Provisions of the Senate Amendment to H.R. 3762

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Summary

The FY2016 budget resolution (S.Con.Res. 11) established the congressional budget for the government for FY2016 and set forth budgetary levels for FY2017-FY2025. It also included reconciliation instructions for House and Senate committees to submit changes in laws to reduce the federal deficit to their respective budget committees.

Specifically, S.Con.Res. 11 instructed three committees of the House and two committees of the Senate to submit changes in laws within each committee's jurisdiction to reduce the deficit by not less than $1 billion for the period FY2016-FY2025. Additionally, S.Con.Res. 11 provided that these committees shall "note the policies discussed in title VI [of S.Con.Res. 11] that repeal the Affordable Care Act and the health care related provisions of the Health Care and Education Reconciliation Act of 2010" and "determine the most effective methods" by which these provisions "shall be repealed in their entirety."

On October 23, 2015, the House passed the Restoring Americans' Healthcare Freedom Reconciliation Act of 2015 (H.R. 3762). The bill would repeal several provisions of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended), and it could restrict federal funding for the Planned Parenthood Federation of America (PPFA) and its affiliates and clinics for a period of one year. The bill also would appropriate an additional $235 million for each of FY2016 and FY2017 to the Community Health Center Fund. The Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) estimate that H.R. 3762 would reduce federal deficits by $78.1 billion over the 2016-2025 period.

In lieu of action on a Senate reconciliation bill, on December 1, 2015, the Senate majority leader made a motion to proceed to the consideration of H.R. 3762. The motion was non-debatable and was approved by voice vote. The majority leader then offered an amendment encompassing the recommendations of the instructed Senate committees as a substitute for the House language (S.Amdt. 2874). Over the course of December 1, 2, and 3, the Senate debated this substitute and considered a number of amendments. On December 3, Senator Enzi, chairman of the Budget Committee, offered an amendment for himself and the majority leader as a substitute for S.Amdt. 2874 (S.Amdt. 2916). On a point of order, a section of S.Amdt. 2874 concerning repeal of certain premium-stabilization programs was stricken, but the remainder of the amendment was subsequently adopted by the Senate by voice vote. The Senate then voted to pass the bill, 52-47.

Similar to H.R. 3762, the Senate amendment to H.R. 3762 would repeal several provisions of the ACA, could restrict federal funding for PPFA and its affiliated clinics for a period of one year, and would appropriate an additional $235 million for each of FY2016 and FY2017 to the Community Health Center Fund. Unlike the House bill, the Senate bill includes many more ACA amendments or repeal provisions, as well as other non-ACA provisions. CBO and JCT estimate that the Senate bill would reduce federal deficits by $281.6 billion over the 2016-2025 period.

This report includes a table listing all provisions in H.R. 3762 and the Senate amendment to H.R. 3762 that would amend or repeal ACA provisions. It also provides a brief explanation of the provisions included in the Senate Amendment to H.R. 3762. For information about H.R. 3762, see CRS Report R44238, *Potential Policy Implications of the House Reconciliation Bill (H.R. 3762)*, coordinated by Annie L. Mach.

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Specifically, S.Con.Res. 11 instructed three committees of the House and two committees of the Senate to submit changes in laws within each committee's jurisdiction to reduce the deficit by not less than $1 billion for the period FY2016-FY2025.[1] Additionally, S.Con.Res. 11 provided that these committees shall "note the policies discussed in title VI [of S.Con.Res. 11] that repeal the Affordable Care Act and the health care related provisions of the Health Care and Education Reconciliation Act of 2010" and "determine the most effective methods" by which these provisions "shall be repealed in their entirety."

On October 23, 2015, the House passed the Restoring Americans' Healthcare Freedom Reconciliation Act of 2015 (H.R. 3762).[2] The bill would repeal several provisions of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended), and it could restrict federal funding for the Planned Parenthood Federation of America (PPFA) and its affiliates and clinics for a period of one year.[3] The bill also would appropriate an additional $235 million for each of FY2016 and FY2017 to the Community Health Center Fund. The Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) estimate that H.R. 3762 would reduce federal deficits by $78.1 billion over the 2016-2025 period.[4]

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Similar to H.R. 3762, the Senate amendment to H.R. 3762 would repeal several provisions of the ACA, could restrict federal funding for PPFA and its affiliated clinics for a period of one year, and would appropriate an additional $235 million for each of FY2016 and FY2017 to the Community Health Center Fund. However, the Senate bill includes many more ACA amendments

[1] The three House committees are the Committees on Education and the Workforce, Energy and Commerce, and Ways and Means. The two Senate committees are the Committees on Finance and on Health, Education, Labor, and Pensions (HELP).

[2] For information about H.R. 3762, see CRS Report R44238, *Potential Policy Implications of the House Reconciliation Bill (H.R. 3762)*, coordinated by Annie L. Mach.

[3] For more information on Planned Parenthood Federation of America and the services its facilities provide, see CRS Report R44295, *Factors Related to the Use of Planned Parenthood Affiliated Health Centers (PPAHCs) and Federally Qualified Health Centers (FQHCs)*, by Elayne J. Heisler.

[4] Congressional Budget Office (CBO) and Joint Committee on Taxation (JCT), *Estimate of Direct Spending and Revenue Effects of* H.R. 3762*, the Restoring Americans' Healthcare Freedom Reconciliation Act, As Passed by the House and Following Enactment of the Bipartisan Budget Act of 2015*, November 4, 2015, at https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/costestimate/hr3762aspassed.pdf.

or repeal provisions, as well as other non-ACA provisions. CBO and JCT estimate that the Senate bill would reduce federal deficits by $281.6 billion over the 2016-2025 period.[5]

This report includes a table listing all provisions in H.R. 3762 and the Senate amendment to H.R. 3762 that would amend or repeal ACA provisions. It also provides a brief explanation of the provisions included in the Senate Amendment to H.R. 3762. For information about H.R. 3762, see CRS Report R44238, *Potential Policy Implications of the House Reconciliation Bill (H.R. 3762)*, coordinated by Annie L. Mach.

Reconciliation and the ACA

Table 1 lists the ACA provisions that would be modified or repealed by H.R. 3762, the Senate amendment to H.R. 3762, or both. Neither bill would repeal the ACA in its entirety. The provisions included in the Senate bill are described in more detail in the subsequent section.

Table 1. ACA Provisions Affected by H.R. 3762, the Senate Amendment to H.R. 3762, or Both

ACA Provision		H.R. 3762	Senate Amendment to H.R. 3762
General Provisions			
42 U.S.C. Section 300u-11	Prevention and Public Health Fund (PPHF)	Section 101 would eliminate the authority and permanent annual appropriation for the PPHF and rescinds any unobligated funds for the fiscal year in which the bill is enacted	Section 101 would repeal all PPHF appropriations for FY2016 and subsequent fiscal years; rescinds any unobligated PPHF balances from prior years
26 U.S.C. Section 5000A	Individual Mandate	Section 201 would repeal the individual mandate and its associated penalty, effective January 1, 2015	Section 204 would effectively eliminate the penalty for noncompliance with the individual mandate by reducing it to $0, effective January 1, 2015
26 U.S.C. Section 4980H	Employer Mandate	Section 202 would repeal the employer mandate, effective January 1, 2015	Section 205 would modify the tax penalty associated with the employer mandate, effectively eliminating it by reducing the penalties to $0 beginning in calendar year 2015
Subchapter E of IRC Chapter 32	Medical Device Tax	Section 203 would repeal the tax, effective in calendar quarters beginning after the bill is enacted	Section 214 would repeal the tax, effective for sales in calendar quarters beginning after December 31, 2015
26 U.S.C. Section 4980I	Excise Tax on High-Cost Employer-Sponsored Coverage	Section 204 would repeal the tax, effective January 1, 2015	Section 209 would repeal the tax, effective taxable years beginning after December 31, 2017
42 U.S.C. Section 18043	Territories	No provision	Section 103 would provide that the section of the ACA providing funding for territories would have "no force or effect" as of January 1, 2018

[5] CBO and JCT, Estimate of Direct Spending and Revenue Effects of H.R. 3762, The Restoring Americans' Healthcare Freedom Reconciliation Act, as Passed by the Senate on December 3, 2015, December 8, 2015.

