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COMMITTEE ON THE BUDGET
CHAIRMAN TOM PRICE, M.D.

H.R. 3762, THE RESTORING AMERICANS' HEALTHCARE FREEDOM RECONCILIATION ACT OF 2015

Section-by-Section Summary

TITLE I - Committee on Education and the Workforce

Section 101. Repeal of Automatic Enrollment Requirement.
Repeals Section 18A of the Fair Labor Standards Act (29 U.S.C. 218a), as added by section 1511 of the Affordable Care Act [ACA].

Background

Automatic Enrollment Requirement
Sec. 1511 of the ACA requires employers with more than 200 employees to automatically enroll new full-time equivalents [FTEs] into a qualifying health plan offered by the employer. Employers must also continue automatic enrollment of current employees in a health insurance plan. Under current law, the Congressional Budget Office [CBO] and the Joint Committee on Taxation [JCT] estimate that roughly 750,000 individuals would retain health insurance through their employer in most years after 2018 because of the automatic enrollment requirements. This provision was scheduled to take effect in 2014, but the Department of Labor [DOL] has yet to enforce the measure. In 2012, DOL announced that employers would not be forced to comply with the auto-enroll requirement until it issues implementing regulations, yet to date no regulations have been offered. Hence, CBO and JCT do not anticipate requirements for automatic enrollment to be enforced in 2016.

CBO Estimate of Net Change in Deficit: -$7.9 Billion

CBO estimates that enacting this legislation would reduce Federal deficits by $7.9 billion over the fiscal year 2016-2025 period. The projected savings consist of an increase of $12.2 billion in revenues, partially offset by an increase of $4.3 billion in spending. The change in revenues stems from an increase in taxable wages and salaries, relative to current law. The projected spending increase reflects higher projected enrollment in Medicaid and the exchanges. CBO and JCT estimate that enacting the legislation would not increase on-budget deficits in any of the four consecutive 10-year periods beginning in 2026. It would, however, increase net direct spending by at least $5 billion in one or more of the four 10-years periods.

TITLE II - Committee on Energy and Commerce

Section 201. Repeal Prevention and Public Health Fund.
Repeals the Prevention and Public Health Fund and rescinds unobligated balances.

Section 202. Federal Payment to States.
Prohibits Medicaid reimbursement for one year for a defined entity, which is defined to include its affiliates, subsidiaries, successors, and clinics.

Section 203. Funding for Community Health Center Program.
Increases funding to the Community Health Center Fund by $235 million in each of the fiscal years 2016 and 2017, as extended by the Medicare Access and CHIP Reauthorization Act (H.R. 2).

Background

Prevention and Public Health Fund [PPHF]
The PPHF allows the Secretary of the Department of Health and Human Services (HHS) to transfer amounts from the fund to HHS accounts to increase funding for Public Health Service Act (PHSA)-authorized prevention, wellness, and public health activities, including prevention research and health screenings. The ACA also provided House and Senate appropriators with the authority to transfer monies from the PPHF to eligible activities. Under current law, PPHF annual funding is $1.0 billion in 2016 and gradually rises to $2.0 billion in 2022 and each year thereafter.

Federal Payments to States
The prohibition of Federal funds made available through Medicaid restricts available monies to defined entities for a one-year period beginning on the day of enactment. The legislation defines an entity, including affiliates, subsidiaries, successors, and clinics, as nonprofit (501(c)(3)) organizations considered an essential community provider primarily engaged in providing family planning and reproductive health services and related medical care that also provides abortions, and that had expenditures through Medicaid exceeding $350 million for fiscal year 2014.

Community Health Center Program
The Community Health Center [CHC] fund provides grants to health centers that offer primary and preventive care to patients regardless of their ability to pay. Under current law, the program will receive $3.6 billion in each of the fiscal years 2016 and 2017. The legislation would increase available funds to CHCs by $235 million in each of the fiscal years 2016 and 2017. For fiscal years 2016 and 2017, total available funds for CHCs amounts to $3.835 billion.

CBO Estimate of Net Change in Deficit: -$12.4 Billion

CBO estimates that enactment of the legislation reported by the Committee on Energy and Commerce would decrease direct spending by $12.4 billion over the 2016-2025 period.

