effective December 31, 2019.

DSH Payments: Repeals the reduction in Medicaid Disproportionate Share Hospital (DSH) payments. Non-expansion states would see their DSH payments restored immediately, whereas states that expanded Medicaid to the able-bodied under Obamacare would see their DSH payments restored in 2019. *This language varies from both Section 208 of the 2015/2016 reconciliation bill and the leaked discussion draft.*

Medicaid Program Integrity: Beginning January 1, 2020, requires states to consider lottery winnings and other lump sum distributions as income for purposes of determining Medicaid eligibility. Effective October 2017, restricts retroactive eligibility in Medicaid to the month in which the individual applied for the program; current law requires three months of retroactive eligibility.

Requires, beginning six months after enactment, Medicaid applicants to provide verification of citizenship or immigration status prior to becoming presumptively eligible for benefits during the application process. With respect to eligibility for Medicaid long-term care benefits, reduces states' ability to increase home equity thresholds that disqualify individuals from benefits; within six months of enactment, the threshold would be reduced to \$500,000 in home equity nationwide, adjusted for inflation annually. *These provisions were not included in the leaked discussion draft.*

Non-Expansion State Funding: Includes \$10 billion (\$2 billion per year) in funding for Medicaid non-expansion states, for calendar years 2018 through 2022. States can receive a 100 percent federal match (95 percent in 2022), up to their share of the allotment. A non-expansion state's share of the \$2 billion in annual allotments would be determined by its share of individuals below 138% of the federal poverty level (FPL) when compared to non-expansion

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states. This funding would be excluded from the Medicaid *per capita* spending caps discussed in greater detail below. *This provision was not included in the leaked discussion draft.*

Eligibility Re-Determinations: Requires states, beginning October 1, 2017, to re-determine eligibility for individuals qualifying for Medicaid on the basis of income at least every six months. *This provision was not included in the leaked discussion draft.*

Medicaid *Per Capita* Caps: Creates a system of *per capita* spending caps for federal spending on Medicaid, beginning in Fiscal Year 2019. States that exceed their caps would have their federal match reduced in the following fiscal year.

The cap would include all spending on medical care provided through the Medicaid program, with the exception of DSH payments and Medicare cost-sharing paid for dual eligibles (individuals eligible for both Medicaid and Medicare). The cap would rise by medical CPI plus one percentage point annually.

While the cap would take effect in Fiscal Year 2019, the “base year” for determining cap levels would be Fiscal Year 2016 (which concluded on September 30, 2016), adjusted forward to 2019 levels using medical CPI. *The adjustment between years 2016 and 2019 was reduced from medical CPI plus one percentage point in the leaked discussion draft; however, the adjustment for years after 2019 remains medical CPI plus one percentage point.*

Creates five classes of beneficiaries for whom the caps would apply: 1) elderly individuals over age 65; 2) blind and disabled beneficiaries; 3) children under age 19; 4) expansion enrollees (i.e., able-bodied adults enrolled under Obamacare); and 5) all other non-disabled, non-elderly, non-expansion adults (e.g., pregnant women, parents, etc.). Excludes State Children’s Health Insurance Plan enrollees, Indian Health Service participants, breast and cervical cancer services eligible individuals, and certain other partial benefit enrollees from the *per capita* caps.

Requires the Department of Health and Human Services (HHS) to reduce states’ annual growth rate by one percent for any year in which that state “fails to satisfactorily submit data” regarding its Medicaid program. Permits HHS to adjust cap amounts to reflect data errors, based on an appeal by the state, increasing cap levels by no more than two percent.

For the period including calendar quarters beginning on October 1, 2017 through October 1, 2019, increases the federal Medicaid match for certain state expenditures to improve data recording, including a 100 percent match in some instances.

Some conservatives may note the bill’s creation of a separate category of Obamacare expansion enrollees, and its use of 2016 as the “base year” for the *per capita* caps, benefit states who expanded Medicaid to able-bodied adults under Obamacare. The most recent [actuarial report](#) on Medicaid noted that, while the actuary originally predicted that adults in the expansion population would cost less than existing populations, in reality each newly eligible enrollee cost 13.6% more than existing populations in 2016. Some states have used the 100% federal match for their expansion populations—i.e., “free money from Washington”—to raise provider reimbursement levels.

