

American Health Care Act

The House Passes the American Health Care Act

SUMMARY

On May 4, 2017, the House of Representatives (the “House”) passed the American Health Care Act (the “AHCA”) by the vote of 217 for, 213 against and 1 abstaining. The AHCA, a budget reconciliation bill, is a key part of the Administration’s “three-prong approach” to repealing and replacing the Patient Protection and Affordable Care Act (as amended by the Health Care and Education Reconciliation Act of 2010, collectively the “ACA”).¹ Key elements of the AHCA in its current form include:

- **No Individual Mandate:** Under the ACA, individuals are subject to a tax penalty if they are not covered by minimum essential coverage as defined under the ACA (“Individual Mandate”). The AHCA would repeal the Individual Mandate effective January 1, 2016 but proposes a “continuous coverage incentive” that would require insurers, beginning (for most enrollments) in 2019, to assess a 30% penalty premium on individuals who have not maintained continuous coverage over the previous year (“Continuous Coverage Incentive”), other than in states that receive a waiver for this feature (as discussed below).
- **No Employer Mandate:** Under the ACA, businesses beyond a certain size must provide employees with minimum essential coverage as defined under the ACA or be subject to tax penalties (“Employer Mandate”). The AHCA would repeal the Employer Mandate effective January 1, 2016.
- **Repeal of Taxes Imposed by the ACA:** The AHCA would repeal or defer the taxes imposed by the ACA. In particular, the AHCA would repeal both the 3.8% tax imposed by the ACA with respect to net investment income and the 0.9% additional FICA tax with respect to wages and self-employment income in excess of certain thresholds. These taxes would be repealed for taxable years beginning after December 31, 2017. In addition, the AHCA would defer the 40% “Cadillac” tax on “excess benefits” arising under employer-sponsored group plans until taxable years beginning on or after January 1, 2025. The AHCA would also eliminate taxes and fees imposed by the ACA on health insurers, the branded pharmaceutical industry and the sale of medical devices, and change the itemized deduction for medical expenses.
- **State Waivers:** The AHCA would not technically repeal provisions in the ACA that require insurers to cover individuals regardless of pre-existing medical conditions, require insurers to offer “essential health benefits”² in all policies sold in Individual and Small Group Markets,³ or

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prohibit insurers from varying the premium rates charged for policies sold in Individual and Small Group Markets with respect to a particular plan or coverage (other than for rate changes based on factors specified in the ACA). The AHCA, however, would permit a state to submit an application to the Secretary of Health and Human Services (the "SHHS") for a 10-year waiver with respect to three required coverage terms under the ACA. The waiver would be deemed automatically approved if the SHHS does not notify the state of denial and the reason for the denial within 60 days of the submission of the waiver application. The three waivable coverage terms are:

- **Age Rating Ratio:** The AHCA would permit states to apply to waive the 5 to 1 age rating ratio proposed under the AHCA, and establish any ratio that is higher than 5 to 1 for plan years beginning in 2018, provided that the application submitted by the state shows how the waiver will provide for one or more of the following policy goals: reducing average premiums, increasing the choice of health plans, increasing enrollment, stabilizing the state's health insurance market, or stabilizing premiums for individuals with preexisting conditions.
- **Essential Health Benefits:** The SHHS is mandated under the ACA to specify what constitutes the "essential health benefits" that must be covered by insurers in the Individual and Small Group Market. The AHCA permits states to apply to the SHHS to define their own essential health benefits for plan years beginning in 2020, provided the application submitted by the state shows how the waiver will provide for one or more of the policy goals outlined above.
- **Continuous Coverage Incentive and Community Rating:** Under the "community rating" requirements of the ACA, insurers are prohibited from varying the premium rates charged for policies sold in Individual and Small Group Markets except based on four specified factors (age, geographic area, tobacco use and individual vs. family coverage). Under these rules, insurers cannot vary premium rates based on other factors, such as an individual's health status or preexisting medical conditions. Under the AHCA, in lieu of instituting the Continuous Coverage Incentive, states could apply to waive, for plan years beginning in 2019, the ACA's community rating requirements and permit the use of "health status" as a factor in varying the premium rates for policies sold in Individual and Small Group Markets to individuals who have not maintained continuous coverage ("Community Rating Waiver"), provided that the application shows how the waiver will provide for one or more of the policy goals outlined above. Including health status as a factor would permit insurers, for individuals who fail to maintain continuous coverage, to vary premiums based on an individual's preexisting medical conditions.

In effect, coverage for preexisting conditions or the full suite of essential health benefits in states that have obtained waivers will continue to be available but at rates that may be unaffordable for many individuals. The AHCA contains risk mitigation features and other provisions intended to address this risk. In addition to having to meet one of the specified policy goals, in order to obtain a Community Rating Waiver, the state must participate in a risk-mitigation program ("Risk Mitigation Program"). Risk Mitigation Programs are defined to include: (i) programs that "help, through financial assistance, high-risk individuals without access to health insurance coverage by an employer enroll in health insurance coverage in the individual market...(whether through establishment of a new mechanism or maintenance of an existing mechanism for such purpose);" (ii) programs that provide incentives for entities to enter into arrangements to help stabilize premiums for health insurance coverage in the individual market; and (iii) the Federal Invisible Risk-Sharing Program ("FIRSP"), a new program that would provide payments to insurers with respect to "eligible individuals" (a term to be specified by the SHHS) for the purpose of lowering premiums for insurance coverage offered in the individual market (the so-called "high-risk pool").

- **Patient and State Stability Fund:** The AHCA would create a new fund for the stabilization of health insurance premiums and other purposes (the "Patient and State Stability Fund"). Total available funds would be \$15 billion each year for 2018 and 2019, and \$10 billion each year from 2020 through 2026 (except that an additional \$15 billion would be allocated in 2020 solely to be used for maternity coverage and newborn care and mental health and substance use disorders);

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plus an additional \$15 billion over nine years (from 2018 through 2026) to be allocated to the FIRSP and an additional \$8 billion over six years to be allocated to states with Community Rating Waivers to provide assistance to reduce premiums or other out-of-pocket costs for individuals subject to higher premiums resulting from the waiver.

