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## Overview of the American Health Care Act

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# HEALTH REFORM POLICY BRIEF

March 2017

## OVERVIEW OF THE AMERICAN HEALTH CARE ACT

On March 6, 2017, the U.S. House of Representatives' Ways and Means and Energy and Commerce committees unveiled a plan to repeal and replace the Affordable Care Act (ACA). The plan, the American Health Care Act (AHCA; H.R. 1628), was the most recent in a series of ACA replacement proposals circulated among Washington policymakers. On March 24, 2017, the legislation was opened to the House floor for consideration, and after four hours of debate, was withdrawn prior to a vote. What follows is an overview of key provisions of the AHCA, as amended on March 20, 2017, and March 23, 2017, including proposed changes to Medicaid and the individual insurance market, as well as federal cost estimates.

### KEY FEATURES OF THE AHCA INCLUDE:

- Medicaid reforms via per capita caps or block grants of federal funding, permitting work requirements for some beneficiaries, and ending the ACA's Medicaid expansion enhanced federal match;
- Continuous coverage lapse penalty instead of an individual mandate and tax penalty;
- Health care tax credits based on age instead of income and health insurance cost;
- Directing states to define essential health benefits (EHBs);
- State funding for high-risk pools or other programs to help manage the expense of insuring individuals with chronic and costly conditions, including maternity, newborn, and mental health care;
- Repeal of taxes on high-income individuals and the health care industry; and
- Expansion of health savings accounts (HSAs)

### REMAINING PROVISIONS OF THE ACA

Despite making substantial changes to the ACA, the following insurance market provisions would remain:

- No preexisting condition exclusions;
- No health status underwriting;
- Guaranteed issue and renewability;
- No annual or lifetime limits;
- Dependents can remain covered until age 26; and
- Caps on out-of-pocket expenses.

Several of the themes from previous ACA replacement proposals were not included in the AHCA. Some of these policies may have been excluded because they did not meet the requirements of budget reconciliation, which was being used as the legislative vehicle for the AHCA. For example, the AHCA did not address the purchase of insurance across state lines or malpractice reform. Although these reforms were not covered by the AHCA, they may be subsequently addressed.

According to the White House, the AHCA was just the first step of a three-pronged federal health reform approach of reconciliation, regulation, and regular order. Regulation would include regulatory changes from the Department of Health and Human Services, as well as state waiver encouragement by the new Centers for Medicare and Medicaid Services (CMS) administrator. Regular order would consist of further legislation containing nonbudgetary changes, passed through the normal legislative process.

*The Georgia Health Policy Center (GHPC) Health Reform Work Group is a multidisciplinary team composed of faculty and staff from Georgia State University's Andrew Young School of Policy Studies, J. Mack Robinson College of Business, School of Public Health, College of Law, and Rollins School of Public Health at Emory University.*

## CHANGES TO MEDICAID

### Per Capita Caps and Block Grants

Starting in 2020, the AHCA would have funded Medicaid with per capita caps and optional block grants. Per capita caps would apply to five eligibility groups — elderly, blind and disabled, children (under 19), expansion adults, and other nonelderly, nondisabled, nonexpansion adults based on 2016 expenditures.<sup>1</sup> Per capita cap growth rates were to be based on variations of the medical care component of the Consumer Price Index for All Urban Consumers (CPI-U). States that exceeded their per capita caps would have been required to repay the overage amount the following fiscal year.

States would have had the option to provide health care for nonelderly and nondisabled groups through a 10-fiscal-year renewable block grant, rather than per capita caps. Funding for the block grant would have been based on the formula used to determine per capita caps. As with per capita caps, block grant growth rates would have been based on the CPI-U, but without adjustment for changes in population. States would have rolled over any unused funds for as long as they retained the block grant.

### Work Requirements

On Oct. 1, 2017, states could have begun instituting work requirements for nondisabled, nonelderly, nonpregnant adults as a condition of receiving Medicaid coverage. Countable work activities and exemptions were modeled after similar requirements in Temporary Assistance for Needy Families. States would have received a 5% administrative Federal Medical Assistance Percentage (FMAP) bump if they implemented the work requirement.

