

MEMORANDUM

To: ACRM

From: Peter Thomas, Peggy Tighe, Steve Postal, Leif Brierley, and Cara Peterson

Date: March 9, 2017

Re: The House GOP Affordable Care Act Repeal and Replacement Legislation (the American Health Care Act)

Summary

On Monday, March 6, 2017, the House Committee on Ways and Means and the House Committee on Energy and Commerce released [legislation](#) to repeal and replace the Patient Protection and Affordable Care Act (ACA [Public Law 111-148](#) and [Public Law 111-152](#)). The House bill, called the American Health Care Act (AHCA), was accompanied by section-by-section analyses, one from each of the Committees (found [here](#) and [here](#)). House Republicans leading the two committees touted the legislation as their replacement plan to the ACA. The long-awaited legislation would significantly impact the individual and small group markets for health care coverage, with many of its sections repealing or significantly altering key components of the ACA, which has been federal law since 2010.

The House conducted two separate markups this week of the legislation in the Energy & Commerce and Ways & Means committees. From there, the House Budget and Rules committees are expected to markup the bill in the following two weeks. House Republicans are expected to bring the bill to the floor in mid- to late-March. However, currently, several conservative members of the House and several Senate Republicans have come out in opposition to the AHCA, labelling it as “Obamacare Lite” and claiming that the proposal to issue refundable tax credits to assist individuals with purchasing insurance coverage constitutes a major new entitlement program. Several legislators from both parties are currently demanding that Republicans not mark up any legislation without first seeing a Congressional Budget Office (CBO) score on the cost of the legislation, which should be released on Monday, March 13th. Despite these concerns, the bill has the support of key members of GOP leadership, including President Donald Trump, HHS Secretary Tom Price, House Speaker Paul Ryan, House Energy and Commerce Committee Chairman Greg Walden, and House Ways and Means Committee Chairman Kevin Brady.

The following memorandum offers a summary of current law, contrasted with the proposals made in the AHCA, followed by analysis of the bill’s key provisions, impact, and associated commentary.

Insurance Reforms

The AHCA makes significant health insurance changes, directly addressing the financing, coverage, and requirements surrounding the individual and small group markets. Among the key insurance provisions addressed by the AHCA are:

- **Individual Mandate**

- **ACA:** The ACA requires U.S. citizens and legal residents to have health insurance coverage. Individuals without coverage are assessed a tax penalty of the greater of \$695 per year, indexed by inflation, or 2.5% of household income. Exemptions are granted for affordability, financial hardship, religious objections, and other reasons.¹ That penalty grows over time and this current tax year, it can reach as high as \$2000 for some taxpayers.
- **AHCA:** The House proposal effectively eliminates the individual mandate. It changes the tax penalty for lack of coverage to zero percent of household income and \$0 per year. The repeal of the individual mandate applies to months beginning after December 31, 2015, a retrospective provision intended to assist Americans filing tax returns for 2016. However, the proposal includes a new provision, Section 133, which incentivizes individuals to maintain continuous coverage. Beginning in open enrollment for plan year 2019, health insurers are allowed to conduct a 12-month look-back to see if applicable policyholders have maintained continuous coverage without a period of at least 63 days without “creditable coverage.” Individuals can be charged a penalty by insurers equal to 30 percent of the monthly premium rate for the first year of new coverage if they do not meet continuous coverage requirements. This penalty is not based on health status and applies equally to all those who do not maintain continuous coverage and then seek to become insured.

- **Employer Mandate**

- **ACA:** Requires employers with 50 or more full-time employees to offer coverage that meets standards for affordability and minimum value or face a penalty. Employers with more than 200 employees must auto-enroll employees into a group health plan, although employees may opt out of coverage.
- **AHCA:** Effectively repeals the penalty on employers with 50 or more full-time employees by reducing the penalty to \$0, retroactive to January 1, 2016.

- **“Cadillac” Tax**

- **ACA:** The law currently will apply a tax penalty on high-cost (“Cadillac”) employer-sponsored health plans beginning in 2020.
- **AHCA:** The AHCA changes the effective date of this tax to January 1, 2025, five years later. [Commentators have suggested that this delay will allow Congress to replace this tax with an alternative in the future, for instance, limiting the amount the employer can deduct for providing employees with health insurance. Notably,

¹ <http://kff.org/interactive/proposals-to-replace-the-affordable-care-act/>

the AHCA does not include this employer deduction limit proposal, although it had been seriously considered in the past several weeks.]