- **Individual Tax Credits:** The AHCA would repeal, for plan and tax years beginning in 2020, the income-based tax credits and cost-sharing subsidies for individuals provided for in the ACA. Instead, the AHCA creates a new tax credit, for tax years beginning in 2020, for premium expended for eligible health insurance for the months during which the taxpayer did not qualify for other coverage under certain plans (including a qualifying group health plan, Medicare, Medicaid, CHIP, TRICARE, and veterans' benefits programs), up to a maximum monthly limitation amount determined based on the age of the taxpayer and the taxpayer's qualifying family members. The tax credits are intended to be advanceable and refundable, such that the tax credit could generally be used to directly pay premiums due for eligible health insurance. The AHCA provides that the Department of the Treasury must establish a program for making the advance payments to health insurance providers on behalf of individuals eligible for the tax credits.
- **Repeal of Disallowance of Deductions for Remuneration by Covered Health Insurance Providers:** The AHCA would repeal the disallowance of federal income tax deductions for compensation paid by any "covered health insurance provider" to an employee, officer, director or other individual service provider in excess of \$500,000. The AHCA would repeal this limitation for taxable years beginning after December 31, 2017.
- **Health Savings Accounts (HSAs):** The AHCA would relax existing rules relating to qualifying expenses, contributions and taxable distributions of HSAs.
- **Medicaid and Funding Changes:** The AHCA would limit the expansion of Medicaid under the ACA and contains several other provisions that affect Medicaid; would de-fund the Prevention and Public Health Fund established under the ACA; and would prohibit funding and tax credits in respect of abortion services (subject to limited exceptions).
- **Key Retained Elements of the ACA:** The AHCA retains certain ACA provisions, including those that: (i) require insurers to cover children on their parents' insurance policies until age 26; (ii) establish the state exchanges where insurers may offer qualified health plans (the "ACA Exchanges"); and (iii) require insurers to disclose annual medical loss ratios and provide rebates if the ratios of health care expenditures to premiums in a plan year are below certain thresholds. Other ACA requirements are technically retained but may be affected by the ability of states to waive the requirements (or related requirements). For example, the AHCA would retain the ACA prohibition on insurers setting lifetime or annual limits on essential health benefits; however, this would be subject to any waivers permitting states to provide their own definition of essential health benefits rather than continue to rely on the SHHS's. Likewise, the AHCA would continue to prohibit insurers from varying the premium rate charged in policies based on age by greater than a specified ratio, but the AHCA would increase the ratio from 3 to 1 to 5 to 1, and would allow states to waive this requirement and set their own ratio.

BACKGROUND

A. THE ACA

The ACA, signed into law on March 23, 2010, has effected comprehensive changes to the regulation of health insurance and the delivery of health care generally in the United States. The ACA substantially increased the number of Americans having access to health insurance. The ACA is financed in part by an increase in the level of federal insurance contribution taxes (known as FICA taxes), an expansion of such taxes to investment income, codification of the economic substance doctrine and other tax increases.

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The ACA also significantly amended aspects of Medicare, Medicaid, student loan programs and other public programs and introduced additional projects, expenditures and other requirements with respect to public health programs.⁴

B. TRUMP ADMINISTRATION'S ACA REPEAL STRATEGY

The current Administration has been clear on its intention to repeal and replace the ACA. On January 20, 2017, President Donald Trump signed, as one of the first-day executive orders, an executive order intended to “minimize the economic burden” of the ACA (the “Executive Order”). The Executive Order stated that it is the Administration’s policy to promptly repeal the ACA, and directed all applicable federal agencies to exercise available authority and discretion to (i) avoid enforcing provisions under the ACA that impose costs on states or individuals, (ii) provide flexibility to and cooperate with states in implementing health care programs, and (iii) encourage developing “a free and open market in interstate commerce for the offering of health care services and health insurance.”⁵

Subsequently, on March 10, 2017, the White House announced its “three-prong approach” to repealing the ACA, consisting of:⁶

- enacting the AHCA through the budget reconciliation process;⁷
- providing regulatory relief aimed at stabilizing health insurance markets and reducing costs, in order to: (i) stabilize insurance markets and increase coverage choices, (ii) loosen “restrictions on the financial structure” of insurance plans offered on the ACA Exchanges with the goal of “providing individuals and families access to lower premium options,” and (iii) curb enrollment-related abuses and encourage full-year enrollment; and
- enacting additional legislation outside the budget reconciliation process to address additional aspects of the health insurance industry, in order to: (i) permit health insurance to be sold across state lines, (ii) permit HSAs to be used to cover more health care costs, (iii) streamline the processes for drug approvals by the Food and Drug Administration, (iv) allow small businesses to form groups for association health plans, (v) reform the medical malpractice lawsuit system, and (vi) permit states to (a) determine requirements for their own insurance markets, (b) set priorities and enact their own solutions for vulnerable citizens, and (c) lower premiums through the use of high-risk pools, reinsurance, HSAs and other solutions, and provide assistance to the low-income population.

C. THE COMPETITIVE HEALTH INSURANCE REFORM ACT (“CHIRA”); THE SMALL BUSINESS HEALTH FAIRNESS ACT (“SBHFA”)

As part of the Administration’s strategy, on March 22, 2017, the House passed the Competitive Health Insurance Reform Act (“CHIRA”) and the Small Business Health Fairness Act (“SBHFA”).

CHIRA would amend the McCarran-Ferguson Act⁸ to clarify that the McCarran-Ferguson Act does not limit or supersede the operation of the Sherman Antitrust Act, Clayton Act, and Federal Trade Commission Act (“FTC Act”) (except to the extent the FTC Act applies to “unfair methods of competition”) with respect to the “business of health insurance.”⁹

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Safe harbors from the application of the Sherman Antitrust Act, Clayton Act and FTC Act are provided under CHIRA for certain industry practices, including collecting, compiling or disseminating historical loss data and determining loss development factors applicable to such data, performing actuarial services that do not involve a restraint of trade, and developing or disseminating a standard insurance policy form. CHIRA was referred to the Senate Judiciary Committee on March 23, 2017.