### Medicaid Expansion

Under the AHCA, states that as of March 1, 2017, had already expanded Medicaid under the ACA to cover childless, nondisabled, nonelderly, nonpregnant adults up to 133% of the federal poverty level (FPL) would have retained eligibility for an enhanced FMAP for their expansion population who had no more than a one-month break in eligibility. All other states would have had until Dec. 31, 2017, to expand Medicaid, although these states would have only received the regular FMAP for their expanded population.

### Safety Net Funding for Nonexpansion States

Nonexpansion states could have applied for safety net funding to increase payments to safety net providers. States could access up to \$2 billion each year for five years (fiscal years [FYs] 2018-2022) if their Medicaid program remained unexpanded. The actual allotment to states would have been based on a ratio comparing the number of individuals in the state with incomes below 138% FPL in 2015 to the total number of individuals

meeting the same income criterion for all nonexpansion states. While payment adjustments could not exceed provider costs, they could have been applied to the costs of furnishing health care services for Medicaid members, the underinsured, and the uninsured. Payments would have been funded at 100% by the federal government in FY 2018-2021 and at 95% in FY 2022.

## CHANGES TO THE INDIVIDUAL MARKET

### Continuous Coverage Lapse Penalty

Under the ACA, individuals faced a tax penalty for not having health insurance (2.5% of household income or \$695, whichever was greater). The AHCA retroactively repealed the individual mandate by reducing the tax penalty to 0% of household income, or \$0, effective Jan. 1, 2016. To encourage continuous health insurance enrollment, the AHCA introduced a premium penalty to be levied on individuals seeking coverage who were without health insurance for at least 63 continuous days in the 12 months prior to enrollment. The penalty would require insurers to charge policyholders 30% above the premium rate for the plan year.

### Tax Credits

To provide assistance for purchasing nongroup health coverage, the AHCA proposed replacing the ACA's sliding-scale, premium tax credits, cost-sharing subsidies, and requirements for minimum actuarial value with an advanceable, refundable flat tax credit variable only by age.

THE FOLLOWING TAX CREDIT AMOUNTS  
WOULD HAVE BEEN AVAILABLE TO  
INDIVIDUALS EARNING UP TO \$75,000  
(\$150,000 FOR A COUPLE FILING JOINTLY)  
BEGINNING IN 2020:

Age 29 and under	\$2,000
Age 30 to 39	\$2,500
Age 40 to 49	\$3,000
Age 50 to 59	\$3,500
Age 60 and over	\$4,000

For each dollar an individual earned over \$75,000, the tax credit would have been reduced by 10 cents. A family could claim tax credits for its five eldest members, but the tax credit amount could not exceed \$14,000. Unlike the ACA's tax credits and subsidies, the AHCA credits did not vary based on the price of available health insurance or by income. The AHCA tax credit could have been used to purchase plans on the health care exchange, including plans offering catastrophic coverage and certain plans sold outside the exchange

<sup>1</sup> Payment adjustments made for administrative costs, disproportionate share hospitals, Medicare cost sharing, and safety net provider payment adjustments in nonexpansion states are excluded from total expenditures. Medicaid members enrolled under the Children's Health Insurance Program (CHIP), Indian Health Service beneficiaries, breast and cervical cancer enrollees, and partial-benefit enrollees are excluded from the enrollee count.

that met essential health benefit (EHB) standards. Additionally, as amended, the AHCA directed states to define EHBs for their own markets. Tax credits could not have been used to purchase plans that offered coverage for abortion services, except for pregnancies that are life-threatening or the result of rape or incest.

### Age Rating

The AHCA modified the amount premiums were permitted to vary by age. Beginning in 2018, insurers would have been allowed to charge older enrollees up to five times more for insurance premiums than younger enrollees (5:1 ratio), whereas the ACA limited this ratio to 3:1.

