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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), is the most recent in a series of ACA replacement proposals that have circulated among Washington policymakers. What follows is an overview of key provisions of the AHCA, including proposed changes to Medicaid and the individual insurance market, as well as federal cost estimates.

Key Provisions of the AHCA

Key features of the AHCA include:

- Medicaid reforms via per capita caps on federal funding and ending the ACA's Medicaid expansion in 2020;
- 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;
- State innovation funding that may be used toward high-risk pools or other programs to help manage the expense of insuring individuals with chronic and costly conditions;
- Repeal of taxes on high-income individuals and the health care industry; and
- Expanded health savings accounts (HSAs).

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.

Remaining Provisions of the ACA

Despite making substantial changes to the ACA, the following insurance market provisions 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;
- Caps on out-of-pocket expenses; and
- Essential Health Benefits (other than Medicaid expansion plans).

Several of the themes from previous ACA replacement proposals are not included in the AHCA. Some of these policies may be excluded because they do not meet the requirements of budget reconciliation, which is being used as the legislative vehicle for the AHCA. For example, the AHCA does not address the purchase of insurance across state lines or malpractice reform. Although these reforms are not covered by the AHCA, they may be subsequently addressed. According to some policymakers, the AHCA is just the first step in a multipronged federal health reform approach that will include regulatory changes from the Department of Health and Human Services, waiver encouragement by the new Centers for Medicare and Medicaid Services (CMS) director for state innovation in Medicaid administration, and further legislation containing nonbudgetary changes, passed through the normal legislative process.

Changes To Medicaid

Per Capita Caps

Starting in 2020, the AHCA converts funding for Medicaid from an open-ended matching grant paid by the federal government to the states to a program with per capita caps, a fixed amount of federal funding per Medicaid beneficiary. 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 divided by the number of enrollees in each of the five eligibility groups.[1] Per capita cap growth would be based on the medical care component of the consumer price index. States that exceed their per capita caps will have their federal funding reduced by the overage amount the following fiscal year.

Medicaid Expansion

Under the AHCA, states have the option to expand their Medicaid programs through Jan. 1, 2020. States will be eligible for an enhanced match for those enrolled by the end of 2019 and who do not have more than a one-month break in eligibility. For expansion adults not meeting these criteria, states would lose access to the enhanced match, and this population would be subject to per capita cap funding. Nonexpansion states may apply for safety net funding that can be used to increase payments to safety net providers. States may access up to $2 billion each year for five years (calendar years 2018-2022) if the Medicaid program remains unexpanded. The actual allotment to states is based on a ratio comparing the number of individuals in the state with incomes below 138% of the federal poverty level (FPL) in 2015 to the total number of individuals meeting the same income criteria for all nonexpansion states. While payment adjustments cannot exceed provider costs, they may be applied to the costs of furnishing health care services for Medicaid members, the underinsured, and the uninsured. Payments are funded at 100% by the federal government in CY 2018-2021 and at 95% in CY 2022.

Additional Medicaid Changes

The proposal makes a number of other notable changes to Medicaid, including:

- Repealing cuts to disproportionate share hospital (DSH) payment adjustments for nonexpansion states;
- Reducing the Medicaid eligibility level for children 6-19 from 138% FPL to 100% FPL;
- Removing the three-month retroactive eligibility for Medicaid;
- Eliminating the reasonable opportunity period for citizenship/immigrant status verification;
- Requiring a redetermination of eligibility every six months for the expansion population;
- Repealing the essential health benefit requirement for individuals receiving alternative benefit packages;
- Freezing payments for one year to large nonprofit community family planning providers that also provide abortions; and
- Increasing the federal matching percentage to 100% to support data reporting improvements and 60% to support new data requirements for FY 2018-2019.

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 "repeals" 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 introduces a premium penalty to be levied on individuals seeking coverage who are without health insurance for at least 63 continuous days in the 12 months prior to enrollment. The penalty will 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 proposes 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 are available to individuals earning up to $75,000 ($150,000 for a couple filing jointly) beginning in 2020:

Age	Credit
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 is reduced by 10 cents. A family can claim tax credits for its five eldest members, but the tax credit amount cannot exceed $14,000. Unlike the ACA's tax

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

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 and plans sold outside the exchange that meet essential health benefit standards. 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 will be 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 creates a Patient and State Stability Fund, with $15 billion appropriated for 2018 and 2019 (and $10 billion annually thereafter). This fund allows states to design their own programs to stabilize and lower costs in the insurance market. Programs could include high-risk pools, reinsurance, and subsidies. State funding allotments are 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, CMS will use the money to stabilize the insurance market.