SBHFA would provide an option for small businesses to purchase health insurance for their workers through association health plans (“AHPs”).¹⁰ AHPs would be sponsored by a bona fide trade, industry, or professional organization that has a substantial purpose other than purchasing health insurance. AHPs would provide benefits to workers of participating small businesses by purchasing a fully insured group health plan from an insurer. Alternatively, AHPs may offer self-insured health benefits that meet specified requirements. Self-insured AHPs must establish and maintain (i) sufficient reserves with respect to additional benefit options, (ii) minimum surplus in addition to claims reserves, and (iii) excess/stop loss insurance and indemnity insurance in respect of additional benefit options for which risk of loss has not been transferred, and such self-insured AHPs must contribute to an Association Health Plan Fund, which would be set up by the Treasury Department to guarantee self-insured AHPs. Both fully insured and self-insured AHPs would be subject to certifications by the Secretary of Labor with respect to specified financial, actuarial, reporting, participation and other requirements to be specified by the Secretary of Labor. SBHFA was referred to the Senate Health, Education, Labor, and Pensions Committee on March 23, 2017.

D. PROCEDURAL HISTORY OF THE AHCA

On March 9, 2017, the AHCA was introduced pursuant to resolutions passed in January 2017 by the Senate and the House instructing certain committees in the Senate and the House to develop a budget reconciliation bill to reduce the budget deficit (the “Budget Resolution”). The Administration expressed its support for the AHCA on March 10, 2017, stating that the President would sign it into law if the AHCA passed the Congress.

The Congressional Budget Office (the “CBO”) published a report on the original version of the AHCA on March 9, 2017, and then published a follow-up report on the AHCA reflecting the manager’s amendment introduced by Representatives Greg Waldon and Kevin Brady on March 20, 2017.¹¹ According to the CBO, the March 20, 2017 version of the AHCA would: reduce federal deficits by \$150 billion over the 2017-2026 period; increase the uninsured population by 14 million in 2018, 21 million in 2020 and 24 million in 2026, relative to the projections under the ACA; and increase the average premiums in the nongroup market before 2020 and lower average premiums thereafter, relative to the projections under the ACA. The CBO has not published an update reflecting the impact of the manager’s amendment introduced on March 23, 2017 or any other subsequent amendments.¹² The CBO is expected to update the original report in light of the final version of the AHCA in the coming weeks as the Senate considers the AHCA.

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The original version of the AHCA was amended twice, on March 20, 2017 and March 23, 2017 respectively as discussed above, before the original scheduled vote on March 24, 2017, which was postponed due to a lack of votes needed for passage. Since then, three amendments to the AHCA were introduced and adopted into the final version of the AHCA that passed on May 4, 2017:

- On April 6, 2017, Representatives Gary Palmer and David Schweikert introduced an amendment adding a Federal Invisible Risk-Sharing Program to be established within the Patient and State Stability Fund.
- On April 26, 2017, Representative Tom MacArthur introduced an amendment permitting states to apply for waivers from certain federal requirements in the underlying bill, including (as discussed) (i) the age-rating ratio, (ii) the federal definition of essential health benefits, and (iii) the prohibition on varying premium rates based on health status.
- On May 3, 2017, Representative Fred Upton, along with eight other Representatives, introduced an amendment earmarking \$8 billion over six years to subsidize coverage for individuals with higher premiums as a result of Community Rating Waivers.

THE AMERICAN HEALTH CARE ACT

On May 4, 2017, the House passed the AHCA by the vote of 217 for, 213 against and 1 abstaining. 217 Republican representatives voted for the bill, with 20 Republicans voting against and one abstaining; all 193 Democratic representatives voted against the bill.

A. KEY AHCA PROVISIONS

- ***Repeal of Individual Mandate and Individual Health Care Subsidies:*** Under the ACA's Individual Mandate, an individual and any of his or her dependents are required to have coverage under certain health plans ("Minimum Essential Coverage"),¹³ or be subject to a tax penalty. To help qualifying individuals pay for premiums to meet the Individual Mandate, the ACA provides for (i) income-based tax credits for certain eligible individuals, and (ii) cost-sharing subsidies for Minimum Essential Coverage offered through the ACA Exchanges. The AHCA would repeal the Individual Mandate effective January 1, 2016, and, beginning in 2020, the tax credit and cost-sharing subsidies under the ACA.¹⁴
- ***AHCA Refundable Tax Credit:*** In lieu of the tax credit and cost-sharing subsidies under the ACA, the AHCA would create, for tax years beginning in 2020, a new refundable tax credit for premiums expended to obtain health insurance coverage meeting certain requirements ("Eligible Health Insurance")¹⁵ for the taxpayer and the taxpayer's qualifying family members. The refundable tax credit would be granted for the months during which the taxpayer did not qualify for other coverage under certain plans (including, among other things, a qualifying group health plan, Medicare, Medicaid, CHIP, TRICARE, and veterans' benefits programs), up to a maximum monthly limitation amount. The monthly limitation amount would take into account the age of the taxpayer (e.g., the monthly tax credit would equal \$2,000 for individuals who are age 29 and younger, and \$4,000 for individuals age 60 and older), and the taxpayer's qualifying family members (e.g., families would be limited to a maximum annual tax credit amount of \$14,000). In addition, the monthly limitation would be reduced (such that the credit phases out) by 10% of the amount, if any, by which the taxpayer's modified adjusted gross income exceeds \$75,000 (\$150,000 in the case of a joint return). Thus, the tax credit would be reduced to zero for single individuals who are age 29 or younger and have modified adjusted gross income of \$95,000 or more, and for individuals aged 60 or older and that have income of \$115,000 or more. As with the tax credits under the ACA, the tax credits are intended to be advanceable and refundable, such that the tax credit could generally be used to directly pay premiums due for Eligible Health

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Insurance. The AHCA provides that the Department of the Treasury must establish a program not later than January 1, 2020 for making the advance payments to providers of Eligible Health Insurance on behalf of individuals eligible for the tax credits. Under the AHCA, if the amount paid for the Eligible Health Insurance is less than the amount of the tax credit, the Treasury may deposit the excess into an HSA of the individual or a qualifying family member designated by the individual; otherwise, as with the ACA tax credits, an individual may be eligible to claim any such excess on his or her annual tax return, which would either lower the amount of taxes owed on that return or increase the applicable refund.

