KANSAS HEALTH INSTITUTE

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ISSUE BRIEF

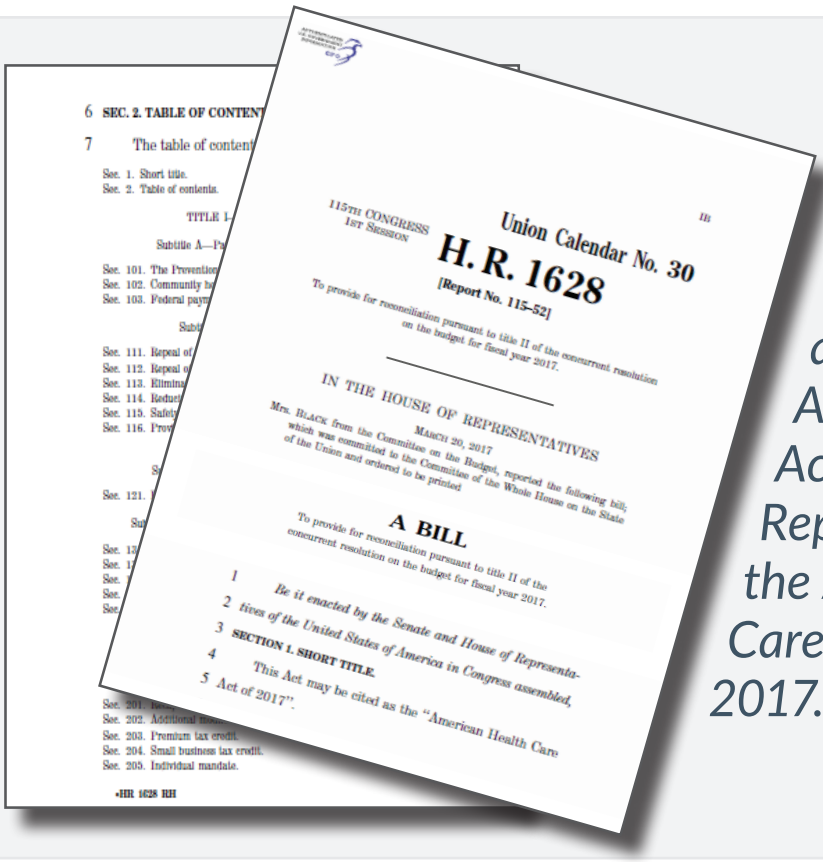
APRIL 2017

REPEALING AND REPLACING THE AFFORDABLE CARE ACT

Key Provisions of the American Health Care Act

Since the enactment of the Affordable Care Act (ACA) in 2010, Republican members of Congress have attempted to repeal the law more than 50 times. Following the November 2016 elections—in which Republicans gained control of the White House and both chambers of Congress—President Donald Trump and Republican members of Congress frequently stated that repealing and replacing the ACA was a top priority. On March 6, 2017, House Republicans made the first move toward that goal with the release of H.R. 1628, the American Health Care Act (AHCA).

When the bill was "scored" by the Congressional Budget Office (CBO) on March 13, it estimated that 14 million more people would be uninsured in 2018, and that number would continue to increase to 24 million by 2026. The CBO report also estimated that the AHCA would reduce the federal deficit by $337 billion over the 2017–2026 period, primarily from savings due to reductions in payments to states for Medicaid, and from elimination of the ACA's cost-sharing subsidies for low-income individuals who purchase insurance on the federal marketplace. Following the announcement of several proposed amendments to the bill on March 20, the CBO released an updated scoring of the bill. It showed no significant change in the estimate of the number of uninsured by 2026, but it lowered the projected reduction to the federal deficit to $151 billion, which was $186 billion less than the original projection.


115TH CONGRESS
1ST SESSION

Union Calendar No. 30

H. R. 1628

[Report No. 115–52]

To provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017.

IN THE HOUSE OF REPRESENTATIVES

MARCH 20, 2017

Mrs. BLACK from the Committee on the Budget, reported the following bill; which was committed to the Committee of the Whole House on the State of the Union and ordered to be printed

A BILL

To provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "American Health Care Act of 2017".

Congress made the first step toward repealing and replacing the Affordable Care Act when House Republicans released the American Health Care Act in March 2017.

Following weeks of negotiation and debate involving both House Republicans and President Donald Trump, a vote of the full House of Representatives was scheduled for the week of March 20. However, on March 24, Speaker of the House Paul Ryan determined that there were not enough votes to pass the AHCA, and announced the bill was dead.