- Repeal of the Prevention and Public Health Fund would reduce direct spending by $12.7 billion over the 2016-2025 period.
- Prohibiting Medicaid funding for certain providers for one year would reduce direct spending by $235 million over the 2016-2025 period. The CBO estimate weighs whether the Medicaid services would be sought from non-affected entities, the extent to which Medicaid beneficiaries would continue to receive services by the prohibited provider or non-affected entities, and the possibility that additional births would result in increased Medicaid spending.
- Increasing the availability of funds to the Community Health Center Program [CHC] would increase direct spending by $470 million over the 2016-2025 period. The legislation would increase funding for the program by $235 million in each of the fiscal years 2016 and 2017.

Additionally, enacting the legislation would not increase direct spending or on-budget deficits in any of the four consecutive 10-year periods beginning in 2026.

TITLE III - Committee on Ways and Means

Subtitle A - Revenue Provisions

Section 301. Repeal of Individual Mandate.
Repeals the penalty on individuals who do not obtain qualified health insurance, effective after December 1, 2014.

Section 302. Repeal of Employer Mandate.
Repeals the penalty on employers who do not offer their employees qualified health insurance, effective after December 1, 2014.

Section 303. Repeal Medical Device Tax.
Repeals the 2.3-percent excise tax, effective December 31, 2012, on the sale of any taxable medical device by a manufacturer, producer, or importer of such device.

Section 304. Repeal of the Excise Tax on Employee Health Insurance Premiums and Health Plan Benefits and Related Reporting Requirements (i.e., Cadillac Tax).
Repeals the 40-percent excise tax on high-value health plans.

Subtitle B - Repeal of Independent Payment Advisory Board

Section 311. Repeal Medicare Independent Payment Advisory Board (IPAB).
Repeals IPAB, a board tasked with making recommendations to modify Medicare spending and achieve specified savings in the Medicare program.

Background

Individual Mandate

Starting in 2014, the ACA requires individuals to obtain qualified health coverage or pay a penalty. A qualified health plan must meet the standard of "minimum essential coverage" as stipulated in the ACA. An individual must pay a penalty that is the greater of a flat dollar amount or a percentage of applicable income, not to exceed a cap:

Annual Individual Mandate Penalty

Year	% of Applicable Income	Flat Dollar Amount
2014	1.0%	$95
2015	2.0%	$325
2016	3.0%	$695
2017 and beyond	2.5%	$695 adjusted for inflation

Source: IRC, Section 5000A.
Note: The penalty is assessed on a monthly basis, so the penalty would be 1/12 of the annual penalty in this table. The penalty was capped in 2014 at $204 per month per individual, and is capped in 2015 at $207 per month. Caps have not been established for 2016 and beyond.

The excise tax exempts certain individuals for reasons including affordability of coverage, income, membership in an Indian tribe, religious reasons, a coverage gap of less than three months, and general hardship.[1]

Employer Mandate
The ACA imposes a penalty on employers with at least 50 full-time equivalent [FTE] employees if at least one of the FTEs obtains a premium credit through the health insurance exchange (healthcare.gov). The measure was scheduled to take effect in 2014, but the administration delayed enforcement by one year, then provided employers with 50-100 employees an additional year to comply as long as certain criteria are met. For employers that do not offer insurance coverage, the fixed amount is $2,000, multiplied by the number of full-time employees in excess of 30. For those that offer coverage that fails to meet the Federal standard for minimum value and affordability, the penalty equals the lesser of 1) $3,000 per full-time employee who receives subsidized coverage in the exchange or 2) the penalty the employer would have to pay if it did not offer health insurance. Full-time employees are defined as those working on average at least 30 hours per week. Under the recommendation, the employer mandate excise tax would be repealed. The provision would apply to months beginning after 2014.

Medical Device Tax

[1] Mach, Annie L. "Individual Mandate Under the ACA." Congressional Research Service. R41331.