ACA Provision		H.R. 3762	Senate Amendment to H.R. 3762
42 U.S.C. Section 18061	Reinsurance Program	No provision	Section 104 would prohibit the HHS Secretary from collecting fees and making payments under the reinsurance program, effective January 1, 2016
26 U.S.C. Section 36B	Reconciliation of Premium Tax Credits	No provision	Section 201 would temporarily repeal the repayment limits for qualifying individuals who receive excess premium tax credits, effective taxable years ending after December 31, 2015 and before January 1, 2018
26 U.S.C. Section 36B	Premium Tax Credits	No provision	Section 202 would repeal authorization for the premium tax credits, effective taxable years beginning after December 31, 2017
42 U.S.C. Section 18071	Cost-sharing Subsidies	No provision	Section 202 would repeal authorization for the cost-sharing subsidies, effective December 31, 2017
42 U.S.C. Sections 18081 and 18082, 26 U.S.C. Section 6103(l)	Administration of Premium Tax Credits and Cost-sharing Subsidies	No provision	Section 202 would repeal requirements related to premium tax credits and cost-sharing subsidies, specifically, provisions related to eligibility determinations, advanceability, and disclosure of taxpayer information
26 U.S.C. Section 45R	Small Business Tax Credit	No provision	Section 203 would stipulate that the small business credit would not be available beginning tax year 2018
26 U.S.C. Sections 223, 220, 106	Definition of Medical Expenses	No provision	Section 210 would repeal the requirement that expenses for medicine or drugs are only qualified expenses for Health FSAs, HRAs, Archer MSAS, and HSAs if made for prescribed drugs or insulin, generally effective beginning tax year 2016
26 U.S.C. Sections 223, 220	Penalty for Nonqualified Archer MSA and HSA Distributions	No provision	Section 211 would reduce the tax imposed on distributions from Archer MSAs and HSAs that are used for purposes other than paying for qualified medical expenses from 20% to 15% and 10%, respectively, effective for distributions made after December 31, 2015
26 U.S.C. Section 125	Limit Health FSA to $2,500	No provision	Section 212 would repeal the $2,500 contribution limit on health FSAs, effective beginning tax year 2016
Section 9008 of the ACA	Annual Fee on Pharmaceutical Manufacturers and Importers of Branded Drugs	No provision	Section 213 would repeal the annual fee on pharmaceutical manufacturers and importers of branded drugs, effective beginning calendar year 2016
Section 9010 of the ACA	Annual Fee on Health Insurance Providers	No provision	Section 215 would repeal the annual fee on health insurance providers, effective beginning calendar year 2016

ACA Provision		H.R. 3762	Senate Amendment to H.R. 3762
26 U.S.C. Section 139A	Eliminate Deductions for Expenses Allocable to Medicare Part D Subsidy	No provision	Section 216 would reinstate business expense deductions for retiree prescription drug costs without reduction by the amount of any federal subsidy, effective for taxable years beginning after December 31, 2015
26 U.S.C. Section 213	Medical Expenses Deduction	No provision	Section 217 would reduce the threshold for deducting medical expenses from 10% to 7.5%, effective beginning tax year 2016
26 U.S.C. Sections 1401(b) and 3101(b)	Additional Hospital Insurance (Medicare) Surtax	No provision	Section 218 would repeal the 0.9% Medicare surtax, effective beginning tax year 2016
IRC Chapter 49	Excise Tax on Indoor Tanning Services	No provision	Section 219 would repeal the tax, effective for services performed on or after December 31, 2015
Chapter 2A of IRC Subtitle A	Net Investment Tax	No provision	Section 220 would repeal the net investment tax, effective beginning tax year 2016
26 U.S.C. Section 162(m)(6)	Remuneration	No provision	Section 221 would repeal the provision that prohibits covered health insurance providers from deducting the remuneration paid to employees in excess of $500,000, effective beginning tax year 2016
26 U.S.C. Sections 7701(o), 6662(b)(6)&(i), 6664, 6676.	Economic Substance Doctrine	No provision	Section 222 would repeal the codification of the economic substance doctrine, as well as the related penalty provisions, effective for transactions entered into after December 31, 2015
Medicaid Provisions			
42 U.S.C. Section 1308(g)	Medicaid Funding for Territories	No provision	Section 207(1) would make additional Medicaid funding to the territories available through September 30, 2017 rather than September 30, 2019
42 U.S.C. Section 1396a(a)(10)(i)(VIII)	Eligibility for ACA Medicaid Expansion	No provision	Section 207(2)(A) would repeal the ACA Medicaid expansion eligibility pathway after December 31, 2017
42 U.S.C. Section 1396a(a)(10)(ii)(XX)	Optional Medicaid Eligibility for Adults with Income Above 133% of FPL	No provision	Section 207(2)(A) would repeal the optional Medicaid eligibility pathway for adults with income above 133% of the federal poverty level after December 31, 2017
42 U.S.C. Section 1396a(l)(2)(C)	Medicaid Eligibility for Stairstep Children	No provision	Section 207(2)(C) would repeal the mandatory eligibility pathway for stairstep children after December 31, 2017

ACA Provision		H.R. 3762	Senate Amendment to H.R. 3762
42 U.S.C. Section 1396a(gg)(2)(C) and 42 U.S.C. Section 1397ee(d)(3)(A)	Medicaid and CHIP Maintenance of Effort	No provision	Section 207(3) would repeal Medicaid and CHIP maintenance of effort for children after September 30, 2017
42 U.S.C. Section 1396d(b)	FMAP Rate for the Territories	No provision	Section 207(4)(A) would change the federal medical assistance percentage rate for the territories from 55% to 50% on or after January 1, 2018
42 U.S.C. Section 1396d(y)(1)(B)	Newly Eligible Medicaid Matching Rate	No provision	Section 207(4)(B) would repeal the newly eligible matching rate on January 1, 2018
42 U.S.C. Section 1396d(z)(2)	Expansion State Medicaid Matching Rate	No provision	Section 207(4)(C) would repeal the expansion state matching rate on January 1, 2018
42 U.S.C. Section 1396n(k)(2)	FMAP Enhancement for Community First Choice Option	No provision	Section 207(5) would repeal the increased FMAP rate for the Community First Choice Option on January 1, 2018
42 U.S.C. Section 1396a(a)(47)(B)	ACA Medicaid Presumptive Eligibility	No provision	Section 207(2)(B) would terminate authority for existing and future state ACA presumptive eligibility elections as of January 1, 2018
42 U.S.C. Section 1396r-1(e)	Medicaid Presumptive Eligibility for Pregnant Women and Children	No provision	Section 207(6) would repeal the state option to provide a presumptive eligibility period any time after December 31, 2017 for pregnant women and children in: (1) the ACA expansion group, (2) the mandatory foster care group through age 26, or (3) for low-income families
42 U.S.C. Section 1396w-3(a)	Streamlined Enrollment System for Medicaid	No provision	Section 207(8) would repeal the requirement for states to coordinate their eligibility and enrollment systems across all of the ACA low-income subsidy programs as of January 1, 2018
42 U.S.C. Section 1396u-7(b)(5)	Medicaid Benchmark Coverage	No provision	Section 207(7) would repeal the ACA amendments to benchmark coverage after December 31, 2017
42 U.S.C. Section 1396r-4(f)	Medicaid DSH Reductions	No provision	Section 208 would repeal Medicaid disproportionate share hospital allotment reductions

Source: H.R. 3762; S. Amdt. 2874.