- **Repeal of Employer Mandate and Small Business Tax Credits:** Under the ACA's Employer Mandate, all businesses with 50 or more full-time employees must offer their full-time employees and their dependents Minimum Essential Coverage under a group health plan, or pay a non-deductible penalty tax if at least one employee enrolls in a qualified health plan and obtains a premium tax credit or cost-sharing subsidy with respect to such health plan. To help small businesses pay for premiums to meet the requirement, the ACA provides small business tax credits. The AHCA would repeal the Employer Mandate effective January 1, 2016, and the accompanying small business tax credits for taxable years beginning after December 31, 2019.
- **State Waivers:** The AHCA would permit a state to submit an application to the SHHS for a 10-year waiver with respect to three coverage requirements under the ACA. The waiver application must specify how approval of the waiver will provide for one or more of the following policy goals: reducing average premiums for patients in the state, increasing patients' health care plan options in the state, increasing enrollment for residents in the state, stabilizing the state's health insurance market, or stabilizing premiums for individuals with preexisting conditions. In addition, with respect to Community Rating Waivers, the state must participate in a Risk Mitigation Program. Each waiver application would be deemed approved automatically if the SHHS does not notify the state of denial and the reason for the denial within 60 days of the submission of the application. The waiver may be renewed after the initial 10-year term upon request by the state unless the SHHS rejects the application within 90 days after the request is submitted.
- **Age Rating Ratio:** Under the ACA, insurance premiums may vary by age but by no more than a ratio of 3 to 1; under the AHCA, the ratio would be changed to 5 to 1, and states would be permitted to apply to waive the 5 to 1 ratio and establish a higher ratio for plan years beginning in 2018.
- **Essential Health Benefits:** Under the ACA, the SHHS is mandated to specify what constitutes the "essential health benefits" that must be covered in the Individual and Small Group Market. For plan years beginning on or after 2020, a state may submit an application to the SHHS for a 10-year waiver to specify its own essential health benefits.¹⁶
- **Continuous Coverage Incentive and Community Rating:** Under the "community rating" requirements of the ACA, insurers are prohibited from varying the premium rates charged for policies sold in Individual and Small Group Markets with respect to a particular plan or coverage except based on four specified factors: (i) whether the plan or coverage covers an individual or family, (ii) geographic "rating areas" established by each state, (iii) age, except that the rate may not vary by more than the specified age rating ratio (3 to 1 for adults under the ACA, which would be changed to 5 to 1 under the AHCA), and (iv) tobacco use, except that the rate may not vary by more than 1.5 to 1. Under these rules, insurers cannot vary premium rates based on other factors, such as an individual's health status or preexisting medical conditions. Under the AHCA, in lieu of instituting the Continuous Coverage Incentive, states that participate in a Risk Mitigation Program could apply to waive, for plan years beginning in 2019, the ACA's community rating requirements and permit the use of "health status" as a factor in varying the premium rates for policies sold in Individual and Small Group Markets to individuals who have not maintained continuous coverage. The "health status" rating would only apply during the relevant "enforcement period" – generally for one entire plan year. A state with a Community Rating Waiver must maintain in place a Risk Mitigation Program in order for the waiver to stay in effect.

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The above waivers would not apply to plans provided under certain programs created under the ACA, including: (i) qualified health plans offered under the CO-OP Programs;¹⁷ (ii) qualified health plans that constitute “multi-state plans” offered by the Director of the Office of Personnel Management, (iii) basic health programs established by the SHHS for low-income individuals not eligible for Medicaid, (iv) qualified health plans offered by “health care choice compacts,”¹⁸ and (v) qualified health plans that are multi-state plans. Additionally, the above state waivers would not apply with respect to any state already benefiting from an “innovation waiver” provided under the ACA.¹⁹ Finally, waivers would not apply to health plans created under the ACA or offered through ACA Exchanges to provide health benefits to members and staff of Congress, although a separate amendment has been proposed that would eliminate this provision upon enactment of the AHCA.

- **Patient and State Stability Fund:** The AHCA would create a new Patient and State Stability Fund (“PSSF”) to allocate funds to be deployed for specified permitted uses, including to provide financial assistance to high-risk individuals so they may enroll in health insurance, stabilize health insurance premiums, promote participation and increase options in the health insurance market, pay providers for services, and provide financial assistance to enrollees to reduce out-of-pocket costs.²⁰ Total available funds for the PSSF would be \$15 billion each year for 2018 and 2019, and \$10 billion each year from 2020 through 2026 (except that an additional \$15 billion would be allocated in 2020 solely to be used for maternity coverage and newborn care and mental health and substance use disorders), plus an additional \$15 billion to be allocated to the FIRSP and an additional \$8 billion to be allocated to states with Community Rating Waivers (as described further below). Total aggregate funding would therefore equal \$138 billion. With respect to the primary PSSF (i.e., not including the FIRSP or the \$8 billion allocated for Community Rating Waiver states, which are discussed below), the funds would be allotted to each state (i) for years 2018 and 2019, based on certain factors, including the state’s relative portion of incurred claims out of the incurred claims of all states, the state’s relative portion of the uninsured population below the federal poverty level, and the number of plans offered in the state’s ACA Exchange, and (ii) from 2020 through 2026, a methodology to be specified by the administrator for the Centers for Medicare and Medicaid Services (“CMS”). If a state does not successfully apply to CMS to receive the full amount of the state’s allotment from the PSSF, CMS must (in collaboration with the state’s insurance commissioner) use any remaining funds for paying to insurers 75% of the amount of certain types of claims as market-stabilization payments in such state. Claims that are eligible for such market stabilization payments are those that exceed \$50,000 but do not exceed \$350,000 in 2018 and 2019, and in 2020 and beyond, claims that fall within parameters to be determined by CMS. Any remaining funds from the primary PSSF annual funding amounts at year end would be re-allocated to the FIRSP.

A state receiving these PSSF funds must provide matching state funds equal to 7% of the funds received in 2020, phasing up to 50% of funds received in 2026. A different state matching schedule applies for the CMS-administered market stabilization payments described above (10% in 2020, phasing up to 50% in 2024.) A state may not be allocated any funding under the PSSF unless the state provides the required matching funds.

- **Federal Invisible Risk-Sharing Program.** The AHCA would additionally appropriate an aggregate \$15 billion for years 2018 through 2016 to establish the FIRSP within the PSSF to provide payments to insurers with respect to eligible individuals for the purpose of lowering premiums for insurance coverage offered in the individual market. As noted above, in addition to the \$15 billion funding over nine years, the FIRSP would also be funded with any otherwise unallocated funds from the PSSF. CMS would be responsible for establishing relevant parameters of the program, including the definition of “eligible individuals” after (i) consultation with health care consumers, health insurers, state insurance commissioners and other stakeholders, and (ii) taking into account high-cost health conditions and other health trends that generate high costs.
- **Financial Hardship Assistance.** The AHCA would additionally appropriate an aggregate of \$8 billion to the PSSF for years 2018 through 2023, to be allocated to states that have obtained Community Rating Waivers. The funding must be used by the state to reduce

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premiums or other out-of-pocket costs for individuals who are subject to increases in their monthly premium rate for health insurance coverage as a result of the Community Rating Waiver. The additional \$8 billion would be allocated to eligible states in accordance with a methodology to be specified by the SHHS.