- **Essential Health Benefits (EHBs)**
 - **ACA:** The ACA requires individual and small group plans to cover ten categories of essential health benefits (EHBs). Those benefit categories include ambulatory care, emergency care, hospitalization, maternity and newborn care, mental health and substance use care, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive care, chronic disease management, and pediatric dental and vision care.
 - **AHCA:** The Republican proposal eliminates the requirement to cover essential health benefits for Medicaid expansion plans, sunsetting the requirement to cover these benefit categories after December 31, 2019. This would impact roughly half of individuals who have attained coverage under the ACA. However, the bill contains no explicit directive on EHB for individual or small group market plans.
- **Actuarial Value of Health Coverage**
 - **ACA:** Exchange plans must be offered at four cost-sharing levels based on actuarial value (AV) categories, and are labeled across four metal tiers including Bronze (60% AV); Silver (70% AV), Gold (80% AV) and Platinum (90% AV).
 - **AHCA:** Section 134 of the legislation repeals the AV standards, sunsetting them by 2020. This should provide greater flexibility in EHB benefit design, which could lead to less generous benefit packages for individual and small group plans.
- **Premium Tax Credits**
 - **ACA:** Current law provides refundable premium tax credits to individuals or families based on their income, ranging from 100-400 percent of the federal poverty level (FPL), to purchase health insurance.
 - **AHCA:** The AHCA makes several modifications to premium tax credits from the ACA:
 - For 2018-2019, premium tax credits are increased for young adults above 150 percent FPL, are decreased for adults age 50 and above, cannot be used to pay for plans that cover abortion, can be used to purchase plans sold outside of exchanges, and can be used to purchase catastrophic insurance coverage. Individuals who have been overpaid in premium tax credits during the course of the year are required to repay the excess amount in full.
 - In 2020 and beyond, the ACA income-based tax credits are replaced with an age-adjusted annual credit (indexed annually at the consumer price index plus 1%) in the following amounts:
 - \$2,000 per individual up to age 29;
 - \$2,500 per individual age 30-39;
 - \$3,000 per individual age 40-49;

- \$3,500 per individual age 50-59;
 - \$4,000 per individual age 60 and older; and
 - Up to \$14,000 per family combined
- Eligibility for tax credits is extended to only individuals who are U.S. Citizens or legal immigrants who do not have access to coverage through an employer plan or federal program.
 - Tax credits begin to phase-out for individuals with incomes above \$75,000 (\$150,000 if filing jointly), with tax credits decreasing by \$100 for each \$1000 of income above the thresholds.
- **Cost-Sharing Subsidies**
 - **ACA:** Current law provides cost-sharing subsidies to help eligible individuals pay for cost-sharing associated with insurance coverage such as deductibles and copays. These subsidies are available for individuals with household income between 100%-250% FPL.
 - **AHCA:** The AHCA repeals cost sharing subsidies effective in 2020. [These subsidies are the subject of a pending lawsuit between the House of Representatives and the Obama Administration, the appeal of which has been placed on hold. The D.C district court struck down these cost-sharing subsidies, handing a temporary victory to the House in this lawsuit. If these subsidies are ultimately discontinued, either by the legal case or by passage of this legislation, low income ACA enrollees will have greater difficulty meeting their health care expenses.]

Medicaid Reforms

The AHCA makes the following structural changes to “original” Medicaid, including:

- **Per Capita Caps:** The AHCA would transform Medicaid federal financing from an entitlement program into a “per capita cap” model beginning in FY 2020.
 - Based on each state’s spending in FY 2016, CMS would establish targeted spending for each category (elderly, blind and disabled, children, non-expansion adults, and expansion adults) in FY 2019 and subsequent years for each state.
 - The targeted spending amounts would increase by the percentage increase in the medical care component of the consumer price index for all urban consumers from September 2019 to September of the next fiscal year.
 - Beginning in FY 2020, any state with spending higher than its specified targeted aggregate amount would receive reductions to their Medicaid funding for the following fiscal year.
 - There are several exemptions from the per capita cap, including Disproportionate Share Hospital (DSH) payments and state administrative payments
 - Exemptions also include certain types of Medicaid beneficiaries such as:

- Individuals covered under a CHIP Medicaid expansion program; and
- Some partial-benefit enrollees, including:
 - Dual-eligible individuals eligible for coverage of Medicare cost sharing; and
 - Individuals eligible for premium assistance
- **Home and Community-Based Attendant Services and Supports**
 - **ACA:** The ACA contains a six percentage point payment bonus in the federal match rate for home and community-based attendant services and supports provided by state Medicaid plans.
 - **AHCA:** The AHCA repeals this provision. This will likely lead to a reduction in home and community based care and a shift back toward greater nursing home and institution-based care under Medicaid.
- **Effective Date of Retroactive Coverage**
 - **AHCA:** Retroactive coverage would be effective the month in which the applicant applied for Medicaid. This would apply to applications made on or after October 1, 2017.

Medicaid Expansion Reforms

The AHCA makes the following changes to Medicaid expansion, including:

- **Codifying Right of States to Choose Medicaid Expansion**
 - **ACA:** In *NFIB v. Sebelius* in June 2012, the U.S. Supreme Court ruled that Medicaid expansion was optional for states under the ACA.
 - **AHCA:** The AHCA codifies *NFIB v. Sebelius*, affirming that Medicaid expansion is optional for states.
- **Coverage based on Federal Poverty Level**
 - **ACA:** The ACA expanded Medicaid to nearly all adults under age 65 with incomes up to 138 percent of the Federal Poverty Level (FPL) (\$16,394 for an individual in 2016, including seniors and people with disabilities).²
 - **AHCA:** AHCA repeals the option of states to grant Medicaid coverage to adults over 133 percent of the FPL by December 31, 2019. The AHCA also returns poverty-related income eligibility for children back to 100 percent of FPL.
- **Medicaid’s Essential Health Benefits Package**
 - **ACA:** The ACA required Medicaid “expansion” plans to provide the “essential health benefits” package, as required of plans in the individual and small group markets.
 - **AHCA:** The AHCA repeals this requirement, effective December 31, 2019

² <https://www.medicaid.gov/affordable-care-act/eligibility/index.html>

- **Medicaid Disproportionate Share Hospital (DSH) Cuts**
 - **ACA:** Under the ACA, states that did not expand Medicaid would have their Medicaid DSH payments eliminated.
 - **AHCA:** The AHCA repeals Medicaid DSH cuts in non-expansion states in 2018. Medicaid DSH cuts in expansion states will be repealed in 2020, two years later.
- **Safety Net Funding for Non-Expansion States**
 - **AHCA:** The AHCA provides \$10 billion over five years to non-expansion States for safety net funding.
 - Each state that has not expanded Medicaid as of July 1, 2017 is eligible to participate in these payments.
 - Funds are intended to adjust payment amounts for Medicaid providers and the state has significant discretion in terms of how to achieve this goal.
 - There is a matching rate of 100% for these payments (i.e., 100% federal funds) in CY 2018 through CY 2021 and 95% for CY 2022.
- **Federal Medical Assistance Percentages (FMAP)**
 - **ACA:** For states that chose to expand Medicaid, the federal government subsidized all payments for newly eligible individuals between 2014 and 2016, and gradually decreased to 90 percent by 2020.
 - **AHCA:** The AHCA eliminates the enhanced match for Medicaid expansion enrollees as of January 1, 2020 (except for Medicaid expansion enrollees as of December 31, 2019 who do not have a break in eligibility of more than one month).
- **Eligibility Redeterminations**
 - **AHCA:** States with Medicaid expansion populations must to re-determine expansion enrollees' eligibility every six months.

Taxes and Financing

The AHCA repeals many of the funding mechanisms (i.e., taxes) used to fund expansion of coverage under the ACA, and addresses some deductions and tax-related provisions related to current law, including:

- **Pharmaceutical, Device, Insurance, and Medicare Taxes**
 - **ACA:** The ACA imposed new taxes on over-the-counter medications, a 2.3 percent excise tax on the sale of certain medical devices (the “medical device tax”), a 0.9 percent surtax on an employee’s wages (the Medicare Hospital Insurance surtax) over \$250,000 of annual income, and new taxes on health insurers and pharmaceutical manufacturers.
 - **AHCA:** The AHCA repeals all of these taxes.
- **Deduction for Expenses Allocable to Medicare Part D**