Notes: ACA = Patient Protection and Affordable Care Act (P.L. 111-148, as amended); U.S.C. = United States Code; FSA = flexible spending account; HRA = health reimbursement arrangement; MSA = medical savings account; HSA = health savings account; FPL = federal poverty level; FMAP = federal medical assistance percentage; DSH = disproportionate share hospital; CHIP = State Children's Health Insurance Program.

Summary of Provisions in the Senate Amendment to H.R. 3762

Title I—Health, Education, Labor, and Pensions

Section 101: The Prevention and Public Health Fund

Background

ACA Section 4002 established the Prevention and Public Health Fund (PPHF), to be administered by the Secretary of the Department of Health and Human Services (HHS), and provided the PPHF with a permanent annual appropriation.[6] Under the ACA, the PPHF's annual appropriation would increase from $500 million for FY2010 to $2 billion for FY2015 and each subsequent fiscal year. However, the Middle Class Tax Relief and Job Creation Act of 2012 (P.L. 112-96) reduced the PPHF appropriation from FY2013 through FY2021 as part of a package of offsets. Annual appropriations to the PPHF are now as follows:[7]

- $500 million for FY2010;
- $1 billion for each of FY2012 through FY2017;
- $1.25 billion for each of FY2018 and FY2019;
- $1.5 billion for each of FY2020 and FY2021; and
- $2 billion for FY2022 and each fiscal year thereafter.

Amounts for each fiscal year are available to the HHS Secretary beginning October 1, the start of the respective fiscal year. Congress may explicitly direct the distribution of PPHF funds and did so for FY2014 and FY2015.

Provision

Section 101 of the Senate bill would amend ACA Section 4002(b) by repealing all PPHF appropriations for FY2016 and subsequent fiscal years. It also would rescind any unobligated PPHF balances from prior fiscal years.

Section 102: Community Health Center Program

Background

Section 221(a) of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA; P.L. 114-10)[8] provided a mandatory appropriation of $3.6 billion to the Community Health Center Fund[9] for each of FY2016 and FY2017.

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[6] For more information on the Prevention and Public Health Fund, see Appendix C in CRS Report R43304, *Public Health Service Agencies: Overview and Funding (FY2010-FY2016)*, coordinated by C. Stephen Redhead and Agata Dabrowska.

[7] As provided in the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) §4002(b), as amended (42 U.S.C. §300u–11(b)).

[8] CRS Report R43962, *The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA; P.L. 114-10)*, (continued...)

Provision

Section 102 of the Senate bill would provide an additional $235 million for each of FY2016 and FY2017 to the Community Health Center Fund. It would do so by adding $235 million to the mandatory appropriation provided in Section 221(a) of MACRA.

Section 103: Territories

Background

Under the ACA, a U.S. territory may elect to establish a health insurance exchange but is not required to do so. ACA Section 1323(c) provides funding to territories that establish exchanges; the funds provided under an agreement between a territory and HHS can be used only for financial assistance for individuals who obtain health insurance through an exchange. Section 1323(c) provides $1 billion to be available for this purpose beginning in 2014 and ending in 2019. The HHS Secretary is directed to allocate $925 million to Puerto Rico and divide the remaining $75 million among American Samoa, Guam, the Northern Mariana Islands, and the Virgin Islands. If a territory does not establish an exchange, the territory is entitled to an increase in Medicaid funds.

Provision

Section 104 of the Senate bill would provide that ACA Section 1323(c), which provides funding for territories, shall have no "force or effect," as of January 1, 2018.

Section 104: Reinsurance, Risk Corridor, and Risk Adjustment Programs

Background

ACA Section 1341 requires the HHS Secretary to determine standards enabling states to establish and maintain a reinsurance program. Under the program, certain health insurers are required to make payments into the reinsurance program; those payments are then used to compensate a subset of health insurers for a portion of the cost of high-risk (i.e., high-cost) individuals who enrolled in their plan. The program runs for the three-year period beginning January 1, 2014. The HHS Secretary is required to determine both the methodology for calculating contributions to the reinsurance program and a method for equitable allocation of funds, although the total amount of funds to be collected is specified in statute.

Provision

Section 105 of the Senate bill would prohibit the HHS Secretary from collecting fees and making payments under ACA Section 1341, the reinsurance program, effective January 1, 2016.

(...continued)

coordinated by Jim Hahn and Kirstin B. Blom.

[9] For more information about the Community Health Center Fund, see CRS Report R43911, *The Community Health Center Fund: In Brief*, by Elayne J. Heisler.

Section 105: Support for State Response to Substance Abuse Public Health Crisis and Urgent Mental Health Needs

Background

The Substance Abuse and Mental Health Services Administration (SAMHSA) supports community-based substance abuse and mental health treatment and prevention services through formula grants to the states and U.S. territories and through competitive grant programs to states, territories, tribal organizations, local communities, and private entities.[10] SAMHSA and most of its programs and activities are authorized under Public Health Service Act (PHSA) Title V; its two largest grant programs, the Substance Abuse Prevention and Treatment block grant and the Community Mental Health Services block grant, are authorized under PHSA Title XIX. PHSA Section 399O requires the HHS Secretary to award formula grants to states to support state prescription drug monitoring programs (PDMPs);[11] appropriations were authorized through FY2010, and the grant program has not received funding since then. Other agencies within HHS also support substance abuse or mental health prevention and treatment under more general authorities.

Provision

Section 105 of the Senate bill would authorize to be appropriated, and would appropriate, out of monies in the Treasury not otherwise obligated, $750 million for each of FY2016 and FY2017, to the HHS Secretary to award grants to states to address the substance abuse public health crisis or respond to urgent mental health needs by (1) improving state prescription drug monitoring programs, (2) implementing and evaluating substance abuse prevention activities, (3) training health care practitioners in topics related to substance abuse, (4) supporting access to substance abuse or mental health services, and/or (5) other public health-related activities related to substance abuse or mental health.

Title II—Finance

Section 201: Recapture Excess Advance Payments of Premium Tax Credits

Background

Internal Revenue Code (IRC) Section 36B and related amendments, as added by Section 1401 of the ACA, authorize new federal tax credits to help eligible individuals pay for health insurance.[12] The tax credits apply toward premiums for private health plans offered through exchanges. Under the ACA, the amount received in premium tax credits is based on the prior year's income tax returns. Section 1412 of the ACA requires the credit to be both refundable and advanceable, meaning tax filers may claim the full credit amount even if they have little or no federal income tax liability, and may receive the credits in "advance" (during the tax year) by direct payment to

[10] For more information about the Substance Abuse and Mental Health Services Administration, see CRS Report R43968, *SAMHSA FY2016 Budget Request and Funding History: A Fact Sheet*, by Erin Bagalman.

[11] For more information about prescription drug monitoring programs, see CRS Report R42593, *Prescription Drug Monitoring Programs*, by Kristin Finklea, Lisa N. Sacco, and Erin Bagalman.

