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American health care ACT (AHCA) update

Georgia Health Policy Center

AMERICAN HEALTH CARE ACT (AHCA) UPDATE

May 2017

On May 4, 2017, the U.S. House of Representatives passed its plan to repeal and replace the Affordable Care Act (ACA), the American Health Care Act (AHCA; H.R. 1628), by a narrow margin of votes. What follows is an overview of the AHCA's key elements, as passed by the House, and corresponding cost and insurance coverage estimates, calculated by the Congressional Budget Office (CBO).

Key Features of the AHCA:

- Medicaid reforms through federal funding per capita caps or block grants, and permitting work requirements for some beneficiaries
- 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
- Increased amount that individual market insurance premiums may vary by age
- State option to waive essential health benefits (EHBs) and community rating (including preexisting conditions requirements)
- Federal invisible high-risk pool and state funding for high-risk pools or other programs to help manage the expense of insuring individuals with costly, chronic conditions
- Repeal of most of the ACA's taxes
- Enhanced health savings accounts (HSAs)

A Three-Pronged Approach to Reform

According to the White House, the AHCA is just the first step of a three-pronged, federal approach to health reform that relies on reconciliation, regulation, and regular order. The AHCA uses reconciliation to fast-track legislation through Congress. Accordingly, several of the themes from previous ACA replacement proposals (e.g., purchase of insurance across state lines and malpractice reform) were not included in the AHCA as they did not meet the requirements of budget reconciliation. Regulation includes regulatory changes, such as the Department of Health and Human Services (HHS) Market Stabilization Rule, or administrative actions, such as HHS communications encouraging state participation in Medicaid 1115 waivers and ACA 1332 waivers. Regular order consists of additional legislation containing nonbudgetary changes, passed through the normal legislative process.

Changes to Medicaid

Per Capita Caps and Block Grants

Starting in 2020, the AHCA will change Medicaid funding to per capita caps or block grants, depending on state preference. Per capita caps will apply to five eligibility groups — elderly, blind and disabled, children (under 19), expansion adults, and other nonelderly, nondisabled, nonexpansion adults based on 2016 state Medicaid expenditures.[1]

Per capita cap growth rates will be based on variations of the medical care component of the Consumer Price Index for All Urban Consumers (CPI-U). States that exceed their per capita caps will be required to repay the overage amount the following fiscal year (FY). States also have the option to

[1] 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, Indian Health Service beneficiaries, breast and cervical cancer enrollees, and partial-benefit enrollees are excluded from the enrollee count.

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provide health care for nonelderly and nondisabled groups through a 10-fiscal-year renewable block grant. Funding for the block grant will use a formula similar to the one used to determine per capita caps. As with per capita caps, block grant growth rates will be based on the CPI-U, but without adjustment for changes in population. States will be able to roll over unused funds while they retain the block grant.

Medicaid Expansion

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) will retain eligibility for an enhanced Federal Medical Assistance Percentage (FMAP) for their expansion population, provided they have no more than a one-month break in eligibility. Under the AHCA, all other states will have until Dec. 31, 2017, to expand Medicaid, although they will only receive the regular FMAP for their expanded population.

Work Requirements

On Oct. 1, 2017, states will be able to institute work requirements for nondisabled, nonelderly, nonpregnant adults as a condition of receiving Medicaid coverage. Countable work activities and exemptions are modeled after similar requirements in Temporary Assistance for Needy Families. States implementing the work requirement will receive a 5% administrative FMAP bump.

Safety Net Funding for Nonexpansion States

Nonexpansion states can apply for funding to increase payments to safety net providers. States can access up to $2 billion each year for five years (FYs 2018-2022) if their Medicaid program remains unexpanded. The actual allotment to states will be 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 cannot exceed provider costs, they can be applied to the costs of furnishing health care services for Medicaid members, the underinsured, and the uninsured. Payments will be funded at 100% by the federal government in FYs 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 will retroactively repeal the individual mandate by reducing the tax penalty to 0% of household income ($0), effective Jan. 1, 2016. To encourage continuous health insurance enrollment, the AHCA introduces a premium penalty, 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 requires 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 replaces the ACA's sliding-scale, premium tax credits, cost-sharing subsidies, and requirements for minimum actuarial value with an advanceable, refundable flat tax credit that varies only by insured's age.

AHCA Tax Credits

The following tax credit amounts will be available to individuals earning up to $75,000 (or $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 earns over $75,000, the tax credit will be reduced by 10 cents. A family can claim tax credits for its five eldest members, with a maximum tax credit of $14,000. Unlike the ACA's tax credits and subsidies, the AHCA credits do not vary based on the price of available health insurance or by income. The AHCA tax credit can be used to purchase plans on the health care exchange, including plans offering catastrophic coverage, as well as certain plans sold outside the exchange. Tax credits cannot be used to purchase plans that offer coverage for abortion services, except for pregnancies that are life-threatening or the result of rape or incest.