Since 2013, the manufacturer, producer, or importer of any non-retail medical device – including X-ray equipment, MRI machines, surgical equipment, and pacemakers – must pay an excise tax equal to 2.3 percent of the sales price of a qualifying device. The excise tax does not apply to a device regularly available for purchase and use by individual consumers and not intended for use by a medical institution, office, or medical professional. For example, eyeglasses, contact lenses, and hearing aids are exempt from the medical device tax. Taxpayers are required to pay their excise tax liability on a quarterly basis.

Excise Tax on Employee Health Insurance Premiums and Health Plan Benefits and Related Reporting Requirements
Beginning in 2018, the ACA is scheduled to impose an excise tax (the "Cadillac tax") on employers equal to 40 percent multiplied by the excess of the aggregate cost of health insurance coverage for any employee over a fixed threshold amount, pro-rated on a monthly basis.

- The fixed threshold amount for 2018 is $10,200 (for self-only coverage) or $27,500 (for any other coverage) and indexed for inflation.
- The fixed threshold amount is adjusted if the cost of a standard Federal Employee Health Benefit Plan for 2018 exceeds the cost for 2010.

As part of compliance, beginning in 2010, employers were also required to report the cost of employer-sponsored health coverage as an item on each employee's annual Form W-2.

Independent Payment Advisory Board [IPAB]
Beginning in 2014, the IPAB is tasked with making recommendations to cut per capita Medicare spending if such spending exceeds certain economic growth targets. The Secretary of Health and Human Services is directed to implement the Board's proposals automatically unless Congress affirmatively acts to alter the Board's proposals or to discontinue the automatic implementation of such proposals.

CBO Estimate of Net Change in Deficit: -$37.1 Billion

CBO and JCT estimate that enacting the legislation would reduce Federal deficits by $37.1 billion over the 2016-2025 period. Additionally, CBO and JCT estimate that enacting the legislation would increase on-budget deficits by at least $5 billion in each of the four consecutive 10-year periods beginning in 2026. According to CBO and JCT estimates:

- Repeal of the individual and employer mandate would result in a net budgetary savings of $147.1 billion over the 2016-2025 period. This projection consists of an estimated $256.9 billion decrease in direct spending, offset by a reduction in revenues of $109.8 billion.
- Repealing the medical device tax would reduce revenues by roughly $23.9 billion over the 2016-2025 period.
- Repealing the excise tax on high premium insurance plans would result in net budgetary costs of $91.1 billion over the 2016-2025 period, which consists of a $109.3 billion reduction in revenue and an $18.2 billion decrease in direct spending. Furthermore, the

interaction of repealing this tax with the individual mandate and the employer mandate would result in additional savings of roughly $12.1 billion.

- Repealing the IPAB would increase direct spending by $7.1 billion over the 2022-2025 period.

Interaction Effects Across Titles

According to CBO and JCT, the total interaction effects of the previously mentioned titles results in a decrease of direct spending of $2 billion and an increase in revenues of $19.4 billion over the 2016-2025 period, for a total of $21.4 billion in deficit reduction. Taken together, the legislation estimates a decrease in direct spending of $278.2 billion and an increase in revenues of $199.3 billion. This results in a total deficit reduction of $78.9 billion, with $41.3 billion in on-budget savings and $37.6 in off-budget savings.

Amendment at Rules

The amendment to H.R. 3762, Restoring Americans' Healthcare Freedom Reconciliation Act of 2015, made technical modifications to the underlying bill. Following the determination of the Senate Parliamentarian, Subtitle B of Title III, The Independent Payment Advisory Board, was stricken from the reconciliation bill as reported by the House Budget Committee. This results in additional deficit reduction of $7.1 billion over the 2016-2025 period. Additionally, the amendment provided technical modifications under Title II to the definition of a defined entity.

Macroeconomic Effects

According to CBO and JCT, total deficit reduction of enacting H.R. 3762 would be approximately $130 billion over the 2016-2025 period. In addition to the deficit reduction of $78.9 billion, the macroeconomic feedback would further reduce deficits by $51 billion. The bill would boost GDP by 0.2 percent, largely due to the effects of repealing provisions within the ACA that discourage work and capital investment. The legislation would increase the supply of labor, increase capital investment, and decrease Federal borrowing, further increasing the money available for capital investment. This estimate does not reflect the amended language to H.R. 3762, which would likely result in additional deficit reduction.