[12] For more information about the premium credits, see CRS Report R43945, *Health Insurance Premium Credits in the Patient Protection and Affordable Care Act (ACA) in 2015*, by Bernadette Fernandez.

insurers to coincide with monthly insurance premiums. These amounts are reconciled when individuals file tax returns for the actual year in which they receive the credits. If a tax filing unit's income decreases during the tax year, and the filer should have received a larger credit, this additional credit amount will be included in the tax refund for the year. On the other hand, any excess amount that was overpaid in credits will have to be repaid to the federal government as a tax payment. The ACA imposes limits on the excess amounts to be repaid under certain conditions. For households with incomes below 400% of the federal poverty level (FPL), the ACA includes specific limits that apply to single and joint filers separately.

Provision

Section 201 of the Senate bill would *not* apply IRC Section 36B(f)(2)(B), relating to limits on the excess amounts to be repaid with respect to the premium tax credits, to taxable years ending after December 31, 2015 and before January 1, 2018. In other words, for tax years 2016 and 2017, any individual who was overpaid in premium tax credits would have to repay the entire excess amount, regardless of income.

Section 202: Premium Tax Credit and Cost-Sharing Subsidies

Background

As noted, IRC Section 36B and related amendments, as added by Section 1401 of the ACA, authorize new federal premium tax credits. According to Section 1411 of the ACA, the premium tax credit generally is available to those who do not have access to subsidized public coverage (e.g., Medicaid) or employer-sponsored coverage that meets certain standards. Eligibility for and amount of the credit are based on household income. The credit is designed to provide larger amounts to eligible individuals with lower incomes compared to eligible individuals with higher incomes. Section 1412 of the ACA requires the credit to be both refundable and advanceable, meaning tax filers may claim the full credit amount even if they have little or no federal income tax liability and may receive the credits in "advance" (during the tax year) by direct payment to insurers to coincide with monthly insurance premiums. Section 1414 of the ACA authorizes the disclosure of taxpayer information by amending IRC Section 6103(l).

Section 1402 of the ACA also authorizes subsidies to reduce cost-sharing expenses (e.g., annual out-of-pocket, or OOP, limit) for eligible individuals.[13] Cost-sharing assistance is provided in two forms. The first form of assistance reduces the OOP limit applicable to a given exchange plan; the second reduces actual cost-sharing requirements (e.g., lowers the deductible or reduces a co-payment) applicable to a given exchange plan. Both subsidy types provide greater subsidy amounts to individuals with lower household incomes.

Provision

Section 202 of the Senate bill would repeal authorization for the premium tax credits (IRC Section 36B), effective beginning tax year 2018, and for the cost-sharing subsidies (ACA Section 1402), effective on December 31, 2017. This provision also would repeal relevant ACA provisions regarding eligibility determinations for these programs (generally ACA Section 1411) and for receiving premium credits and cost-sharing subsidies in advance (ACA Section 1412),

[13] For more information about the cost-sharing subsidies, see CRS Report R43945, *Health Insurance Premium Credits in the Patient Protection and Affordable Care Act (ACA) in 2015*, by Bernadette Fernandez.

effective on December 31, 2017. In addition, the new provision would amend IRC Section 6103(l), related to the disclosure of taxpayer information, by providing that no disclosures may be made after December 31, 2017.

Section 203: Small Business Tax Credit

Background

IRC Section 45R, as added by Section 1421 of the ACA, provides for a small business health insurance tax credit.[14] The credit is intended to help make the premiums for small-group health insurance coverage more affordable for certain small employers. The credit generally is available to nonprofit and for-profit employers with fewer than 25 full-time equivalent (FTE) employees with average annual wages that fall under a statutorily specified cap. To qualify for the credit, employers must cover at least 50% of the cost of each of their employees' self-only health insurance coverage.

As of 2014, small employers must obtain insurance through a Small Business Health Options Program (SHOP) exchange to receive the credit, and the credit is available for two consecutive tax years only. The two-year period begins with the first year an employer obtains coverage through a SHOP exchange. For example, if an employer first obtains coverage through a SHOP exchange in 2016, the credit will only be available to the employer in 2016 and in 2017.

Provision

Section 203 of the Senate bill would provide that IRC Section 45R, the small business health insurance tax credit, would not be available beginning tax year 2018.

Section 204: Individual Mandate

Background

IRC Section 5000A, as added by Section 1501 of the ACA, creates an individual mandate, a requirement for most individuals to maintain health insurance coverage or pay a penalty for noncompliance.[15] To comply with the mandate, most individuals need to obtain *minimum essential coverage*, which includes most types of private (e.g., employer-sponsored) coverage and public coverage (e.g., Medicare and Medicaid). Certain individuals are exempt from the mandate and its associated penalty.

The individual mandate went into effect in 2014. Individuals who are not exempt from the mandate are required to pay a penalty for each month of noncompliance. The annual penalty is the *greater* of a percentage of income or a flat dollar amount (but not more than the national average premium of a specified health plan). The percentage of income increases from 1.0% in 2014 to 2.5% in 2016 and beyond. The flat dollar amount increases from $95 in 2014 to $695 in 2016 and is adjusted for inflation thereafter.

[14]For more information, see CRS Report R41158, *Summary of the Small Business Health Insurance Tax Credit Under ACA*, by Annie L. Mach.

[15]For more information, see CRS Report R41331, *Individual Mandate Under the ACA*, by Annie L. Mach.

Provision

Section 204 of the Senate bill would effectively eliminate the annual penalty associated with IRC Section 5000A, the individual mandate, by reducing the percentage of income to 0% and the flat dollar amount to $0, retroactively beginning calendar year 2015.

Section 205: Employer Mandate

Background

IRC Section 4980H, as added by Section 1513 of the ACA, requires that employers either provide health coverage or face potential employer tax penalties.[16] The potential employer penalty applies to all common-law employers, including government entities (such as federal, state, local, or Indian tribal government entities) and nonprofit organizations that are exempt from federal income taxes. The penalties are imposed on firms with at least 50 full-time equivalent (FTE) employees if one or more of their full-time employees obtain a premium tax credit through a health insurance exchange. Transition relief in 2015 limits the penalty to employers with at least 100 FTE employees.

The total penalty for any applicable large employer is based on its number of full-time employees (averaging 30 hours or more per week) and whether the employer offers affordable health coverage that provides minimum value.

Provision

Section 205 of the Senate bill would modify the tax penalty associated with IRC Section 4980H, effectively eliminating it by reducing the penalties to $0 beginning in calendar year 2015.

Section 206: Federal Payments to States

Background

The PPFA is an umbrella organization supporting 59 independent affiliates that operate approximately 700 health centers across the United States. Government funding—which includes federal, state, and local funds—constitutes the PPFA's largest source of revenue, an estimated 41% in the year ending June 30, 2014.[17] CBO estimates that federal funds accounted for about one-third of PPFA's total revenue in 2013.[18] PPFA receives federal grants (either directly or through another entity, such as a state) and reimbursements for providing services to beneficiaries enrolled in federally-funded programs (e.g., Medicaid). It does not receive a direct annual appropriation of any kind.

CBO and the U.S. Government Accountability Office (GAO) found that PPFA's largest source of federal funding is reimbursements for covered services provided to Medicaid beneficiaries.

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[16]For more information, see CRS Report R43981, *The Affordable Care Act's (ACA) Employer Shared Responsibility Determination and the Potential ACA Employer Penalty*, by Julie M. Whittaker.

[17] For more information about the Planned Parenthood Federation of America and the services it provides, see CRS Report R44295, *Factors Related to the Use of Planned Parenthood Affiliated Health Centers (PPAHCs) and Federally Qualified Health Centers (FQHCs)*, by Elayne J. Heisler.