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Some conservatives may therefore be concerned that the draft bill would retain the increased spending on adults in expansion states—extending the inequities caused by states that have used Obamacare's "free money" to raise Medicaid spending while sending Washington the tab.

Cost-Sharing Subsidies: Repeals Obamacare's cost-sharing subsidies, effective December 31, 2019. However, the bill does not include an appropriation for cost-sharing subsidies for 2017, 2018, or 2019. The House of Representatives filed suit against the Obama Administration (*House v. Burwell*) alleging the Administration acted unconstitutionally in spending funds on the cost-sharing subsidies without an explicit appropriation from Congress. The case is currently on hold pending settlement discussions between the Trump Administration and the House. *Similar language regarding cost-sharing subsidies was included in Section 202(b) of the 2015/2016 reconciliation bill.*

On a related note, the bill does NOT include provisions regarding reinsurance, risk corridors, and risk adjustment, all of which were repealed by Section 104 of the 2015/2016 reconciliation bill. While the reinsurance and risk corridor programs technically expired on December 31, 2016, insurers have outstanding claims regarding both programs. Some conservatives may be concerned that failing to repeal these provisions could represent an attempt to bail out health insurance companies.

Patient and State Stability Fund: Creates a Patient and State Stability Fund, to be administered by the Centers for Medicare and Medicaid Services (CMS), for the years 2018 through 2026. Grants may be used to cover individuals with pre-existing conditions (whether through high-risk pools or another arrangement), stabilizing or reducing premiums, encouraging insurer participation, promoting access, directly paying providers, or subsidizing cost-sharing (i.e., co-payments, deductibles, etc.).

In the leaked discussion draft, the program in question was called the State Innovation Grant program. The new bill changes the program's name, and includes additional language requiring the CMS Administrator, in the case of a state that does not apply for Fund dollars, to spend the money "for such state," making "market stabilization payments" to insurers with claims over \$50,000, using a specified reinsurance formula. Some conservatives may view this as a federal infringement on state sovereignty—Washington forcibly intervening in state insurance markets—to bail out health insurers.

Provides for \$15 billion in funding for each of calendar years 2018 and 2019, followed by \$10 billion for each of calendar years 2020 through 2026 (\$100 billion total). Requires a short, one-time application from states describing their goals and objectives for use of the funding, which will be deemed approved within 60 days absent good cause.

For 2018 and 2019, funding would be provided to states on the basis of two factors. 85% of the funding would be determined via states' relative claims costs, based on the most recent medical loss ratio (MLR) data. The remaining 15% of funding would be allocated to states 1) whose uninsured populations increased from 2013 through 2015 or 2) have fewer than three health insurers offering Exchange plans in 2017. *This formula is a change from the leaked discussion*

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draft, which determined funding based on average insurance premiums, and guaranteed every state at least a 0.5% share of funding (\$75 million).

For 2020 through 2026, CMS would be charged with determining a formula that takes into account 1) states' incurred claims, 2) the number of uninsured with incomes below poverty, and 3) the number of participating health insurers in each state market. The bill requires stakeholder consultation regarding the formula, which shall "reflect the goals of improving the health insurance risk pool, promoting a more competitive health insurance market, and increasing choice for health care consumers." *The formula language and criteria has been changed compared to the leaked discussion draft.*

Requires that states provide a match for their grants in 2020 through 2026—7 percent of their grant in 2020, 14 percent in 2021, 21 percent in 2022, 28 percent in 2023, 35 percent in 2024, 42 percent in 2025, and 50 percent in 2026. *For states that decline to apply for grants, requires a 10 percent match in 2020, 20 percent match in 2021, 30 percent match in 2022, 40 percent match in 2023, and 50 percent match in 2024 through 2026. In either case, the bill prohibits federal allocation should a state decline to provide its match.*

Some conservatives may note the significant changes in the program when compared to the leaked discussion draft—let alone the program's initial variation, proposed by House Republicans in their [alternative to Obamacare](#) in 2009. These changes have turned the program's focus increasingly towards "stabilizing markets," and subsidizing health insurers to incentivize continued participation in insurance markets. Some conservatives therefore may be concerned that this program amounts to a \$100 billion bailout fund for insurers—one that could infringe upon state sovereignty.