- **Changes to the Required Coverage Terms under the ACA for Individual and Small Group Coverage:** The AHCA would make the following changes to the coverage term requirements that are imposed under the ACA for coverage offered in Individual and Small Group Markets:
 - **Levels of Coverage.** The AHCA would repeal, for plan years beginning 2020, the ACA provisions requiring all coverages to be one of four levels of coverage (i.e., bronze, silver, gold or platinum) based on actuarial values of the benefits.²¹
 - **Continuous Coverage Incentive and Community Rating.** The AHCA would require an insurer, effective for enrollments beginning (with some exceptions) in 2019, to assess a penalty of 30% of the monthly premium rate for the first plan year if a new applicant has had any lapse in coverage greater than 63 consecutive days within the prior 12 months. As noted above, if a state participates in a Risk Mitigation Program, the state may submit an application to the SHHS for a 10-year waiver with respect to this requirement. If approved, the waiver would permit the state to not institute the Continuous Coverage Incentive for plan years beginning in 2019, and instead permit insurers to waive the ACA's "community rating" requirements and use "health status" as an additional factor in varying the premium rate for policies sold in Individual and Small Group Markets.
 - **Age Rating Ratio.** Under the AHCA, the premium rate charged for health insurance coverage offered in the Individual and Small Group Markets would be permitted to vary based on age for adults by up to 5 to 1 for plan years beginning after January 1, 2018, compared to the 3 to 1 ratio permitted under the ACA. As noted above, a state may submit an application to the SHHS for a 10-year waiver to apply a higher age rating ratio.
- **Rules Relating to HSAs/FSAs/Archer MSAs:** The AHCA would also relax, effective January 1, 2018, existing rules relating to qualifying expenses, contributions and taxable distributions of health savings accounts ("HSAs") and flexible spending accounts ("FSAs"). For instance, the AHCA would increase the maximum annual contribution to an HSA from \$2,250 to \$5,000 for self-only coverage and \$10,000 for family coverage, and repeal the ACA's \$2,500 upward annual limit on contributions to a health FSA. The AHCA would also provide a 60-day lookback period to permit certain medical expenses incurred before the establishment of an HSA to be treated as qualified medical expenses for the HSA. Additionally, over-the-counter medications would become qualified medical expenses for distributions from HSAs and Archer MSAs. Taxes on distributions from an HSA or Archer MSA of amounts that are not used for qualified medical expenses would revert to pre-ACA levels.
- **Repeal of 3.8% Net Investment Income Tax:** The AHCA would repeal the 3.8% tax imposed by the ACA on net investment income for taxable years beginning after December 31, 2017. The ACA imposes the new 3.8% tax on an uncapped basis on the lesser of (i) the net investment income of an individual, estate or trust for a taxable year, and (ii) the excess of the taxpayer's modified gross income for such taxable year over certain thresholds. "Net investment income" is the excess of (1) gross income from interest, dividends, annuities, royalties, rents, and net gains from the disposition of property, in each case, other than in connection with an active trade or business over (2) the deductions allowed by the Internal Revenue Code which are properly allocable to such income or gain.
- **Repeal of 0.9% Additional FICA Tax:** The AHCA would repeal the 0.9% additional FICA tax imposed by the ACA on wages and net self-employment income for taxable years beginning after December 31, 2017. The ACA imposes the additional 0.9% tax on an uncapped basis on wages and net self-employment income above certain thresholds. This additional ACA tax increased the prior rate of the hospital insurance portion of the FICA tax on wages above the thresholds from 1.45% to 2.35% and on net self-employment income above the thresholds from 2.9% to 3.8%.

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- ***Cadillac Health Plan Tax Delay:*** The AHCA provides that the “Cadillac Health Plan Tax” would be suspended for tax years 2020 through 2025. The ACA imposes a 40% tax on “excess benefits” arising under employer-sponsored group plans. The tax is currently scheduled to be effective for taxable years beginning after December 31, 2019. Liability for the tax is imposed on the health insurance issuer in the case of group health plans (for this purpose, a plan of, or contributed to by, an employer (including a self-employed individual) or employee organization to provide health care, directly or otherwise, to employees, former employees, the employer and other associated persons). Employers must pay the tax in the case of plans under which the employer makes contributions to an HSA or Archer MSA. In all other cases, the tax is paid by the person that administers the plan benefits. The tax also applies to group health coverage obtained by self-employed individuals (including partners in a partnership) if a tax deduction is allowed for any part of their coverage.
- ***Repeal of Disallowance on Deductions for Remuneration by Covered Health Insurance Providers:*** The AHCA would repeal the disallowance imposed by the ACA of federal income tax deductions for compensation paid by any “covered health insurance provider” to an employee, officer, director or other individual service provider in excess of \$500,000. The AHCA would repeal this disallowance for taxable years beginning after December 31, 2017. A “covered health insurance provider” is any employer that is an insurance company, insurance service or insurance organization (including an HMO) that is licensed to engage in the business of insurance in a state that is subject to state insurance law and regulation and that derives at least 25% of its gross health insurance premiums from providing Minimum Essential Coverage.
- ***Annual Fees on Entities in Certain Health-Related Industries:*** The ACA imposes a fee on entities in the business of providing health insurance for any U.S. health risks. These entities are required to pay their share of an annual industry-wide fee (based on each entity's share of net premiums written and third-party administration costs), which is set at \$14.3 billion for 2018 and is indexed to the rate of premium growth for subsequent years. The ACA also imposes a fee on entities “engaged in the business of manufacturing or importing branded prescription drugs.” Those entities are required to pay their share (based on each entity's share of sales of branded prescription drugs pursuant to specified governmental programs) of an annual industry-wide fee, which is set at \$4.1 billion for 2018 and at \$2.8 billion for 2019 and each year thereafter. The AHCA would repeal all such fees for calendar years beginning after December 31, 2017.
- ***Medical Device Sales Tax:*** The ACA imposes a 2.9% tax on the sale of “taxable medical devices” (a medical device intended for humans other than FDA class I devices, eyeglasses, contact lenses, hearing aids and any other medical device determined by the Internal Revenue Service to be of a type generally purchased by the public at retail for individual use). The AHCA would repeal such taxes for sales after December 31, 2017.
- ***Itemized Deduction Threshold:*** Prior to the passage of the ACA, the itemized deduction for medical expenses was allowed to the extent such expenses exceeded 7.5% of a person's adjusted gross income. Under the ACA, this threshold increased to 10% of adjusted gross income. The AHCA would reduce the threshold to 7.5%, effective, in the case of taxpayers under 65, for taxable years beginning after December 31, 2017 and, in the case of taxpayers 65 or older, immediately.
- ***Other Tax-Related Provisions:*** The AHCA would also repeal the following tax-related provisions of the ACA, for taxable years beginning after December 31, 2017:
 - ***Elimination of Deduction for Expenses Related to Medicare Part D Subsidy.*** Prior to the passage of the ACA, an employer was entitled to a tax deduction with respect to expenses of offering retiree prescription drug coverage, even if the employer also was receiving a federal subsidy under Medicare Part D with respect to a portion of that coverage. The ACA provides that employers would no longer be allowed a deduction for expenses allocable to the Medicare Part D subsidy.
 - ***Tanning Services.*** The ACA imposes a tax of 10% on amounts paid for indoor tanning services.