[18]Letter from Congressional Budget Office to Senator Mike Enzi, Chairman of the Committee on the Budget, August 3, 2015, at https://www.cbo.gov/publication/50700.

Specifically, CBO estimated that PPFA's federal Medicaid revenue was approximately $390 million in 2013. [19] GAO examined FY2012 PPFA reimbursements and expenditures and found that PPFA had either received reimbursements or expended funds from discretionary programs and from direct spending (as defined in the Balanced Budget and Emergency Deficit Control Act of 1985, 2 U.S.C. 900(c)(8)). Direct spending refers to budget authority provided by laws other than through appropriations acts; entitlement authority; and the Supplemental Nutrition Assistance Program (SNAP).[20] PPFA's reimbursements or expenditures from direct spending include reimbursements from Medicaid, Medicare, and the State Children's Health Insurance Program (CHIP) (listed in order of the amount of reimbursements received according to GAO); certain expenditures from the Social Service Block Grant, the Crime Victims Assistance Program (administered by the Department of Justice), the Personal Responsibility and Education Program, and SNAP (administered by the Department of Agriculture). PPFA also received funds from a number of discretionary programs either directly or through another entity (e.g., a state). For example, in FY2012, GAO found that PPFA had expended discretionary funds from the Maternal and Child Health Block Grants programs, which are provided to states and some states provided funds to PPFA entities to provide services.[21]

Under federal law, federal funds are generally not available to pay for abortions, except in cases of rape, incest, or endangerment of a mother's life. This restriction is the result of statutory and legislative provisions like the Hyde Amendment,[22] which has been added to the annual HHS appropriations measure since 1976. Similar provisions exist in the appropriations measures for foreign operations, the District of Columbia, the Department of the Treasury, and the Department of Justice. Other codified restrictions limit the use of funds made available to the Department of Defense and the Indian Health Service.

Provision

Section 206 of the Senate bill would prohibit federal funds made available to a state through direct spending from being provided to a prohibited entity (as defined), either directly or through a managed care organization, for a one year period beginning on the date of enactment of this act. The provision specifies that this prohibition would be implemented notwithstanding certain programmatic rules (e.g., the Medicaid freedom of choice of provider requirement).

This provision does not explicitly specify that certain federal funds would not be made available to PPFA or its affiliated entities; instead it refers to and defines a "prohibited entity," as an entity that meets the following criteria at enactment: (1) it is designated as a not-for-profit by the Internal Revenue Service (IRS); (2) it is described as an essential community provider that is

[19] Government Accountability Office (GAO), *Health Care Funding: Federal Obligations to and Expenditures by Selected Entities Involved in Health-Related Activities*, 2010–2012, GAO-15-270R, March 20, 2015, http://www.gao.gov/products/GAO-15-270R. GAO does not provide a grand total for federal funding to PPFA affiliates in FY2012; however, for specific federal funding sources see report Tables 15, 16, 24, 25, and 26 and Congressional Budget Office (CBO), *Budgetary Effects of Legislation that Would Permanently Prohibit the Availability of Federal Funds to Planned Parenthood*, September 22, 2015; https://www.cbo.gov/publication/50833.

[20] Direct spending is explained in CRS Report 98-721, *Introduction to the Federal Budget Process*, coordinated by James V. Saturno.

[21] GAO, *Health Care Funding: Federal Obligations to and Expenditures by Selected Entities Involved in Health-Related Activities*, 2010–2012, GAO-15-270R, March 20, 2015, http://www.gao.gov/products/GAO-15-270R. GAO does not provide a grand total for federal funding to PPFA affiliates in FY2012; however, for specific federal funding sources see report Tables 15, 16, 24, 25, and 26.

[22] For information about the Hyde Amendment and similar provisions, see CRS Report RL33467, *Abortion: Judicial History and Legislative Response*, by Jon O. Shimabukuro.

primarily engaged in family planning services, reproductive health, and related medical care; (3) it is an abortion provider that provides abortion in cases that do not meet the Hyde amendment exception for federal payment; and (4) it received more than $350 million in Medicaid expenditures (both federal and state) in FY2014. When evaluating nearly identical language included in H.R. 3762, CBO determined that the prohibited entity would likely be PPFA because few other health care providers would meet the bill's definition.[23]

Section 207(1): Medicaid Funding for Territories

Background

Federal Medicaid funding to the states and the District of Columbia is open-ended, but the Medicaid programs in the territories are subject to annual federal spending caps (i.e., allotments). In FY2015, the Medicaid allotments to the territories totaled $378.3 million. Prior to the ACA, all five territories typically exhausted their federal Medicaid funding prior to the end of the fiscal year. For this reason, the ACA provides $6.3 billion in additional Medicaid federal funding to the territories available between July 1, 2011, and September 30, 2019. This funding is distributed among the territories in proportion to the capped amounts available to the territories prior to the ACA. The territories claimed $2.4 billion of this funding from July 1, 2011, through September 30, 2014.

Provision

Section 207(1) of the Senate bill would make the $6.3 billion in Medicaid funding to the territories available through September 30, 2017, rather than September 30, 2019, by amending Section 1108(g)(5) of the SSA.

Section 207(2)(A), 207(2)(C), and 207(3): Medicaid ACA Eligibility Provisions

Background

Eligibility for Medicaid is determined by federal and state law, whereby states set individual eligibility criteria within federal standards. Individuals must meet both categorical (e.g., elderly, individuals with disabilities, children, pregnant women, parents, certain non-elderly childless adults) and financial (i.e., income and sometimes assets limits) criteria. In addition, individuals must meet federal and state requirements regarding residency, immigration status, and documentation of U.S. citizenship. Some eligibility groups are mandatory, meaning all states with a Medicaid program must cover them; others are optional. States are permitted to apply to the Centers for Medicare & Medicaid Services (CMS) for a waiver of federal law to expand health coverage beyond the mandatory and optional groups listed in federal statute.[24]

The ACA makes several changes to Medicaid eligibility, including the following:

The ACA Medicaid Expansion. The ACA established 133% of FPL as the new mandatory minimum Medicaid income-eligibility level for most non-elderly individuals beginning January 1, 2014. On June 28, 2012, the U.S. Supreme Court issued its decision in *National Federation of*

[23] Congressional Budget Office and Joint Committee on Taxation, H.R. 3762 *Restoring Americans' Healthcare Freedom Reconciliation Act of 2015*, October 20, 2015, at https://www.cbo.gov/publication/50918.

[24] For more information about Medicaid eligibility, see CRS Report R43357, *Medicaid: An Overview*, coordinated by Alison Mitchell.

Independent Business v. Sebelius, finding that the enforcement mechanism for the ACA Medicaid expansion violated the Constitution, which effectively made the ACA Medicaid expansion optional for states. On January 1, 2014, 24 states and the District of Columbia implemented the ACA Medicaid expansion. Since then, six additional states have decided to implement the expansion.[25]

State Option for Coverage for Individuals with Income that Exceeds 133% of FPL. In addition to the ACA Medicaid expansion, the ACA creates an optional Medicaid eligibility category for all non-elderly individuals with income above 133% of FPL up to a maximum level specified in the Medicaid state plan (or waiver). No state has implemented this option.