Continuous Coverage: Requires insurers, beginning after the 2018 open enrollment period (i.e., open enrollment for 2019, or special enrollment periods during the 2018 plan year), to increase premiums for individuals without continuous health insurance coverage. The premium could increase by 30 percent for individuals who have a coverage gap of more than 63 days during the previous 12 months. Insurers could maintain the 30 percent premium increase for a 12 month period. Requires individuals to show proof of continuous coverage, and requires insurers to provide said proof in the form of certificates. Some conservatives may be concerned that this provision maintains the federal intrusion over insurance markets exacerbated by Obamacare, rather than devolving insurance regulation back to the states.

Essential Health Benefits: Permits states to develop essential health benefits—which include actuarial value and cost-sharing requirements—for insurance for all years after December 31, 2019.

Age Rating: Changes the maximum variation in insurance markets from 3-to-1 (i.e., insurers can charge older applicants no more than three times younger applicants) to 5-to-1 effective January 1, 2018, with the option for states to provide for other age rating requirements. Some conservatives may be concerned that, despite the ability for states to opt out, this provision, by setting a default federal standard, maintains the intrusion over insurance markets exacerbated by Obamacare.

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Special Enrollment Verification: Removes language in the leaked discussion draft requiring verification of all special enrollment periods beginning for plan years after January 1, 2018, effectively codifying [proposed regulations](#) issued by the Department of Health and Human Services earlier this month.

Transitional Policies: Removes language in the leaked discussion draft permitting insurers who continued to offer pre-Obamacare health coverage under President Obama's temporary "If you like your plan, you can keep it" [fix](#) to continue to offer those policies in perpetuity in the individual and small group markets outside the Exchanges.

Title II—Ways and Means

Subsidy Recapture: Eliminates the repayment limit on Obamacare premium subsidies for the 2018 and 2019 plan years. Obamacare's premium subsidies (which vary based upon income levels) are based on estimated income, which must be reconciled at year's end during the tax filing season. Households with a major change in income or family status during the year (e.g., raise, promotion, divorce, birth, death) could qualify for significantly greater or smaller subsidies than the estimated subsidies they receive. While current law caps repayment amounts for households with incomes under 400 percent of the federal poverty level (FPL, \$98,400 for a family of four in 2017), the bill would eliminate the repayment limits for 2018 and 2019. *This provision is similar to Section 201 of the 2015/2016 reconciliation bill.*

Modifications to Obamacare Premium Subsidy: Allows non-compliant and non-Exchange plans to qualify for Obamacare premium subsidies, with the exception of grandfathered health plans (i.e., those purchased prior to Obamacare's enactment) and plans that cover abortions (although individuals receiving subsidies can purchase separate coverage for abortion). *In a change from the leaked discussion draft, individuals with "grandmothered" plans—that is, those purchased after Obamacare's enactment, but before the law's major benefit mandates took effect in 2014—also cannot qualify for subsidies.*

While individuals off the Exchanges can receive premium subsidies, they cannot receive these subsidies in advance—they would have to claim the subsidy back on their tax returns instead.

Modifies the existing Obamacare subsidy regime beginning in 2018, by including age as an additional factor for determining subsidy amounts. Younger individuals would have to spend a smaller percentage of income on health insurance than under current law, while older individuals would spend a higher percentage of income. For instance, an individual under age 29, making just under 400% FPL, would pay 4.3% of income on health insurance, whereas an individual between ages 60-64 at the same income level would pay 11.5% of income on health insurance. (Current law limits individuals to paying 9.69% of income on insurance, at all age brackets, for those with income just below 400% FPL.)

Some conservatives may be concerned that 1) these changes would make an already complex subsidy formula even more complicated; 2) could increase costs to taxpayers; and 3) distract

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from the purported goal of the legislation, which is repealing, not modifying or “fixing,” Obamacare.

Repeal of Tax Credits: Repeals Obamacare’s premium and small business tax credits, effective January 1, 2020. *This language is similar to Sections 202 and 203 of the 2015/2016 reconciliation bill, with one major difference—the House bill provides for a three-year transition period, whereas the reconciliation bill provided a two-year transition period.*

Abortion Coverage: Clarifies that firms receiving the small business tax credit may not use that credit to purchase plans that cover abortion (although they can purchase separate plans that cover abortion).