By the following week, Congressional leaders were again signaling that repealing and replacing the ACA remained a priority. Regardless of the ultimate fate of the AHCA itself, many of the provisions in the bill that had broad support among House Republicans are likely to appear in future legislation. This brief summarizes the key provisions.

Private Insurance Market

Individual and Employer Mandates

Before the November elections, candidate Trump and House Republicans repeatedly vowed to repeal the ACA's individual mandate, which requires that most individuals purchase health insurance or pay a tax penalty. The AHCA would have repealed both the individual mandate and the employer mandate, which requires employers with 50 or more full-time employees to provide "minimum essential coverage" health insurance for their employees or be subject to a tax penalty.

Figure 1. **Comparison of Projected Monthly Premium Tax Credit Available in the Individual Market in 2017 Under the ACA and Proposed in the AHCA in Shawnee County, Kansas**

Income	Age	ACA	AHCA
$22,000	28	$210	$167
	42	$280	$250
	56	$572	$292
	63	$752	$333
$33,000	28	$81	$167
	42	$150	$250
	56	$443	$292
	63	$623	$333
$42,000	28	$0	$167
	42	$46	$250
	56	$338	$292
	63	$518	$333

Blue shading indicates largest monthly premium tax credit in each income/age category.

Source: KHI analysis of AHCA and 2017 estimates from Healthcare.gov.

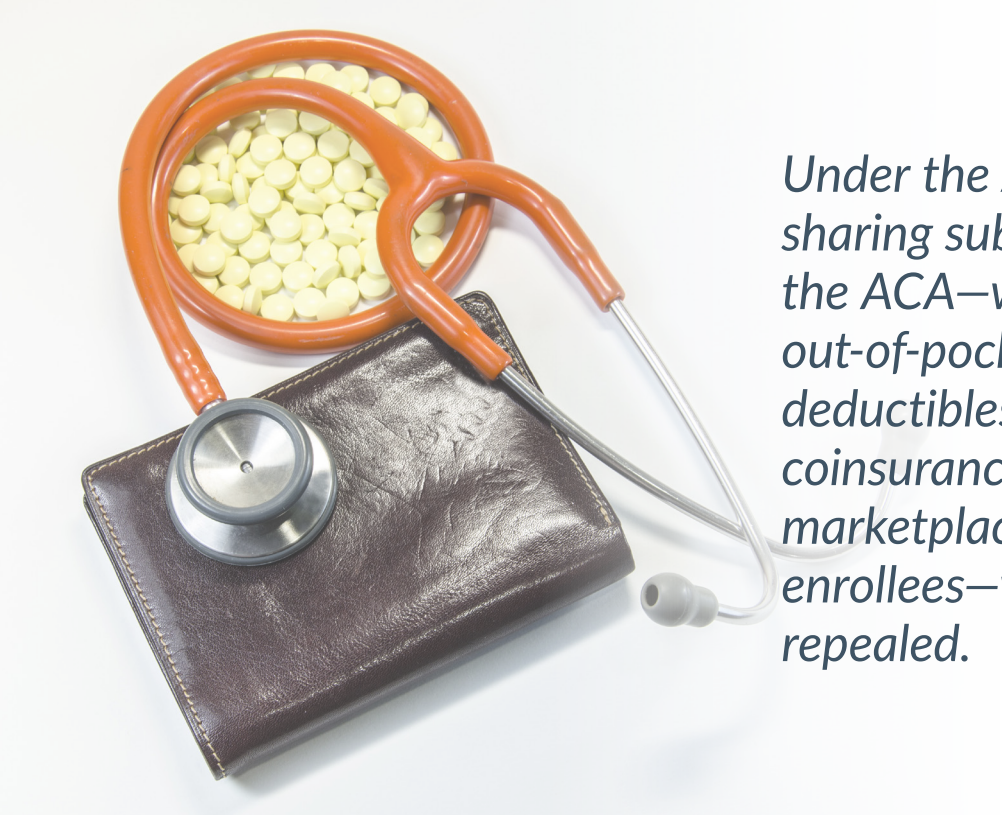
Tax Credits

The AHCA would have repealed the income-based premium tax credits provided for in the ACA, effective December 31, 2019. It also would have made changes in the calculation and use of the current ACA premium tax credits to modify the formula used to calculate the amount of an individual's premium tax credit to account for both the individual's income and age, potentially increasing the amount of an individual's income that must be used to pay for their premiums as they get older. The AHCA also would have allowed the premium tax credits to be used to purchase "catastrophic-only" coverage or other qualified health plans not offered through the ACA's health insurance marketplace. The small employer tax credit would also have been repealed as of December 31, 2019.