Stairstep Children. The ACA changes the mandatory Medicaid income eligibility level for poverty-related children aged 6 through 18 from 100% to 133% of FPL, beginning January 1, 2014. These children are sometimes referred to as *stairstep* children. For the 21 states that transitioned these children from CHIP to Medicaid due to this ACA provision, coverage continues to be financed with states' CHIP annual allotment funding (i.e., state-specific annual limits) at the higher enhanced federal medical assistance percentage (E-FMAP), which is the CHIP federal matching rate.[26]

Medicaid and CHIP MOE. The ACA extends and expands the maintenance of effort (MOE) provisions in the American Recovery and Reinvestment Act of 2009 (ARRA; P.L. 111-5). Under the ACA MOE provisions, states are required to maintain their Medicaid and CHIP programs with the same eligibility standards, methodologies, and procedures in place on the date of enactment of the ACA (March 23, 2010) until January 1, 2014, for adults and through September 30, 2019, for children up to the age of 19. The penalty to states for not complying with the Medicaid and CHIP MOE requirements is the loss of all federal Medicaid matching funds.[27]

Provisions

The provisions in Sections 207(2)(A) and 207(2)(C) of the Senate bill would repeal the ACA Medicaid expansion and state option to extend coverage to adults above 133% of FPL (Section 1902(a)(10)(A)(i)(VIII) and Section 1902(a)(10)(A)(ii)(XX) of the SSA respectively) and the stairstep children provision (Section 1902(l)(2)(C)) of the SSA) by specifying the end dates of these provisions as December 31, 2017. Section 207(3) of the Senate bill would repeal the Medicaid and CHIP MOE for children by changing the end date of this provision to September 30, 2017, instead of September 30, 2019, in Sections 1902(gg)(2) and 2105(d)(3)(A) of the SSA.

Section 207(4) and 207(5): Various Federal Medicaid Matching Rate Provisions

Background

Medicaid is jointly financed by the federal government and the states. The federal government's share of a state's expenditures for most Medicaid services is called the federal medical assistance

[25] For more information about the ACA Medicaid expansion, see CRS Report R43564, *The ACA Medicaid Expansion*, by Alison Mitchell.

[26] For more information about stairstep children, see CRS Report R43627, *State Children's Health Insurance Program: An Overview*, by Evelyne P. Baumrucker and Alison Mitchell.

[27] For more information about the ACA Medicaid and CHIP Maintenance of Effort (MOE) for children, see CRS Report R43909, *CHIP and the ACA Maintenance of Effort (MOE) Requirement: In Brief*, by Alison Mitchell and Evelyne P. Baumrucker.

percentage (FMAP) rate, which varies by state and is designed so that the federal government pays a larger portion of Medicaid costs in states with lower per capita incomes relative to the national average (and vice versa for states with higher per capita incomes). Exceptions to the regular FMAP rate have been made for certain states, situations, populations, providers, and services.[28] The ACA adds a few FMAP exceptions, including the following:

- the *newly eligible* federal matching rate (i.e., the matching rate for individuals who are newly eligible for Medicaid due to the ACA expansion);
- the *expansion state* federal matching rate (i.e., the matching rate for individuals in expansion states[29] who were eligible for Medicaid on March 23, 2010, and are in the new eligibility group); and
- a six-percentage-point increase to the FMAP rate for services covered under the Community First Choice Option, which allows states to offer community-based attendant services and supports as an optional Medicaid state plan benefit.

In addition, the ACA increases the Medicaid FMAP rate available to all of the territories from 50% to 55% beginning July 1, 2011.

Provision

Sections 207(4) and 207(5) of the Senate bill would repeal the (1) newly eligible matching rate on January 1, 2018 (Section 1905(y)(1) of the SSA); (2) expansion state matching rate on January 1, 2018 (Section 1905(z)(2) of the SSA); and (3) increased FMAP rate for the Community First Choice Option on January 1, 2018 (Section 1915(k)(2) of the SSA). Sections 207(4) of the Senate bill also would change the FMAP rate for the territories back to 50% on or after January 1, 2018 (Section 1905(b) of the SSA).

Section 207(2)(B), 207(6), and 207(8): Medicaid ACA Enrollment Facilitation Provisions

Background

Presumptive Eligibility. Prior to the enactment of the ACA, states were permitted to enroll certain groups (i.e., children, pregnant women, and certain women with breast and cervical cancer) for a limited period of time before completed Medicaid applications were filed and processed, based on a preliminary determination of likely Medicaid eligibility by certain specified Medicaid providers. Such individuals then had to formally apply for coverage within a given time frame to continue receiving Medicaid benefits.

The ACA expands the types of entities that are permitted to make Medicaid presumptive-eligibility determinations as well as the groups of individuals for whom presumptive-eligibility determinations may apply. Specifically, the ACA allows states to permit all hospitals that

[28] For more information about the FMAP rate, see CRS Report R43847, *Medicaid's Federal Medical Assistance Percentage (FMAP), FY2016*, by Alison Mitchell.

[29] This definition of expansion state was established prior to the Supreme Court decision making ACA Medicaid expansion optional for states. In this context, *expansion state* refers to states that already had implemented (or partially implemented) the ACA Medicaid expansion at the time the ACA was enacted. Specifically, expansion states are defined as those that, as of March 23, 2010 (the ACA's date of enactment), had provided health benefits coverage meeting certain criteria statewide to parents with dependent children and adults without dependent children up to at least 100% of FPL.

participate in Medicaid to make presumptive-eligibility determinations for all Medicaid-eligible populations, beginning January 1, 2014.

In addition, states that elected the option to provide a presumptive-eligibility period to children and pregnant women are permitted to provide a presumptive-eligibility period for (1) the ACA Medicaid expansion group, (2) the mandatory foster care coverage group through the age of 26, or (3) low-income families eligible under Section 1931 of the SSA.

Streamlined Enrollment System. As a condition of the receipt of federal financial assistance, the ACA requires states to coordinate their eligibility and enrollment systems across all of the ACA low-income subsidy programs (including Medicaid, CHIP, and the health insurance exchanges).

Provision

Presumptive Eligibility. Sections 207(2)(B) and 207(6) of the Senate bill would terminate existing state ACA presumptive-eligibility elections as of January 1, 2018, and would prohibit states from making such elections going forward by modifying Section 1902(a)(47)(B) of the SSA. However, states still would be permitted to enroll children, pregnant women, and certain women with breast and cervical cancer based on a preliminary determination by a specified Medicaid provider of likely Medicaid eligibility.

For states that elected the option to provide a presumptive-eligibility period to children and pregnant women, these provisions would repeal the state option to provide a presumptive-eligibility period any time after December 31, 2017, for (1) the ACA expansion group, (2) the mandatory foster care group through the age of 26, or (3) low-income families (Section 1920(e) of the SSA).

Streamlined Enrollment System. Section 207(8) of the Senate bill would repeal the requirement for states to coordinate their eligibility and enrollment systems across all of the ACA low-income subsidy programs as of January 1, 2018 (Section 1943(a) of the SSA).

Section 207(7): Amendments to Medicaid Benchmark Coverage

Background

As an alternative to providing all the mandatory and selected optional benefits under traditional Medicaid, the Deficit Reduction Act of 2005 (DRA; P.L. 109-171) gives states the option to enroll state-specified groups in what previously was referred to as benchmark or benchmark-equivalent coverage but currently is called *alternative benefit plans* (ABPs). States that choose to implement the ACA Medicaid expansion are required to provide ABP coverage to the individuals eligible for Medicaid through the ACA Medicaid expansion (with exceptions for selected special-needs subgroups). In addition, states have the option to provide ABP coverage to other subgroups.