- **ACA:** The ACA eliminated a retiree drug subsidy for employers to help cover prescription drug costs.
- **AHCA:** The AHCA reinstates this business-expense deduction.
- **Medical Expense Deduction**
 - **ACA:** The medical-expense deduction may be claimed as an itemized tax deduction for qualifying medical expenses only for expenses that exceed a certain percentage of the taxpayer's adjustment gross income (AGI). The ACA increased the AGI percentage threshold from 7.5 percent to 10 percent if the taxpayer or spouse was aged 65 or older.
 - **AHCA:** The AHCA returns the AGI percentage threshold back to 7.5 percent.
- **Flexible Savings Account (FSA) and Health Savings Account (HSA) Provisions**
 - **ACA:** The ACA limited the amount an employer or individual could contribute to Flexible Savings Accounts (FSAs) to \$2,500.
 - **AHCA:** The AHCA removes this limitation. Under the AHCA, the basic limit on aggregate Health Savings Account (HSA) contributions per year is increased to be at least \$6,550 (self-only coverage) and \$13,100 (family coverage).
 - **ACA:** The ACA increased the tax on HSA distributions that are not used for qualified medical expenses from 10 to 20 percent.
 - **AHCA:** The AHCA lowers this percentage back to 10 percent.
 - **AHCA:** Under the AHCA, in certain circumstances, a beneficiary can use HSA withdrawals for qualified medical expenses incurred before the establishment of the HSA.

The Joint Committee on Taxation (JCT) [estimates](#) that the AHCA would cut taxes by approximately \$266 billion from 2017-2026. The Congressional Budget Office has not yet scored these provisions or the entire bill. These provisions are expected to “cost” the federal government:

- \$117.3 billion from repeal of the Medical Hospital Insurance surtax;
- \$49 billion from delaying the Cadillac Tax by five years;
- \$35 billion from revising the Medical Expense Deduction; and
- \$20 billion from eliminating the medical device tax.

Miscellaneous

The AHCA includes a number of other provisions of note, including:

- **The Prevention and Public Health Fund**
 - **ACA:** The ACA established the [Prevention and Public Health Fund](#) (PPHF) as an appropriation for prevention, wellness, and public health initiatives to be administered by the Department of Health and Human Services (HHS).

- **AHCA:** The AHCA repeals PPHF appropriations for fiscal year 2019 onwards. Any unobligated PPHF funds remaining at the end of fiscal year 2018 are to be rescinded. The JCT estimates these federal savings at approximately \$20 billion.
- **Patient and State Stability Fund:** This fund provides states with resources to use in providing financial assistance to high-risk individuals who do not have access to health insurance coverage, and to help reduce the cost of providing health insurance coverage to individuals in the individual and small group market who have high health care utilization rates, among other uses.
- **Community Health Center Program:** This section increases funding by \$100 billion over eight years for the Community Health Center Fund, which awards grants to federally qualified health centers (FQHCs).
- **Federal Payments to States.** The AHCA imposes a one-year freeze on mandatory funding to a class of providers designated as prohibited entities. This funding includes Medicaid, the Children’s Health Insurance Program, Maternal and Child Health Services Block Grants, and Social Services Block Grants. [Senator Lisa Murkowski (R-AK) has stated that if this provision (known as the “Planned Parenthood Provision) is in the final legislation for repeal and replace, she would not vote for it.]
 - Prohibited entity includes one of the following
 - A designated non-profit by the Internal Revenue Service;
 - An essential community provider primarily engaged in family planning and reproductive health services;
 - An entity that provides abortions in cases that do not meet the Hyde amendment exception for federal payment; or
 - An entity that received over \$350 million in federal and state Medicaid dollars in fiscal year 2014.

Conclusion

The American Health Care Act represents the first health care legislative proposal to receive an endorsement from President Trump, his administration, House Speaker Ryan, and the leaders of the two House committees of jurisdiction. The bill is encountering some resistance from within the Republican Party, with members of the more conservative elements of the Party believing it should simply repeal the ACA without replacing it. Other members of the Republican Party oppose the elimination of the Medicaid expansion or the one-year freeze in funding for family planning and reproductive health providers. Democrats appear to be unified in their opposition to the legislation. The American Medical Association, American Hospital Association, AARP, America’s Health Insurance Plans, and a number of other prominent health care organizations have either suggested significant modifications to the bill or have announced their opposition to the legislation in its current form. Thus far, it remains unclear how these dynamics will affect the bill’s viability as it advances through the legislative process.