Beginning in 2020, the AHCA would have enacted a new age-adjusted tax credit for individuals purchasing coverage in the individual market. Like the tax credit in the ACA, this new tax credit would be refundable and advanceable on a monthly basis to pay for an individual's health insurance premiums. However, the amount of the tax credit would have been determined solely based on the age of the individual and the number of family members covered, rather than on household income. Unlike the ACA, geographic differences in the cost of health care were not considered.

The proposed annual tax credit amount—which was capped at $14,000 for up to five people in a family—was:

- $2,000 for individuals under the age of 30;
- $2,500 for those age 30 to 39;
- $3,000 for those age 40 to 49;
- $3,500 for those age 50 to 59; and
- $4,000 for those age 60 and over.



Under the AHCA, the cost-sharing subsidy program in the ACA—which reduces out-of-pocket costs for deductibles, copayments and coinsurance for low-income marketplace health plan enrollees—would have been repealed.

Eligibility for these tax credits would have started to phase out when a taxpayer's modified adjusted gross income reached $75,000, or $150,000 for joint taxpayers.

Individuals who were eligible for employment-based coverage—regardless of the adequacy of the coverage or the cost—would not have been eligible for the AHCA tax credits, and only U.S. citizens, nationals or qualified aliens were eligible.

A proposed amendment to the bill a few days before the scheduled vote would have provided a reported $85 billion in additional funding to increase the value of tax credits for individuals age 50 to 64.

Cost-Sharing Subsidies

Under the AHCA, the cost-sharing subsidy program in the ACA—which reduces out-of-pocket costs for deductibles, copayments and coinsurance for marketplace health plan enrollees with incomes between 100 percent and 250 percent of the federal poverty level (FPL)—also would have been repealed.

The case of *U.S. House of Representatives v. Price* (formerly *House v. Burwell*), which was filed in 2014, challenges the expenditure of federal dollars for these cost-sharing subsidies. This case is pending in the U.S. Court of Appeals for the D.C. Circuit, but is currently on hold at the request of the House of Representatives and the Department of Justice until May 22, 2017. Since it appears this case was placed on hold in anticipation of a repeal of the cost-sharing subsidy program in the ACA, it is not clear how House Republicans and the Trump Administration will respond when the case becomes active again in May.

For plan year 2016, there were 101,555 Kansans enrolled in health coverage through the federal marketplace. More than 83,000 of those individuals received ACA premium tax credits to purchase health insurance coverage and, of those, more than 57,500 received cost-sharing subsidies to reduce out-of-pocket costs.

Insurance Market Changes

Many of the health insurance market changes enacted under the ACA remained unchanged by the original March 6 version of the AHCA, including:

- No pre-existing condition exclusions;
- Guaranteed issue and renewability of coverage;
- Coverage for adult children up to age 26 on a parent's plan;

- No underwriting based on health status;
- No lifetime or annual limits on health plans; and
- Essential health benefit requirements.

However, during the days leading up to the bill being withdrawn on March 24, some House Republicans proposed repealing additional ACA provisions impacting the insurance market, including the ban on pre-existing condition exclusions and the essential health benefits requirements.

Continuous Insurance Coverage Incentive

With the repeal of the individual mandate, the AHCA proposed a continuous insurance coverage incentive and a 12-month lookback period beginning in 2019. For individuals applying for coverage who went without coverage for more than 63 days during the previous 12 months, insurers would have been permitted to assess a flat 30 percent late-enrollment surcharge on top of the base premium. The late-enrollment surcharge would have applied for 12 months. This coverage incentive also would have applied to individuals who enrolled under special enrollment periods starting in 2018.

Actuarial Value of Health Plans

In an effort to expand health plan choices in state insurance markets, the AHCA would have repealed the actuarial value standards established by the ACA, which created the bronze, silver, gold and platinum levels for health plans. Repealing these standards would provide insurers with greater flexibility to design plans offered in the individual and small group markets. The proposed repeal of the essential health benefits requirements during the week leading up to the vote would have provided greater flexibility for insurers when designing their health plans.

Age Rating

Under the ACA, age rating is set at three-to-one, meaning premiums for older adults cannot be more than three times the amount of premiums for younger adults. The AHCA would have repealed the three-to-one age rating limit in the ACA to give states more flexibility to use five-to-one age rating or to set their own ratio, presumably above or below five-to-one. With the expansion of age rating, the cost of health insurance premiums for young adults would likely decrease while the cost for older individuals would increase. During the debate of the ACA in 2009, AARP actively lobbied members of Congress to enact three-to-one age rating to make health insurance more affordable for older adults.