The ACA makes significant changes to both ABP design and requirements. The ACA requires such packages provide at least the 10 essential health benefits, which are (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. In addition, the ACA adds prescription drugs and mental health services to the list of basic services that must be covered under ABPs.[30]

Provision

Under Section 207(7) of the Senate bill, the ACA amendments to benchmark coverage would not apply after December 31, 2017 (Section 1937(b)(5) of the SSA).

Section 208: Repeal of Medicaid Disproportionate Share Hospital Allotment Reductions

Background

The Medicaid statute requires states to make disproportionate share hospital (DSH) payments to hospitals treating large numbers of low-income patients. The federal government provides each state an annual DSH allotment, which is the maximum amount of federal matching funds that each state can claim for Medicaid DSH payments. The ACA included a provision directing the HHS Secretary to make aggregate reductions in Medicaid DSH allotments for FY2014 through FY2020, but multiple subsequent laws have amended these reductions. Under current law, the aggregate reductions to the Medicaid DSH allotments are to impact FY2018 through FY2025. After FY2025, allotments will be calculated as though the reductions never occurred, which means the allotments will include the inflation adjustments for the years during the reductions.[31]

Provision

Section 208 of the Senate bill would repeal the Medicaid DSH allotment reductions.

Section 209: Repeal of the Tax on Employee Health Insurance Premiums and Health Plan Benefits

Background

Section 9001 of the ACA creates a new excise tax on high-cost employer-sponsored coverage (the so-called *Cadillac tax*).[32] The provision is codified at IRC Section 4980I. The tax is scheduled to take effect in 2018. It will be imposed at a 40% rate on the aggregate cost of employer-sponsored health coverage that exceeds a specified dollar limit.

Provision

Section 209 of the Senate bill would repeal IRC Section 4980I; the repeal would be effective taxable years beginning after December 31, 2017.

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[30] For more information on Medicaid benefit coverage, see CRS Report R43357, *Medicaid: An Overview*, coordinated by Alison Mitchell.

[31] For more information about Medicaid DSH allotment reductions, see CRS Report R42865, *Medicaid Disproportionate Share Hospital Payments*, by Alison Mitchell.

[32] For more information, see CRS Report R44147, *Excise Tax on High-Cost Employer-Sponsored Health Coverage: In Brief*, by Annie L. Mach.

Section 210: Repeal of Tax on Over-the-Counter Medications

Background

Under the IRC, taxpayers may use several different types of tax-advantaged health accounts to pay or be reimbursed for qualified medical expenses: health flexible spending accounts (health FSAs), health reimbursement accounts (HRAs), Archer medical savings accounts (Archer MSAs), and health savings accounts (HSAs).[33] Section 9003 of the ACA amends the relevant IRC provisions (IRC Sections 106, 220, and 223) to provide that, for each of these accounts, amounts paid for medicine or drugs are qualified expenses only in the case of prescribed drugs and insulin.

Provision

Section 210 of the Senate bill would repeal the language in IRC Sections 106, 220, and 223 stipulating that a medicine or drug must be a prescribed drug or insulin to be considered a qualified expense in terms of spending from a tax-advantaged health account. The provision would be generally effective beginning tax year 2016.

Section 211: Repeal of Tax on Health Savings Accounts

Background

Section 9004 of the ACA imposes a 20% tax on distributions from Archer MSAs and HSAs that are used for purposes other than paying for qualified medical expenses. Prior to the ACA, IRC Section 220 applied a 15% rate on such distributions if made from an Archer MSA and IRC Section 223 applied a 10% rate on such distributions if made from an HSA.

Provision

Section 211 of the Senate bill would amend IRC Sections 220 and 223 to reduce the applicable rate to 15% and 10% for Archer MSAs and HSAs, respectively. The lower rates would apply to distributions made after December 31, 2015.

Section 212: Repeal of Limitations on Contributions to Flexible Spending Accounts

Background

IRC Section 125 allows employers to establish *cafeteria plans*, benefit plans under which employees may choose between receiving cash (typically additional take-home pay) and certain normally nontaxable benefits (such as employer-paid health insurance) without being taxed on the value of the benefits if they select the latter. (A general rule of taxation is that when given a choice between taxable and nontaxable benefits, taxpayers will be taxed on whichever they choose because they are deemed to be in constructive receipt of the cash.)

Section 9005 of the ACA amends IRC Section 125(i) to provide that a health FSA is not treated as a qualified benefit unless the cafeteria plan provides that an employee may not elect for any taxable year to have a salary reduction contribution in excess of $2,500 made to such

[33] For more information about these accounts, see CRS Report RS21573, *Tax-Advantaged Accounts for Health Care Expenses: Side-by-Side Comparison, 2013*, by Carol Rapaport.

arrangement. Also, the $2,500 limit is indexed for cost-of-living adjustments for plan years beginning after December 31, 2013.

Provision

Section 212 of the Senate bill would repeal IRC Section 125(i), the $2,500 contribution limit to health FSAs, effective beginning tax year 2016.

Section 213: Repeal of Tax on Prescription Medications

Background

Section 9008 of the ACA imposes an annual fee on covered entities engaged in the business of manufacturing or importing branded prescription drugs. In general, the fee is imposed on covered manufacturers and importers with aggregated branded prescription drug sales of more than $5 million to specified government programs or pursuant to coverage under these programs.

Provision

Section 213 of the Senate bill would repeal the fee imposed under ACA Section 9008, effective beginning calendar year 2016.

Section 214: Repeal of Medical Device Excise Tax

Background

Section 1405 of the Health Care and Education Reconciliation Act of 2010 (HCERA; P.L. 111-152) creates a new excise tax that is imposed on the sale of certain medical devices.[34] The tax is equal to 2.3% of the device's sales price and generally is imposed on the manufacturer or importer of the device. The tax is codified in Subchapter E of IRC Chapter 32.

Provision

Section 214 of the Senate bill would repeal the medical device excise tax (Subchapter E of IRC Chapter 32), effective for sales in calendar quarters beginning after December 31, 2015.

Section 215: Repeal of Health Insurance Tax

Background

Section 9010 of the ACA imposes an annual fee on certain health insurers beginning in 2014. The ACA fee is based on net health care premiums written by covered issuers during the year prior to the year that payment is due. The aggregate ACA fee is set at $8.0 billion in 2014, $11.3 billion in 2015-2016, $13.9 billion in 2017, and $14.3 billion in 2018. After 2018, the fee is indexed to the annual rate of U.S. premium growth. Each year, the IRS apportions the fee among affected insurers based on (1) their net premiums written in the previous calendar year as a share of total

[34] For more information about the medical device tax, see CRS Report R43342, *The Medical Device Excise Tax: Economic Analysis*, by Jane G. Gravelle and Sean Lowry, and CRS Report R42971, *The Medical Device Excise Tax: A Legal Overview*, by Andrew Nolan.

net premiums written by all covered insurers and (2) their dollar value of business. Covered insurers are not subject to the fee on their first $25 million of net premiums written. The fee is imposed on 50% of net premiums above $25 million and up to $50 million, and it is imposed on 100% of net premiums in excess of $50 million.

Certain types of health insurers or insurance arrangements are not subject to the fee, including self-insured plans; voluntary employees' beneficiary associations; and federal, state, or other governmental entities, including Indian tribal governments and nonprofit entities incorporated under state law that receive more than 80% of their gross revenues from government programs that target low-income, elderly, or disabled populations. In addition, only 50% of net premiums written by tax-exempt entities are included in determining an entity's market share.

Section 9010(j) of the ACA made these provisions effective for calendar years beginning after December 31, 2013.

Provision

Section 215 of the Senate bill would amend ACA Section 9010(j) to repeal the annual fee on certain health insurance providers, effective beginning calendar year 2016.