Age Rating

The AHCA modifies the amount premiums are permitted to vary by age. Beginning in 2018, insurers are 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.

State Waivers for EHBs and Community Rating

The AHCA also allows states to define EHBs and set aside a variety of ACA insurance market consumer protections related to community rating (including age rating, EHBs, and preexisting condition protections through a waiver program). Specifically, states that receive such waivers can allow insurers to use preexisting conditions as a factor for setting the price of premiums if the state operates and funds a high-risk pool to alternatively cover those with preexisting conditions. States will have to demonstrate that the waiver reduces average premiums, increases enrollment, and stabilizes the state's health insurance market.

Patient and State Stability Fund

The AHCA creates a Patient and State Stability Fund of $138 billion. This fund designates $15 billion for a federal

invisible high-risk-sharing program to be turned over to states in 2020. It also provides additional resources for states to design their own high-risk pool, reinsurance, and subsidy programs to stabilize and lower costs in the insurance market. Funding allotments for state market stabilization programs will 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 choose not to design their own programs, the Centers for Medicare and Medicaid Services will use the money to stabilize the insurance market. The fund also appropriates $15 billion for providing coverage for certain specified services, including maternity, newborn, dental, vision, mental health, and substance use disorder services, plus $8 billion to fund high-risk pools or subsidies in states participating in the community rating waiver program.

Other AHCA Changes

Employer Mandate Repeal

The AHCA repeals 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).

Tax Repeals and HSAs

In addition to delaying the "Cadillac tax" on high-cost, employer-based coverage by six years, the AHCA repeals effective 2017 a number of taxes, 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.

The AHCA also makes a number of tax adjustments to benefit HSA users, including: increasing annual contribution limits, decreasing penalties for unqualified expenses, reimbursing for over-the-counter medicine, and increasing the timeframe for qualified medical expenses prior to HSA establishment.

Federal Cost and Coverage Estimates

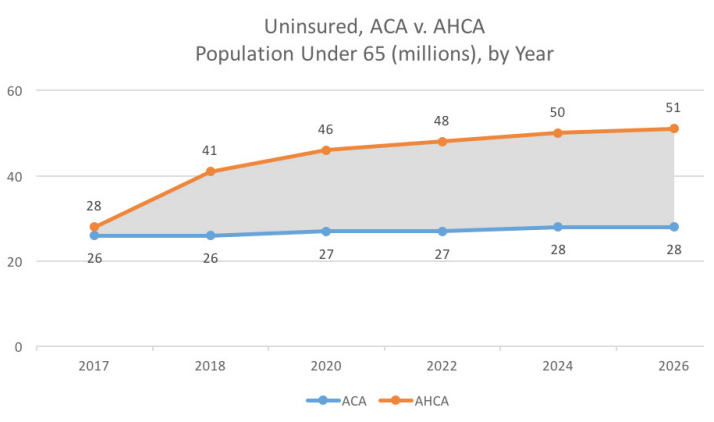
The nonpartisan CBO estimates that over the next 10 years (2017-2026), the AHCA will reduce federal deficits by $119 billion by reducing spending by $1.11 trillion and revenues by $992 billion.[2] The majority of the savings will come from the $834 billion reduction in Medicaid funding. This reduction is achieved primarily through per capita caps and block grants, ending the Medicaid expansion enhanced federal match, and through the $665 billion reduction in Marketplace insurance subsidies. The majority of spending is due to the $375 billion in individual tax credits, $117 billion for the Patient and State Stability Fund, and $661 billion and $210 billion, respectively, in reduced revenue resulting from the elimination of taxes and the individual mandate.

Estimated AHCA Budgetary Effects

AHCA Provision	Savings v. Spending / Revenue Reduction
Medicaid cuts	$834 billion
Insurance subsidy elimination	$665 billion
Small employer tax credit elimination	$6 billion
New individual tax credits	-$375 billion
Employment-based health insurance coverage shifts	$23 billion
Individual mandate penalty elimination	-$210 billion
New Patient and State Stability Fund	-$117 billion
Medicare DSH cuts elimination	-$43 billion
Tax repeals	-$661 billion
Other provisions	-$3 billion
Net savings	$119 billion

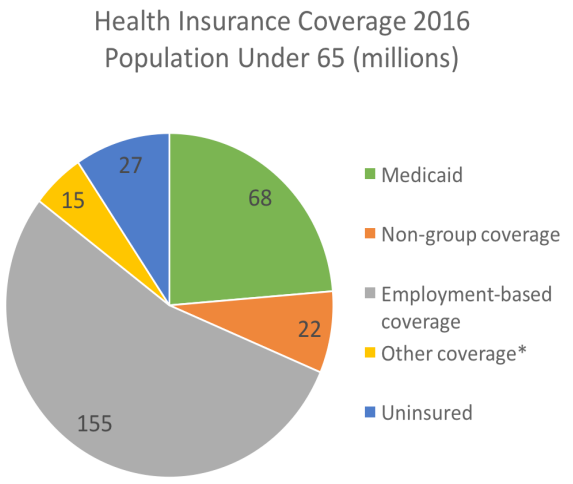
Source: Congressional Budget Office[2]