### Patient and State Stability Fund

Instead of federal reinsurance and cost sharing, the AHCA created a Patient and State Stability Fund, with \$15 billion appropriated for 2018 and 2019 (and \$10 billion annually thereafter). This fund would have allowed states to design their own programs and define EHBs to stabilize and lower costs in the insurance market. Programs could include high-risk pools, reinsurance, and subsidies. The fund also would have appropriated \$15 billion for providing coverage for certain specified services, including maternity, newborn, dental, vision, mental health, and substance use disorder services. State funding allotments were to be calculated based on measures of insurance market instability and high insurance cost, including incurred claims and medical loss ratio, increases in the uninsured population under 100% FPL, and fewer than three plans being offered in the marketplace. In states that chose not to design their own programs, CMS would have used the money to stabilize the insurance market.

## OTHER AHCA CHANGES

### Employer Mandate Repeal

The AHCA would have repealed the employer mandate, which requires employers with over 50 full-time employees (working over 30 hours a week) to offer full-time employees health insurance coverage that is of "minimum value" (pays at least 60% of the cost of covered services) and "affordable" (employee contributions for employee-only coverage do not exceed a certain percentage of an employee's household income), or face penalties.

### Tax Repeals and HSAs

The AHCA, as amended, also would have repealed a number of ACA taxes, effective in 2017, including:

- Medical device tax;
- Tanning bed tax;
- High-income net investment tax;

- Insurance provider remuneration tax;
- Annual tax on certain health insurers; and
- Tax on certain brand pharmaceutical manufacturers.

Additionally, in 2017 the AHCA, as amended, would have reinstated the business expense deduction for retiree prescription drug costs and repealed the ACA's increase in income threshold for deducting taxpayers' qualified medical expenses by lowering it from 10% to 5.8%, an amount lower than the 7.5% required before the ACA. For taxable years 2023 and beyond, the legislation repealed the additional Medicare tax increase.

The AHCA also would have made a number of tax adjustments to benefit health savings accounts (HSA) users, beginning in 2017. The AHCA would have increased annual HSA contribution limits to \$6,550 for individuals and \$13,100 for families, while decreasing tax penalties for spending HSA funds on unqualified expenses (from 20% to 10%). Furthermore, the AHCA added over-the-counter medicines as an HSA-reimbursable, qualified medical expense, allowed both spouses to make catch-up contributions to one HSA, and increased the time frame for qualified medical expenses prior to HSA establishment.

### Population Health

The AHCA would have increased funding for the Community Health Center Fund in 2017 by \$422 million and repealed funding for the Prevention and Public Health Fund, which supports public health initiatives in areas such as diabetes, heart disease, lead poisoning, suicide prevention, immunization, and Alzheimer's disease (budget of \$931 million in 2017).

## FEDERAL COST AND COVERAGE ESTIMATES

The nonpartisan Congressional Budget Office (CBO) and Joint Committee on Taxation estimated that over the next 10 years (2017-2026), the AHCA would have reduced federal deficits by \$150 billion by reducing spending by \$1.15 trillion and revenues by \$999 billion.<sup>2</sup> The majority of the savings would have come from the \$839 billion reduction in Medicaid funding and the \$663 billion reduction in insurance subsidies, while the majority of spending would have been due to the \$357 billion in tax credits, and \$733 billion and \$210 billion in reduced revenue resulting from the elimination of a variety of taxes and the individual mandate, respectively. The AHCA's tax cuts would have depleted the Medicare Trust Fund by \$126.8 billion between 2017 and 2026.

<sup>2</sup> Congressional Budget Office. (March 23, 2017). Cost estimate: H.R. 1628, the American Health Care Act, incorporating manager's amendments 4, 5, 24, and 25. Accessed from <https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/hr1628.pdf>; Congressional Budget Office. (March 13, 2017). Congressional Budget Office cost estimate: American Health Care Act Budget Reconciliation Recommendations of the House Committees on Ways and Means and Energy and Commerce, March 9, 2017. Accessed from <https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/americanhealthcareact.pdf>.