Section 216: Repeal of Elimination of Deduction for Expenses Allocable to Medicare Part D Subsidy

Background

Employers that provide Medicare-eligible retirees with prescription drug coverage that meets or exceeds set federal standards are eligible for federal subsidy payments. The subsidies are equal to 28% of plans' actual spending for prescription drug costs in excess of $360 and not to exceed $7,400 (for 2015). The subsidies were created as part of the Medicare Part D prescription drug program (Medicare Modernization Act of 2003; P.L. 108-173) to provide employers with an incentive to maintain drug coverage for their retirees.

Employers are allowed to exclude qualified retiree prescription drug plan subsidies from gross income for the purposes of corporate income tax. Prior to implementation of the ACA, employers also were allowed to claim a business deduction for their qualified retiree prescription drug expenses, even though they also received the federal subsidy to cover a portion of those expenses. Section 9012 of the ACA amended IRC Section 139A, beginning in 2013, to require employers to coordinate the subsidy and the deduction for retiree prescription drug coverage. The amount allowable as a deduction for retiree prescription drug coverage is reduced by the amount of the federal subsidy received.

Provision

Section 216 of the Senate bill would repeal the ACA change and reinstate business-expense deductions for retiree prescription drug costs without reduction by the amount of any federal subsidy. The change would be effective for taxable years beginning after December 31, 2015.

Section 217: Repeal of Chronic Care Tax

Background

Under IRC Section 213, taxpayers who itemize their deductions may deduct qualifying medical expenses. The medical-expense deduction may be claimed only for expenses that exceed 10% of the taxpayer's adjusted gross income (AGI), which is reduced for taxable years ending before January 1, 2017, to 7.5% if the taxpayer or spouse is aged 65 or older. The 10% threshold was imposed by ACA Section 9013. Prior to the ACA, the AGI threshold was 7.5% for all taxpayers.

Provision

Section 217 of the Senate bill would amend IRC Section 213(a) to reduce the AGI threshold to 7.5% for all taxpayers, effective beginning tax year 2016.

Section 218: Repeal of Medicare Tax Increase

Background

Sections 9015 and 10906 of the ACA impose a Medicare Hospital Insurance (HI) surtax at a rate equal to 0.9% of an employee's wages or a self-employed individual's self-employment income. The surtax, which is found in IRC Sections 1401 and 3101, applies only to taxpayers with taxable income in excess of $250,000 if married filing jointly; $125,000 if married filing separately; and $200,000 for all other taxpayers. The tax is in addition to the regular Federal Insurance Contributions Act (FICA) and Self-Employment Contributions Act (SECA) taxes that generally apply (i.e., Social Security and Medicare taxes).

Provision

Section 218 of the Senate bill would amend IRC Sections 1401(b) and 3101(b) to repeal the 0.9% Medicare surtax, effective beginning tax year 2016.

Section 219: Repeal of Tanning Tax

Background

Section 10907 of the ACA creates a new excise tax on indoor tanning services. The tax is equal to 10% of the amount paid for such services. The provision is codified in Chapter 49 of the IRC.

Provision

Section 219 of the Senate bill would repeal the tax on indoor tanning services (IRC Chapter 49), effective for services performed on or after December 31, 2015.

Section 220: Repeal of Net Investment Tax

Background

Section 1402 of the HCERA imposes a net investment tax on high-income taxpayers. The tax, which is codified in Chapter 2A of Subtitle A of the IRC, applies at a rate of 3.8% to certain net

investment income of individuals, estates, and trusts with income above amounts specified in the statute.

Provision

Section 220 of the Senate bill would repeal the net investment tax (Chapter 2A of IRC Subtitle A), effective beginning tax year 2016.

Section 221: Remuneration

Background

Generally, employers may deduct the remuneration paid to employees as "ordinary and necessary" business expenses under IRC Section 162, subject to any statutory limitations. ACA Section 9014(b) adds a statutory limitation for certain health insurance providers. Under the provision, which is codified at IRC Section 162(m)(6), covered health insurance providers may not deduct the remuneration paid to an officer, director, or employee in excess of $500,000.

Provision

Section 221 of the Senate bill would terminate IRC Section 162(m)(6), effective beginning tax year 2016.

Section 222: Economic Substance Doctrine

Background

The economic substance doctrine is a common law doctrine that is applied by the IRS and courts to disallow transactions that technically comply with the IRC but lack economic substance. HCERA Section 1409 codified the doctrine by adding Section 7701(o) to the IRC. Under IRC Section 7701(o), in those circumstances in which the doctrine is relevant, a transaction will have economic substance only if it changes the taxpayer's economic position in a "meaningful way" (apart from any federal tax effects) and the taxpayer has a "substantial purpose" (other than a federal tax purpose) for entering into it.

HCERA Section 1409 also imposes a penalty on any tax underpayment attributable to a transaction lacking economic substance (IRC Section 6662(b)(6)) and an increased penalty on nondisclosed transactions lacking economic substance (IRC Sec. 6662(i)). HCERA Section 1409 further provides that the reasonable cause exceptions in IRC Section 6664 to the penalties imposed on tax underpayments and reportable transaction understatements do not apply to noneconomic substance transactions. HCERA Section 1409 also affects the application of IRC Section 6676, which imposes a penalty on any claim for an income tax refund or credit that is for an excessive amount unless the claim has a reasonable basis, by providing that a noneconomic substance transaction does not have a reasonable basis.

Provision

Section 222 of the Senate bill would repeal IRC Section 7701(o), as well as the penalty provisions in IRC Sections 6662(b)(6) and 6662(i). The provision would also repeal the provisions in IRC Section 6664 and IRC 6676 that provide that noneconomic substance transactions do not meet the reasonable cause and basis standards. The provision would apply to

transactions entered into (and to underpayments, understatements, or refunds and credits attributable to transactions entered into) after December 31, 2015.

Section 223: Budgetary Savings for Extending Medicare Solvency

Background

Medicare Part A, which covers inpatient hospital services, skilled nursing care, hospice care, and some home health services, is financed through the Hospital Insurance (HI) trust fund. The HI trust fund is funded primarily by a dedicated payroll tax of 2.9% of earnings, shared equally between employers and workers. Beginning in 2013, the ACA has imposed an additional tax of 0.9% on high-income workers with wages over $200,000 for single tax filers and over $250,000 for joint filers. (Section 218 of the Senate bill would repeal this high-income tax.) Other sources of income to the HI trust fund include premiums paid by voluntary enrollees who are not entitled to premium-free Medicare Part A, a portion of the federal income taxes paid on Social Security benefits, and interest on federal securities held by the trust fund. The Medicare Trustees estimate that in 2015 the HI trust fund will bring in about $278 billion in revenues and spend about $276 billion on Medicare Part A benefits and administration.[35] At the end of 2015, the trust fund is expected to have an asset balance of about $200 billion.

As long as the HI trust fund has a balance, the Department of the Treasury is authorized to make payments for Medicare Part A services. However, if the HI trust fund is not able to pay all current expenses out of current income and accumulated trust fund assets, it is considered to be insolvent. The Medicare Trustees estimate that the HI trust fund will become insolvent in 2030, at which time it will only have sufficient income to cover 86% of Part A expenditures.

Provision

Section 223 of the Senate bill states that the full amount of on-budget savings during the fiscal years 2016 through 2025 resulting from this act would be $379.3 billion. Section 223 would transfer this amount from the Treasury to the HI trust fund.

[35] Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2015 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplemental Medical Insurance Trust Funds,* July 22, 2015.

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