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Several provisions of the ACA would remain unchanged under the AHCA, although (as discussed above) the application of some of those provisions (and the availability or affordability of the coverages required to be offered by those provisions) could be affected to the extent the AHCA permits states to waive certain coverage terms. Key ACA provisions that would not be technically changed by the AHCA include:

- **Required coverage terms for group health plans and insurers generally**, such as: (i) extension of dependent coverage for an adult child until 26 years of age; (ii) prohibition on preexisting condition exclusions for enrollees under 19 (subject to potential rate increases in states granted waivers); (iii) limits on rescission except in case of fraud or other specified circumstances; (iv) prohibition on lifetime or annual limits on “essential health benefits” (subject to state waivers relating to “essential health benefits”); (v) required coverage for certain preventive services without any cost-sharing; (vi) prohibition of discrimination by group health plans in favor of “highly compensated individuals”; (vii) certain requirements relating to plans covering obstetric or gynecologic care and emergency services; (viii) required provision of a claims appeals process meeting specified requirements; and (ix) prohibition on gender rating;
- **Required coverage terms for coverage in Individual and Small Group Market only**, including (i) the required coverage of “essential health benefits” (subject to state waivers granting states the authority to establish their own definition of “essential health benefits”), and (ii) guaranteed availability and non-discrimination on the basis of health status for coverage in the Individual and Small Group Market as well as prohibitions on variance of premium rates except for those based on specific criteria (subject to states obtaining Community Rating Waivers);
- **Required provision of disclosures regarding coverage**, such as: (i) standardized benefit summaries, and (ii) additional information such as claims payment policies and procedures, data on disenrollment and denied claims, etc.;
- **Policies toward health care providers**, including: (i) prohibition of discrimination by group health plans and insurers with respect to participation under a plan or coverage under any health care provider that is acting within the scope of the provider’s license or certification under applicable state law,²² and (ii) requirement to permit enrollees to designate any available participating primary care provider;
- **Supervisory activities of the SHHS**, including (i) premium increase review by the SHHS, and (ii) annual reports to the SHHS regarding benefits and reimbursement structures;
- **Minimum medical loss ratio and rebates**, including requirements for insurers to (i) disclose annual medical loss ratios and (ii) provide rebates if the ratios of health care expenditures to premium in a plan year are below certain thresholds;
- **ACA Exchanges**, including (i) the required operation of the ACA Exchanges for Individual and Small Group Markets, and (ii) the required mechanisms for soliciting interest and enrollment in coverage through an ACA Exchange;
- **Transitional risk transfer mechanisms** intended to allocate certain actuarial risks associated with the Individual and Small Group Market across insurers, health plans and the federal and state governments, such as a program of assessment and subsidies that indexes every health plan or insurer’s actuarial risk to average risk within its home state (“actuarial risk adjustment program”); and
- **Other tax-related provisions**, including (i) the codification of the economic substance doctrine, (ii) additional requirements for entities seeking to qualify for tax-exempt status as hospitals, and (iii) the disapplication of special rules applicable to Blue Cross and Blue Shield organizations where such an organization has a medical loss ratio under 85%.

The AHCA also contains several provisions that affect Medicaid, the Prevention and Public Health Fund, and funding to specified “prohibited entities,” some of which are summarized below.

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- **Medicaid Funding Cuts:** With respect to Medicaid, the AHCA would eliminate funding for new enrollees under the ACA's expansion of Medicaid,²³ and the "essential health benefits" requirement would no longer apply to state-provided Medicaid plans. The AHCA would codify that the Medicaid expansion²⁴ is a state option, effective January 1, 2020, and would sunset the enhanced federal matching rates provided for under the ACA for reimbursements for individuals that have newly become eligible for Medicaid under the Medicaid expansion beginning January 1, 2020.²⁵ Additionally, states would be permitted to condition Medicaid assistance to nondisabled, non-elderly and non-pregnant individuals upon satisfaction of a "work requirement," subject to certain exceptions.²⁶ Further, the AHCA would (i) impose a cap, beginning in 2020, on each state's Medicaid expenditures reimbursed by the federal government using a per-capita target medical expenditure cap, using a formula based on the state's 2016 medical assistance expenditures (provided that a state may elect to receive a Medicaid "block grant" for specified categories of enrollees for 10 fiscal years subject to the approval of the SHHS),²⁷ (ii) revise the Medicaid eligibility requirements relating to proof of citizenship or lawful presence, treatment of lottery winnings, allowable home equity limits, retroactive eligibility and presumptive eligibility determinations, and (iii) require states that had elected Medicaid expansion to more frequently re-determine Medicaid eligibility status. Further, the AHCA would lower, from 133% to 100% of the official poverty line, the minimum family income threshold that a state may use to determine the Medicaid eligibility of children between the ages of 6 and 19.
- **Prevention and Public Health Fund De-Funding:** The AHCA would also de-fund the Prevention and Public Health Fund, established under the ACA beginning in fiscal year 2019, and rescind any unobligated funds remaining at the end of 2018.²⁸ The AHCA would, however, provide supplemental funding for community health centers of \$422 million for 2017.
- **Prohibitions Relating to Funding and Tax Credits for Abortion Services:** For one year following the enactment of the AHCA, the federal funds given to states under certain programs²⁹ would be prohibited from being used for payments to "Prohibited Entities." A "Prohibited Entity" is defined as any non-profit "essential community provider" that (i) is primarily engaged in family planning services, reproductive health, and related medical care, (ii) provides for abortions other than if the pregnancy is the result of rape or incest, or would place the woman in danger of death, and (iii) received over \$350 million in federal and state payments under the Medicaid program in fiscal year 2014 (this would include, for example, Planned Parenthood Federation of America). In addition, federal premium tax credits would not be available for plans that cover abortion services (other than for saving the life of the woman or in cases of rape or incest).