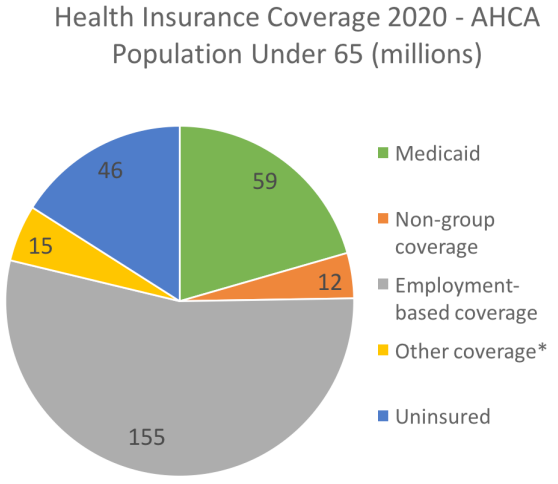
The CBO also estimates that by 2018, 41 million people will be uninsured under the AHCA, versus 26 million under current law — a net of 14 million more uninsured under the AHCA. By 2026, an estimated 51 million people will be uninsured under the AHCA, versus 28 million under current law — a net of 23 million more uninsured under the AHCA). The 2026 estimate of uninsured includes 14 million fewer covered by Medicaid, 6 million fewer covered in the individual marketplace, and 3 million fewer covered by employers under the AHCA.



Source: Congressional Budget Office[2]

[2] Congressional Budget Office. (May 24, 2017). Cost estimate: H.R. 1628, American Health Care Act, as passed by the House of Representatives on May 4, 2017. Accessed from https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/hr1628aspassed.pdf.



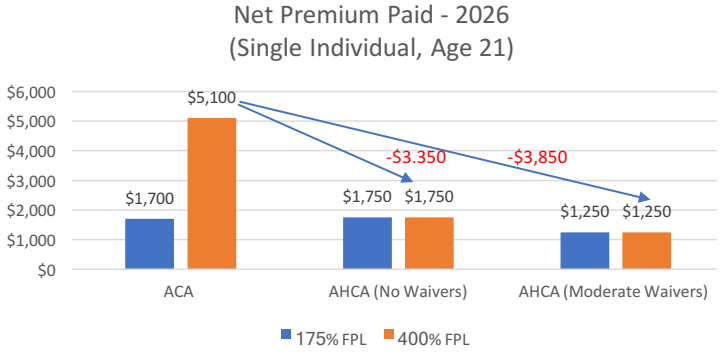


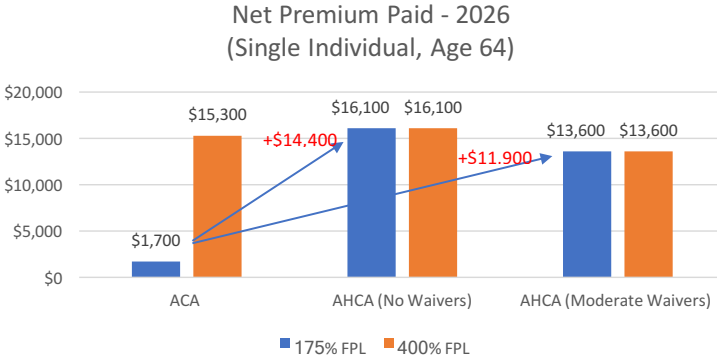
*Other coverage includes Medicare, Basic Health Program, and other categories such as student plans, foreign coverage, and Indian Health Service coverage.

Source: Congressional Budget Office[2]

Further, the CBO predicts that while the health insurance market will continue to be just as stable in many places under the AHCA as it currently is under the ACA, state participation in EHB and community rating waivers may destabilize markets for people with higher health care costs. Individual market single-policy premiums will temporarily rise prior to 2020 (by 20% in 2018 and another 5% in 2019). Starting in 2020, the premiums will depend on the extent to which a state participates in AHCA EHB and community rating waivers. In states with no waivers, premiums should decrease by 4% in 2026, versus the ACA, mainly due to a younger mix of enrollees in the market. States making moderate market changes through waivers should see premium decreases of 20% in 2026, versus the ACA, primarily due to fewer benefits being paid for by insurers. States making full market changes through AHCA waivers should also see decreases in premiums by 2026 due to a younger, healthier mix of enrollees (enrollees with costly health conditions are moved out of the market) and fewer benefits paid for by insurers.

The CBO finds that by 2026, in all AHCA scenarios, insurance premiums will generally increase for older enrollees and decrease for younger enrollees, due to changes in age rating. Additionally, younger, higher-income individuals will likely see their net premium payments drop by approximately $3,350-$3,850 due to the flat tax credit. Older, lower-income individuals will likely see their net premium payments increase by approximately $11,900-$14,400.





Source: Congressional Budget Office[2]

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, 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/health-reform.