Individual and Employer Mandates: Sets the individual and employer mandate penalties to zero, for all years after December 31, 2015. *This language is similar to Sections 204 and 205 of the 2015/2016 reconciliation bill, except with respect to timing—the House bill zeroes out the penalties beginning with the previous tax year, whereas the reconciliation bill zeroed out penalties beginning with the current tax year.*

Repeal of Other Obamacare Taxes: Repeals all other Obamacare taxes, effective January 1, 2018, including:

- Limitation on deductibility of salaries to insurance industry executives;
- Tax on tanning services;
- Tax on pharmaceuticals;
- Health insurer tax;
- Net investment tax;
- Tax on high-cost health plans (also known as the “Cadillac tax”)—but only through 2025;
- Restrictions on use of Health Savings Accounts and Flexible Spending Arrangements to pay for over-the-counter medications;
- Increased penalties on non-health care uses of Health Savings Account dollars;
- Limits on Flexible Spending Arrangement contributions;
- Medical device tax;
- Elimination of deduction for employers who receive a subsidy from Medicare for offering retiree prescription drug coverage;
- Limitation on medical expenses as an itemized deduction;
- Medicare tax on “high-income” individuals;

These provisions are all substantially similar to Sections 209 through 221 of the 2015/2016 reconciliation bill. However, when compared to the leaked discussion draft, the bill delays repeal of the tax increases by one year, until the end of calendar year 2017. Additionally, the bill does NOT repeal the economic substance tax, which WAS repealed in Section 222 of the 2015/2016 bill, as well as the leaked discussion draft.

Refundable Tax Credit: Creates a new, age-rated refundable tax credit for the purchase of health insurance. Credits total \$2,000 for individuals under age 30, \$2,500 for individuals aged 30-39, \$3,000 for individuals aged 40-49, \$3,500 for individuals aged 50-59, and \$4,000 for individuals over age 60, up to a maximum credit of \$14,000 per household. The credit would

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apply for 2020 and subsequent years, and increase every year by general inflation (i.e., CPI) plus one percent. Excess credit amounts can be deposited in individuals' Health Savings Accounts.

When compared to the leaked discussion draft, the bill would also impose a means-test on the refundable credits. Individuals with modified adjusted gross incomes below \$75,000, and families with incomes below \$150,000, would qualify for the full credit. The credit would phase out linearly, at a 10 percent rate—every \$1,000 of income would cause the subsidy to shrink by \$100. Assuming the maximum credit possible (\$14,000), the credit would phase out completely at income of \$215,000 for an individual, and \$290,000 for a family.

The credit may be used for any individual policy sold within a state, or unsubsidized COBRA continuation coverage. *The credit may also not be used for grandfathered or “grandmothered” health plans—a change from the leaked discussion draft. The bill also increases penalties on erroneous claims for the credit, from 20 percent under current law for all tax credits to 25 percent for the new credit—a change from the leaked discussion draft.*

Individuals may not use the credit to purchase plans that cover abortions (although they can purchase separate plans that cover abortion). The credit would be advanceable (i.e., paid before individuals file their taxes), and the Treasury would establish a program to provide credit payments directly to health insurers.

Individuals eligible for or participating in employer coverage, Part A of Medicare, Medicaid, the State Children's Health Insurance Program, Tricare, or health care sharing ministries cannot receive the credit; however, veterans eligible for but not enrolled in VA health programs can receive the credit. Only citizens and legal aliens qualify for the credit; individuals with seriously delinquent tax debt can have their credits withheld.

Some conservatives may be concerned that, by creating a new refundable tax credit, the bill would establish another source of entitlement spending at a time when our nation already faces significant fiscal difficulties.

Some conservatives may also note that, by introducing means-testing into the bill, the revised credit (when compared to the leaked discussion draft) by its very nature creates [work disincentives](#) and [administrative complexities](#). However, whereas Obamacare includes several “cliffs”—where one additional dollar of income could result in the loss of thousands of dollars in subsidies—this credit phases out more gradually as income rises. That structure reduces the credit's disincentives to work—but it by no means eliminates them.

Health Savings Accounts: Increases contribution limits to HSAs, raising them from the current \$3,400 for individuals and \$6,750 for families in 2017 to the out-of-pocket maximum amounts (currently \$6,550 for an individual and \$13,100 for a family), effective January 2018. Allows both spouses to make catch-up contributions to the same Health Savings Account. Permits individuals who take up to 60 days to establish an HSA upon enrolling in HSA-eligible coverage to be reimbursed from their account for medical expenses.

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Cap on Employer-Provided Health Coverage: Does NOT contain a proposed cap on the deductibility of employer-sponsored health insurance coverage included in the leaked discussion draft.

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