NEXT STEPS

The AHCA will need to be passed by the Senate before the President can sign it into law. It is unclear whether the AHCA will be introduced in the Senate, especially as multiple Republican Senators have signaled that the Senate will put forth its own budget reconciliation bill.³⁰ Two budget reconciliation bills pursuant to the Budget Resolution were submitted to the Senate Committee on Finance in January 2017: the Patient Freedom Act of 2017 and the Obamacare Replacement Act.³¹ However, no actions have been taken so far with respect to either of the bills.

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- 1 U.S. Congress, “H.R. 1628 – American Health Care Act of 2017,” accessed on May 6, 2017, available at: <https://www.congress.gov/bill/115th-congress/house-bill/1628?q=%7B%22search%22%3A%5B%22HR+1628%22%5D%7D&r=1>.
- 2 The ACA specifies several categories of benefits that must be included in the definition of “essential health benefits,” including: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance abuse disorder services; prescription drugs; rehabilitation services; laboratory services; preventative and wellness services; and pediatric services. See S&C, “Health Care Legislation,” dated March 26, 2010, available at: <https://www.sullcrom.com/Health-Care-Legislation-03-26-2010> (the “ACA Memo”) at 27.
- 3 The Individual and Small Group Market refers to individual health insurance coverage and plans maintained by employers that had an average of at least one and at most 100 employees on business days in the preceding calendar year.
- 4 For more details on the ACA, please see the ACA Memo.
- 5 Exec. Order. No. 13765, 82 FR 8351 (January 20, 2017), available at: <https://www.federalregister.gov/documents/2017/01/24/2017-01799/minimizing-the-economic-burden-of-the-patient-protection-and-affordable-care-act-pending-repeal>.
- 6 The White House, “Three-Pronged Approach to Repeal and Replace Obamacare,” dated March 10, 2017, available at: <https://www.whitehouse.gov/repeal-and-replace>.
- 7 A budget reconciliation bill may implement any budget-related provisions such as taxing and spending, but may not amend other provisions. Importantly, a budget reconciliation bill only requires a simple majority vote to be passed in the Senate and is not subject to filibuster.
- 8 Under the McCarran-Ferguson Act (15 U.S.C. §§ 1011-1015), passed by Congress in 1945, state laws governing the business of insurance cannot be invalidated, preempted, impaired or superseded by any federal law unless the federal law specifically relates to the business of insurance.
- 9 U.S. Congress, “H.R.372 – Competitive Health Insurance Reform Act of 2017,” accessed on March 23, 2017, available at: <https://www.congress.gov/bill/115th-congress/house-bill/372/committees>.
- 10 U.S. Congress, “H.R.1101 – Competitive Health Insurance Reform Act of 2017,” accessed on March 23, 2017, available at: <https://www.congress.gov/bill/115th-congress/house-bill/1101/committees>.
- 11 The March 20, 2017 manager’s amendment made certain policy changes to the Medicaid-related provisions and tax-related provisions of the AHCA. See the House Committee on Rules, Manager’s Amendment (Policy Changes) to H.R. 1628, dated March 20, 2017, available at: https://rules.house.gov/sites/republicans.rules.house.gov/files/115/AMDT/policy-mngr_01_xml.pdf.
- 12 The March 23, 2017 manager’s amendment made certain policy changes to the repeal of the ACA tax provisions, see the House Committee on Rules, Policy Amendment to the Manager’s Amendment (Policy Changes) to H.R. 1628, dated March 20, 2017, available at: <http://amendments-rules.house.gov/amendments/policyamdmngr32317220032032.pdf>.
- 13 The Minimum Essential Coverage requirement can be satisfied by obtaining coverage under any employer plan, a government-sponsored plan (including Medicare, Medicaid and CHIP), or other plans designated by the SHHS.
- 14 The AHCA would also modify eligibility for the ACA tax credits for 2018 and 2019, including, among other things, by making the tax credit available for catastrophic qualified health plans and

ENDNOTES (CONTINUED)

plans not offered through an ACA Exchange, and by prohibiting the credit from being used for grandfathered health plans or grandmothers health plans or for health plans that cover abortions (other than abortions necessary to save the life of the mother or with respect to a pregnancy resulting from rape or incest). Grandfathered health plans refer to health insurance coverage purchased prior to enactment of the ACA and are exempted from certain ACA coverage term requirements; grandmothers health plans refer to health insurance coverage purchased in the individual market between the ACA's enactment and October 1, 2013 and are also exempted from certain ACA coverage term requirements (but fewer than grandfathered plans),.

15 Eligible Health Insurance includes any health coverage that (i) is offered in the individual health insurance market within a state or an unsubsidized COBRA continuation coverage, (ii) is not a grandfathered health plan or a grandmothers health plan, (iii) is not substantially comprised of "excepted benefits" that are not subject to the ACA requirements, (iv) does not include coverage for abortions (other than if the pregnancy is the result of rape or incest, or would place the woman in danger of death), and (v) is certified by the state in which it is offered as meeting the preceding requirements.

16 It is possible, subject to future determinations by SHHS, that the essential health benefits determined by a state pursuant to a waiver could be used, with respect to large group insured coverage and self-insured coverage offered by employers (which are otherwise exempt from the essential health benefit requirements of the ACA), as a benchmark to determine which essential health benefits would be subject to the annual and lifetime benefit prohibitions applicable to all employees covered under such plans (whether these employees reside in the state that was granted the waiver or in other states).

17 CO-OP Programs are permitted under the ACA to provide for qualified nonprofit health insurers to offer qualified health plans.

