# *House Passes the American Health Care Act of 2017 (H.R. 1628)*

On Thursday May 4, the U.S. House of Representatives passed the American Health Care Act of 2017 ("AHCA") by a vote of 217-213, mostly along party lines. The Senate will now take up the task of reviewing and creating its version of healthcare reform and undoubtedly, changes to the House version of the bill will emerge. The passage of the AHCA is just the first step in the current Administration's desire to repeal and replace the Affordable Care Act ("ACA") which remains the law of the land today. The following is a brief summary of the AHCA provisions that could impact employer-sponsored plans:

- Allows states to seek a waiver to determine an essential benefits ("EHBs") package beginning in 2020, potentially giving insurers more flexibility to design and offer a wider array of benefit plans and enabling employers more benefit options, as well. Under the ACA, employers sponsoring large group and self-funded plans are not required to provide all ten EHBs, although no annual and lifetime limits may be imposed when benefits defined as essential health benefits are covered. For example, if states are allowed to scale back the definition of EHBs, employers may be able to impose limits on those benefits no longer considered EHBs.

- The individual and employer mandate penalties would reduce to zero retroactive to 2016. It seems plausible that employers would also have more flexibility to offer and design medical benefit plans without having to follow the strict ACA "full-time employee" and coverage/affordability rules as no penalties will be assessed for failure to offer minimum value/affordable coverage to ACA-defined full-time employees. However; the reporting requirements under IRC Sections 6055 and 6056 (Forms 1094 and 1095) would remain, although the Secretary of the Treasury may have discretion to not enforce these requirements as the reporting elements become less relevant at a later date. Under the AHCA, an individual who is *eligible* for employer-sponsored coverage, regardless of whether the coverage meets minimum value and/or affordability standards, would not qualify for premium assistance when purchasing a Qualified Health Plan in the individual market. Reporting the number of months an employee is *eligible* for group coverage could easily be reported on Form W-2.

- Implementation of the Cadillac Tax (40% excise tax on high value health plans), initially delayed until 2020 in prior legislation, will be delayed until 2026.

- Effective 2017, allow over-the-counter medications to once again be payable from tax-advantaged accounts such as health flexible spending accounts ("FSAs"), health reimbursement arrangements ("HRAs") and health savings accounts ("HSAs"), without having to secure a prescription.

- Removes the health FSA limit (currently $2,600) beginning with taxable years after December 31, 2016.

- Increases the tax-free amount that individuals may contribute to an HSA to be set at the annual out-of-pocket limit for HSAs. For 2017, this would be $6,550 and $13,100 for self-only and family coverage, respectively. The bill also allows both spouses to make catch-up contributions to a single HSA beginning in 2018 and permits expenses to be paid from an HSA prior to the account being established, if the taxpayer establishes the HSA within 60 days of being enrolled in a High Deductible Health Plan. When HSA distributions are used to pay for expenses other than qualified medical expenses, the taxpayer will be subject to a penalty that will be lowered to 10% from the current 20% assessment.

- Repeals a variety of taxes implemented under the ACA such as the Health Insurer Tax (2017); 10% tanning services tax (July 1, 2017); 2.3% medical device tax (2017); additional Medicare taxes (.9%) that generally apply to income in excess of $200,000 ($250,000 for joint filers) (2023); and the 3.8% net investment income tax (2017).

- Retiree drug subsidies would once again be deductible as a business expense (2017).

- Allow insurers to modify the current premium ratio adjustment (3:1) between younger and older participants to (5:1) in the individual and small group market to better reflect demographic users of healthcare services. The impact would be to shift costs to older enrollees and lower costs for younger enrollees.