Taxes

The original AHCA would have repealed several taxes or tax limitations imposed by the ACA beginning for tax year 2018, including:

- The tax on over-the-counter medications;
- The increased taxes on distributions from health savings accounts (HSAs);
- The limits on the amounts that may be contributed to flexible spending accounts (FSAs);
- The tax on medical devices, such as surgical tools and knee or hip replacements;
- Reinstatement of the tax deduction level prior to the ACA for employers offering prescription drug coverage to retired employees;
- The increased income threshold for the medical expense deduction for taxpayers age 65 and older who itemize their deductions;
- The 0.9 percent increase in the Medicare tax for taxpayers with annual incomes exceeding $200,000 for individual filers or $250,000 for joint filers; and
- The tax imposed on certain brand name pharmaceutical manufacturers and health insurers, as well as the limit on the deduction for compensation in excess of $500,000 paid to insurance company executives.

The original bill also postponed the effective date of the 40 percent excise tax on high-cost, employer-sponsored health plans with rich benefits, also known as "Cadillac plans," from tax year 2020 to tax year 2025. However, a March 20 amendment to the bill would have delayed that effective date to 2026 and would have moved up repeal of the other tax changes to tax year 2017.

The AHCA also proposed increasing in 2018 the annual limit on HSA contributions up to the maximum of the sum of the annual deductible and out-of-pocket expenses permitted for a high-deductible

The AHCA would have established the Patient and State Stability Fund and appropriated $100 billion over nine years for all states to use to lower patient costs and to stabilize their individual and small group insurance markets.

health plan, which for 2018 is $6,550 for self-only coverage and $13,100 for family coverage. It also allowed both spouses to make catch-up contributions to one HSA, and included a special rule for determining whether an expense is a qualified medical expense when the HSA is established within 60 days of the effective date of coverage under a high-deductible plan.

Patient and State Stability Fund

The AHCA would have established the Patient and State Stability Fund and appropriated $100 billion over nine years for all states to use to lower patient costs and to stabilize their individual and small group insurance markets. The bill provided that states could use these funds for any of the following purposes:

- Providing financial assistance to high-cost individuals who do not have access to employer-sponsored insurance to help them enroll in individual coverage;
- Providing incentives to "appropriate entities" to provide reinsurance to stabilize the state's individual health insurance market;
- Reducing the cost of health insurance coverage for individuals who have, or are projected to have, high utilization of high-cost health services;
- Promoting participation and health insurance options in the state's individual and small group markets;
- Promoting access to preventive care, dental care, vision care, mental health and substance use disorder services;
- Making payments directly to health care providers for providing health care services; and
- Providing assistance to individuals to reduce out-of-pocket costs, such as premiums, deductibles, copayments and coinsurance resulting from the use of their health insurance coverage.

States would have been required to apply for the funding, but applications would have been automatically approved if not denied within 60 days. Once a state's program was approved, it would have remained approved for all subsequent years through 2026. For 2018 and 2019, 85 percent of the funding would have been allocated based on each state's relative share of the national incurred health care claims, as reported in the medical loss ratio reporting

required under the ACA. The other 15 percent would have been allocated to states that experienced an increase in the number of uninsured individuals under 100 percent of FPL between 2013 and 2015, and states with fewer than three insurers offering qualified health plans in the state's marketplace. For 2020 through 2026, funds would have been allocated based on a state's relative incurred claims, uninsured population below 100 of FPL, and the number of insurers in the insurance market. Beginning in 2020, states would have been required to provide funding equal to 7 percent of the federal funding, with the state match increasing to 50 percent by 2026.

Medicaid Expansion and Other Changes to Medicaid Funding

Because the AHCA was designed initially to conform to the budget reconciliation process—which only permits policy changes that increase or decrease either revenues or mandatory federal spending—much of the bill's text was devoted to Medicaid. The treatment of states that either did or did not expand Medicaid is a key balancing act for Congress, as 31 states have taken the option to expand the program to adults age 19 to 64 with incomes below 133 percent of FPL (often referred to as 138 percent of FPL because of a statutory 5-percent income disregard). The repeal of the ACA's Medicaid expansion and the creation of a new, per capita cap financing mechanism, received the most attention, but the bill included other changes as well.