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), or face penalties.

Tax Repeals and HSAs

The AHCA also repeals a number of ACA taxes, including:

- Medical device tax;
- Medicare Hospital Insurance surtax on employees;
- 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, the AHCA reinstates the business expense deduction for retiree prescription drug costs and repeals the increase in income threshold (from 10% back down to 7.5%) for deducting qualified medical expenses for taxpayers (or spouses) over 65 years.

The AHCA also makes a number of tax adjustments to benefit HSA users. The AHCA increases 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%). If individuals or families have tax credit funds remaining after purchasing health coverage, the excess credit can be deposited into an HSA. Further, the AHCA adds over-the-counter medicines as an HSA reimbursable qualified medical expense, allows both spouses to make catch-up contributions to one HSA, and increases the time frame for qualified medical expenses prior to HSA establishment.

Population Health

The AHCA increases funding for the Community Health Center Fund in 2017 by $422 million, while repealing 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 estimate that over the next 10 years (2017-2026), the AHCA would reduce federal deficits by $337 billion by reducing spending by $1.2 trillion and revenues by $900 billion.[2] The majority of the savings would come from the $880 billion reduction in Medicaid funding and the $673 billion reduction in insurance subsidies, while the majority of spending would be due to the $361 billion in tax credits, and $599 billion and $210 billion in reduced revenue resulting from the elimination of a variety of taxes, including those related to the individual and employer mandates, respectively. The AHCA's tax cuts

[2] Congressional Budget Office. (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.

would deplete the Medicare Trust Fund by $117 billion between 2017 and 2026.

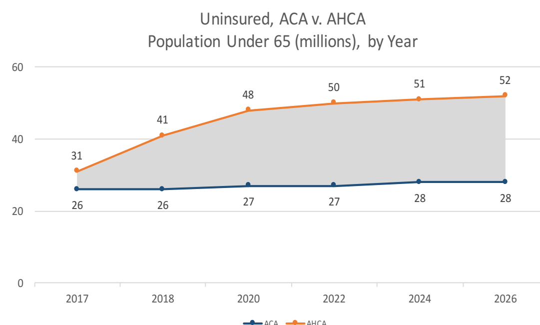
Estimated ACHA Costs

AHCA Provision	Savings v. Spending / Revenue Reduction*
Medicaid cuts	$880 billion
Insurance subsidy elimination	$673 billion
Small employer tax credit elimination	$6 billion
New individual tax credits	-$361 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	-$43 billion
Tax repeals	-$599 billion
Net savings	$337 billion

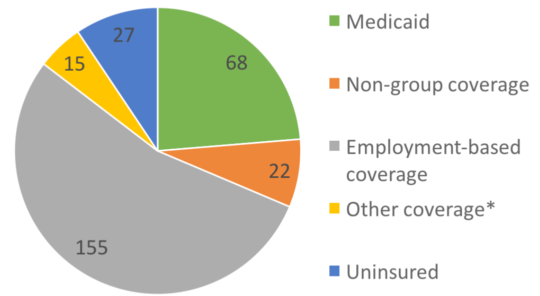
*Numbers do not add up to total because of rounding.
Source: Congressional Budget Office; staff of the Joint Committee on Taxation.

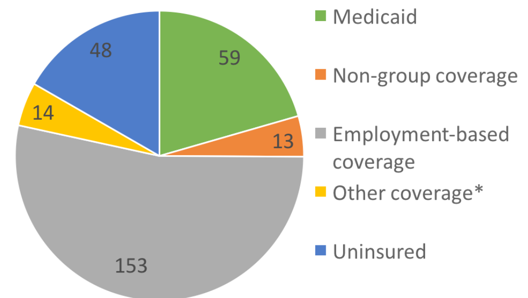
The CBO further predicts that the health insurance market would have the same stability under the AHCA as it currently does under the ACA and that individual market premiums would temporarily rise (by 15%-28% in 2018 and 2019) and then eventually fall by approximately 10% by 2026, as compared to where they would have been under the ACA. Declining premiums after 2020 are due to projections that older and sicker individuals will drop out, leaving a younger mix of enrollees in the individual market and because repeal of the actuarial value requirements will shift premium costs to higher deductibles and cost-sharing. The AHCA's change in rating bands would likely allow younger enrollees to see significant reductions to their premiums, while older enrollees may experience substantially greater premiums.

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



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





*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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