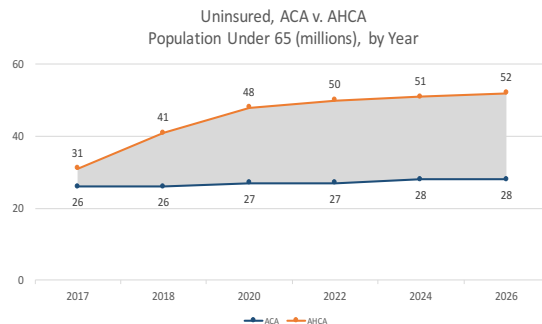
## Estimated AHCA Costs

AHCA PROVISION	SAVINGS V. SPENDING / REVENUE REDUCTION*
Medicaid cuts	\$839 billion
Insurance subsidy elimination	\$663 billion
Small employer tax credit elimination	\$6 billion
New individual tax credits	-\$357 billion
Employment-based health insurance coverage shifts	\$70 billion
Individual mandate penalty elimination	-\$210 billion
New Patient and State Stability Fund	-\$80 billion
Medicare DSH cuts elimination	-\$48 billion
Tax repeals	-\$733 billion
<b>Net savings</b>	<b>\$150 billion</b>

\*Numbers do not add up to total because of rounding.  
Source: Congressional Budget Office; staff of the Joint Committee on Taxation.

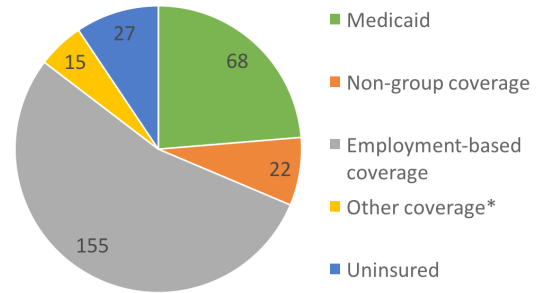
The CBO further predicted that the health insurance market would have had the same stability under the AHCA as it currently does under the ACA and that individual market premiums would have temporarily risen (by 15% to 28% in 2018 and 2019) and then eventually fallen by approximately 10% by 2026, as compared to where they would have been under the ACA. Declining premiums after 2020 were due to projections that older and sicker individuals would have dropped out, leaving a younger mix of enrollees in the individual market and because repeal of the actuarial value requirements would have shifted premium costs to higher deductibles and cost sharing. The AHCA's change in rating bands would have likely allowed younger enrollees to see significant reductions to their premiums, while older enrollees might have experienced substantially greater premiums.

The CBO also estimated that the AHCA's provisions would have had the net effect of reducing health care insurance coverage by 14 million people in 2018 and by 24 million people by 2026.

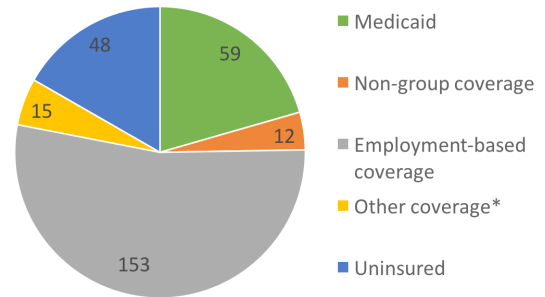


Source: Congressional Budget Office; staff of the Joint Committee on Taxation

Health Insurance Coverage 2016 - ACA  
Population Under 65 (millions)



Health Insurance Coverage 2020 - AHCA  
Population Under 65 (millions)



\*Other coverage includes: Medicare, Basic Health Program, and other categories such as student plans, foreign coverage, and Indian Health Service coverage.

Source: Congressional Budget Office; staff of the Joint Committee on Taxation.

## TRACKING HEALTH REFORM

The Georgia Health Policy Center (GHPC), has been a neutral source of health policy information and analysis for more than 20 years. GHPC's [Health Reform Work Group](#) is composed of faculty and staff from Georgia State University's Andrew Young School of Policy Studies, J. Mack Robinson College of Business, School of Public Health, College of Law, and Rollins School of Public Health at Emory University. Team members have expertise in the areas of health policy, health care administration and finance, economics, insurance, risk management, employee benefits, population health, and health law.

The Health Reform Work Group will continue to track the development of health reform, and translate and disseminate information to stakeholders, through policy briefs, presentations, panel discussions, toolkits, and webinars. For further updates and tools for health reform, please visit GHPC's website at <http://ghpc.gsu.edu/>.

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