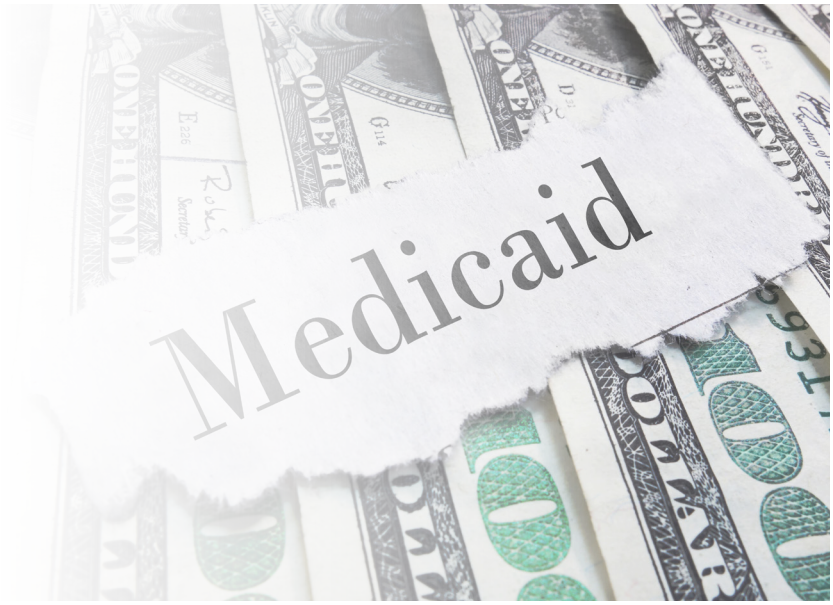
Repeal of Medicaid Expansion

The AHCA would have codified the U.S. Supreme Court's opinion in *NFIB v. Sebelius* that made expanding Medicaid to adults optional for states, and it would have repealed the state option to extend coverage to adults above 133 percent of FPL.

The bill as introduced would have ended the enhanced federal support for Medicaid expansion on December 31, 2019. States that expanded Medicaid to 133 percent of FPL for adults could have continued to receive the ACA-created enhanced match rate until then, but after that date, the equivalent federal support would only have been available for individuals who were enrolled in Medicaid on December 31, 2019, and who maintained eligibility (with no more than a one-month break from eligibility). States would have received the standard match rate for individuals who enrolled after December 31, 2019.

States that had expanded Medicaid prior to ACA enactment in 2010 would have had their federal share capped at 80 percent for expansion adults and, as in other states, those who enrolled after December 31, 2019, would not have been eligible for enhanced federal support. The AHCA also would have repealed the requirement that states provide the same "essential health benefits" for their newly eligible expansion enrollees as those required for individual health plans on the federal marketplace, effective December 31, 2019.

The AHCA would have created per-enrollee limits on federal spending in the Medicaid program in each state.



The March 20 "manager's amendment" to the AHCA would have removed the opportunity to expand with the enhanced federal match rate for states, such as Kansas, that had not already expanded Medicaid for adults as of March 1, 2017.

Per Capita Allotment for Medicaid

The AHCA proposed a substantial change to the way the Medicaid program would be financed. It would have created per-enrollee limits on federal spending in the Medicaid program in each state, based upon the state's fiscal year (FY) 2016 expenditures for five populations—elderly, blind and disabled, children, non-expansion adults and expansion adults. A per-enrollee spending cap for each population in FY 2019 would have been set using the FY 2016 calculations, increased by an inflation rate. In subsequent years, each state's targeted per-enrollee spending amount (or cap) would have grown by the increase in the medical care component of the consumer price index (urban) for all consumers. In FY 2020 and beyond, states spending more than the targeted per-enrollee amount for all the defined populations combined would have had their Medicaid funding reduced by the difference the following year.

The bill (as introduced on March 6) indicated the per capita cap for newly eligible adults in states that expanded Medicaid after FY 2016 would be based on a state's per-enrollee spending on non-expansion adults in FY 2016. (As noted above, in the later manager's amendment, the option to expand with enhanced federal support would have been removed for non-expansion states.)

Some expenses and populations would have been exempt from the caps, including Disproportionate Share Hospital (DSH) payments, administrative costs, individuals receiving assistance through an Indian Health Service provider, the breast and cervical cancer program, and so-called "partial benefit" enrollees, such as Medicare enrollees for whom Medicaid pays cost-sharing.

In response to feedback from some states, the manager's amendment would have allowed states to opt to receive a block grant for traditional adult and child populations starting in FY 2020. Funding for the block grant would have been determined using the same base-year calculation as used for the per capita allotments.