18 Under the ACA, multiple states may enter into "health care choice compacts" through which qualified health plans of insurers meeting certain standards could be offered in the individual markets in all such states but only be subject to the laws of the state in which the plan was written and issued. Such compacts must be approved by the SHHS.

19 Under the ACA's state innovation waiver provisions, a state is permitted to apply to the SHHS to waive, subject to certain conditions, ACA requirements pertaining to qualified health plans, the ACA Exchanges, cost-sharing subsidies, premium tax credits, and the Individual Mandate for plan years beginning in 2017.

20 Specifically, the "permitted uses" under the AHCA include: (i) helping "high-risk individuals" without coverage through their employers to get insurance coverage in the individual market; (ii) providing incentives to appropriate entities to enter into "arrangements" with the state to help stabilize premiums for health insurance coverage in the individual market; (iii) reducing the cost of health insurance coverage in the individual market and small group market for individuals with a high-utilization rate of health services; (iv) promoting participation in the individual market and small group market in the state and increasing health insurance options available through such market; (v) promoting access to preventive services, dental care services, vision care services, or services for mental health and substance use disorders; (vi) maternity coverage and newborn care; (vii) prevention, treatment or recovery support for mental or substance use disorders; (viii) providing payments to health care providers for provision of services specified by the administrator for the Centers for Medicare and Medicaid Services; and (ix) providing assistance to reduce out-of-pocket costs of individuals enrolled in health insurance coverage in the state.

21 For instance, a plan in the bronze level provides a level of coverage that is designed to provide benefits that are actuarially equivalent to 60% of the full actuarial value of the benefits provided under the plan. Silver-level plans, gold-level plans and platinum-level plans are designed to provide benefits actuarially equivalent to 70%, 80% and 90%, respectively, of the full actuarial value of the benefits provided under the plan.

ENDNOTES (CONTINUED)

- 22 However, a group health plan or an insurer (i) is not required to contract with any health care provider willing to abide by its terms and conditions, and (ii) may establish varying reimbursement rates based on quality or performance measures.
- 23 The ACA expanded Medicaid eligibility such that those with income levels between 100% and 133% of the federal poverty line could also be covered by Medicaid. Under the AHCA, states would receive an increased federal medical assistance percentage (“FMAP”) for individuals that have become newly eligible under Medicaid expansion through 2019, but, starting in 2020, the increased FMAP would apply only if the eligible individual were enrolled as of the end of 2019 and has not had a break in coverage longer than one month since December 31, 2019. Beginning in 2020, states that have elected Medicaid expansion may continue to enroll non-pregnant childless adults that are eligible for Medicaid expansion, but will not receive the increased FMAP.
- 24 Under the ACA, a state electing Medicaid expansion could extend coverage to individuals with incomes up to 133% of the federal poverty level and receive matching federal funding, with the matching rate enhanced for individuals that have become newly eligible for Medicaid under the Medicaid expansion.
- 25 The enhanced federal matching rate for individuals that have become newly eligible for Medicaid under the Medicaid expansion will apply for expenditures through December 31, 2019. Thereafter, the enhanced federal matching rate will apply only if the eligible individuals were enrolled in Medicaid as of December 31, 2019 and did not have any break in coverage for more than one month in the period after December 31, 2019.
- 26 The “work requirement” could be satisfied by performing work activities that currently qualify for the Temporary Assistance for Needy Families (TANF) activities for a period of time to be determined by each state. The requirement would not apply to an individual whose pregnancy ended in the past 60 days, an individual who is under 19 years old, an individual who is the sole caretaker of a child under 6 years of age or with disabilities, or an individual who is married or a head of household and has not attained 20 years of age and is currently receiving secondary or vocational education.
- 27 A state may apply to receive a block grant of funds for (i) children and adults who have not become newly eligible under the Medicaid expansion, or (ii) such adults only. The amount of block grants would be determined based on the target per capita medical expenditure multiplied by the number of enrollees under each category, adjusted for inflation. The block grants would become available beginning fiscal year 2020.
- 28 Under the ACA, the Prevention and Public Health Fund is intended to provide for investment in prevention and public health programs to improve health and restrain the rate of growth in health care costs.
- 29 The subject programs include (i) Medicaid, (ii) the children’s health insurance block grants, (iii) the Maternal and Child Health Service Block Grants, and (iv) the social service block grants.
- 30 See, e.g., Washington Post, “While House passes GOP health-care bill, Senate prepares to do its own thing”, dated May 4, 2017, available at https://www.washingtonpost.com/powerpost/if-house-passes-gop-health-care-bill-a-steeper-climb-awaits-in-the-senate/2017/05/04/26a901da-30bd-11e7-8674-437ddb6e813e_story.html?utm_term=.0dd41b72816a; Bloomberg, “Senate Republicans Plan Health Bill That Keeps Some of Obamacare”, dated May 7, 2017, available at: <https://www.bloomberg.com/politics/articles/2017-05-07/senate-republicans-plan-health-bill-that-keeps-some-f-obamacare> (reporting Senator Susan Collins’s statement during an interview with ABC that “the Senate is starting from scratch”).
- 31 The Patient Freedom Act of 2017 (“PFA”) was introduced by Senators Susan Collins, Bill Cassidy, Shelley Moore Capito and Johnny Isakson on January 23, 2017. The PFA contemplates repealing the federal mandates under the ACA and permitting each state to either (i) re-implement the federal mandates under the ACA, (ii) enact a new market-based system with

ENDNOTES (CONTINUED)

federal assistance, or (iii) design an alternative state regime without any federal assistance. The Obamacare Replacement Act (“OCA”) was introduced by Senator Rand Paul on January 25, 2017. OCA contemplates, among other measures, (i) repealing the ACA, (ii) expanding credits for HSAs and permitting HSAs to be used by individuals who are enrolled in health plans that are not high-deductible plans, and (iii) creating means for small businesses and individuals to form association health plans across state lines to purchase health insurance coverage. See S. 191, 115th Congress (2017), available at: <https://www.congress.gov/bill/115th-congress/senate-bill/191/text?q=%7B%22search%22%3A%5B%22%5C%22patient+freedom+act%5C%22%22%5D%7D&r=1>; see also, S. 222, 115th Congress (2017), available at: <https://www.congress.gov/bill/115th-congress/senate-bill/222/text?q=%7B%22search%22%3A%5B%22%5C%22obamacare+replacement+act%5C%22%22%5D%7D&r=2>.

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