New reporting requirements for data on expenditures within defined categories would have been created, and federal matching funding for improving data reporting systems would have increased temporarily. The U.S. Department of Health and Human Services (HHS) also would have been required to conduct audits of each state's reported enrollment and expenditures for FY 2016 and FY 2019 (the years used to set the per capita caps) and subsequent years.

Safety Net Funding for Non-Expansion States

One way that the legislation proposed to address concerns of providers in non-expansion states was to allow states to make adjustments in the amounts paid to Medicaid providers. For calendar years 2018 through 2021, non-expansion states would have received an increased matching rate of 100 percent for these payment adjustments, and 95 percent in calendar year 2022. A state's allotment from the total of $2 billion provided annually would have been calculated based on the number of individuals in the state with incomes below 138 percent of FPL in 2015. States that expanded Medicaid in 2018 or after would not have been eligible for the enhanced safety net funding after expansion.

Disproportionate Share Hospital (DSH) Cuts

Medicaid DSH payments, which are made to hospitals to offset losses on uninsured and Medicaid patients, were to be phased down to about half of their total under the ACA, with the assumption that providers would have less uncompensated care after ACA implementation. However, Congress has delayed the start of the cuts three times, paying for the delay by deepening the cuts scheduled for future years. The AHCA would have repealed DSH cuts scheduled for 2018 in states that did not expand Medicaid, and would have repealed DSH cuts in 2020 for states that had expanded Medicaid.

Other Medicaid Provisions

The bill would have rolled back several other key provisions of the ACA, including states' expanded authority to make presumptive eligibility determinations for beneficiaries, other than for children, pregnant women and breast and cervical cancer patients. It also would have repealed a

6-percentage point bonus in the federal match rate for certain community-based attendant services and supports provided in a 1915(k) waiver, which Kansas does not have.

It also would have reverted the mandatory Medicaid income eligibility level for children back to 100 percent of FPL from 133 percent of FPL. States like Kansas that had used the Children's Health Insurance Program (CHIP) to cover certain age groups of children above 100 percent of FPL were required by the ACA to expand Medicaid eligibility for children up to 133 percent of FPL. The U.S. Supreme Court opinion in the 2012 case *NFIB v. Sebelius* made Medicaid expansion for adults optional for states, but it did not reverse it for children.

In a significant change from current policy, the bill would have limited the effective date for retroactive coverage of Medicaid to the month in which the applicant applied, beginning October 1, 2017. Currently, retroactive medical coverage can extend to three months prior to the month of application.

The manager's amendment would have given states the option to institute work requirements for Medicaid for nondisabled, nonelderly and nonpregnant adults. The amendment was modeled after the requirements and exemptions in the Temporary Assistance for Needy Families program under current law.

The AHCA would have required individuals to provide documentation of citizenship or lawful presence before obtaining Medicaid coverage.

The bill also presented Medicaid proposals that would reduce costs for the states and the federal government, including a change in how income is determined for lottery winners.

The AHCA would have required states to redetermine the eligibility of Medicaid expansion enrollees every six months. The bill also would have increased the civil monetary penalty HHS can levy against someone who intentionally defrauds the Medicaid program.

Prevention and Public Health

Beginning in fiscal year 2019, the AHCA would have repealed appropriations of more than $1 billion each year for the Prevention and Public Health Fund, which was established by the ACA to fund prevention, wellness and public health initiatives administered by HHS. However, the bill would have provided for $422 million in supplemental funding in 2017 for the Community Health Center Fund, which awards grants to federally qualified health centers that provide medical, dental, mental health and reproductive health services to medically underserved populations.

Conclusion

While the American Health Care Act proposed by House Republicans has so far failed to get a vote in the House of Representatives, the contents of the proposed bill provide some insight into the priorities of Republican leadership and President Trump for the future of health reform. The changes made and proposed during negotiations around the bill provide a preview of key issues for future debate.

ABOUT THE ISSUE BRIEF
This brief is based on work done by Linda J. Sheppard, J.D., and Kari M. Bruffett. It is available online at khi.org/policy/article/AHCA.

KANSAS HEALTH INSTITUTE
The Kansas Health Institute delivers credible information and research enabling policy leaders to make informed health policy decisions that enhance their effectiveness as champions for a healthier Kansas. The Kansas Health Institute is a nonprofit, nonpartisan health policy and research organization based in Topeka that was established in 1995 with a multiyear grant from the Kansas Health Foundation.

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