House GOP Affordable Care Act Repeal and Replacement Legislation: American Health Care Act (AHCA)

The "American Health Care Act" (AHCA), legislation seeking to repeal and replace the Affordable Care Act (ACA), was passed out of the House Committee on Ways and Means and the Committee on Energy and Commerce on March 9, 2017. Next, the legislation advanced out of the House Budget Committee and is expected to be considered by the House Rules Committee in the coming days. Republican leadership hopes the bill will be voted on in the full House of Representatives before the April recess. A summary of the key provisions is below.*

Insurance Reforms

Individual and Employer Mandates

- The ACA requires everyone to have health insurance coverage and those without it are assessed a tax penalty. The law also requires employers with 50 or more full-time employees to offer coverage that meets standards for affordability and minimum value or face a penalty.
- The AHCA would reduce the individual and employer coverage mandate tax penalties to zero, beginning in 2016, and instead, use a premium surcharge to incentivize individuals to maintain continuous coverage.
- Beginning in 2019, insurers could assess a penalty on any individual without coverage for 63 or more continuous days during a 12-month look-back period. The penalty charged would not be based on health status but apply equally to those that do not maintain continuous coverage, and cost individuals up to 30 percent of the monthly health plan premium rate for the first year of new coverage.

Tax Credits

- Under current law, refundable premium tax credits are available to individuals or families (based on their **income**) to purchase health insurance. The AHCA makes several modifications to these premium tax credits (based on **age**).
- In 2020, the AHCA would replace the ACA income-based tax credits with an age-adjusted annual credit:
    - $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

Metal Tier Requirements-Actuarial Value of Health Coverage

- Under the ACA, exchange plans must be offered at four cost-sharing levels based on actuarial value (AV) categories (how much of the cost of coverage is the responsibility of the health plan).
- These metal tiers include: Bronze (60% AV); Silver (70% AV), Gold (80% AV) and Platinum (90% AV).

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- Under the AHCA, the metal tiers would be repealed, enabling greater flexibility in plan design and conceivably allow insurers to offer lower cost plans (effective 2020).

Essential Health Benefits (EHBs)

- The ACA requires individual and small group plans to cover ten categories of essential health benefits (EHBs), ambulatory care, hospitalization, maternity, mental health, prescription drugs, preventive care, and chronic disease management, to name some.
- The AHCA repeals the ACA requirement to cover EHBs for Medicaid expansion plans, after December 31, 2019 but contains no directive on EHBs for individual or small group market plans.

Cost-Sharing Subsidies

- The ACA makes subsidies available to eligible individuals to assist with expenses related to cost-sharing (e.g. deductibles and copays). These subsidies are the subject of a pending lawsuit between the House of Representatives and the Obama Administration, which is currently on hold. The AHCA repeals these cost sharing subsidies (effective in 2020).

Changes in Medicaid Structure

Per Capita Cap

- The AHCA replaces the Medicaid entitlement program with a per capita cap structure (effective Oct. 1, 2018/ FY 2019).
- Based on each state's spending in FY 2016, CMS would establish targeted spending for five enrollee categories (elderly, blind and disabled, children, non-expansion adults, and expansion adults).
- The consumer price index for medical care services (CPI-M) would be used to calculate year-by-year targeted spending amounts. To begin in FY 2020, any state with spending higher than its specified targeted aggregate amount would receive reductions in Medicaid funding for the following fiscal year.
- The federal government could recoup funds from states that exceeded their federal allotment.
- Certain expenditures would be exempted from the per capita cap including Disproportionate Share Hospital (DSH) payments and state administrative payments.
- Other exemptions include the following Medicaid beneficiaries:
    - Individuals covered under the Children's Health Insurance Program (CHIP)
    - Some partial-benefit enrollees, such as dual-eligible individuals eligible for coverage of Medicare cost sharing and individuals eligible for premium assistance

Home and Community-Based Services

- The ACA contains a payment bonus in the federal match rate for home and community-based attendant services and supports provided by state Medicaid plans. This provision is repealed by the AHCA.

Retroactive Coverage

- Under the AHCA, retroactive coverage would be effective the month in which the applicant applied for Medicaid; valid for applications made on or after October 1, 2017.

Changes in Medicaid Expansion

Right of States to Choose Medicaid Expansion

- Under current law, Medicaid expansion is optional for states and the AHCA reaffirms this

Coverage

- The ACA permitted states to expand Medicaid eligibility for individuals under age 65 with incomes up to 138 percent of the Federal Poverty Level (FPL). The AHCA repeals the state option to extend coverage to individuals 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.

Disproportionate Share Hospital (DSH) Cuts

- Under the ACA, non-expansion states would have their Medicaid DSH payments eliminated, starting in FY 2018. The AHCA repeals Medicaid DSH cuts in non-expansion states in 2018 and repeals the cuts in expansion states in 2020.

New Safety Net Funding for Non-Expansion States Under the AHCA

- The AHCA provides $10 billion over five years to non-expansion states for safety net funding.
- States that have not expanded Medicaid as of July 1, 2017 are able to participate and the states have discretion to determine eligible providers and payment amounts.
- States qualified for funds would receive an increased matching rate of 100% for CY2018 through CY2021 and 95% for CY2022.
- Distribution of the $10 billion would be determined by the number of individuals in the state with incomes below 138 percent FPL in 2015 relative to the total number of individuals with incomes below 138 percent FPL in all non-expansion states.

Federal Medical Assistance Percentages (FMAP)

- Under the ACA, for Medicaid expansion states, the government subsidized all payments for newly eligible individuals for 2014-2016, to be gradually decreased to 90 percent by 2020. 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

- The AHCA requires states with Medicaid expansion populations to re-determine expansion enrollees' eligibility every six months.

Repeal of the ACA Taxes and Other Funding Provisions

Taxes

- The AHCA would repeal most taxes authorized by the ACA, including the increase in the Medicare payroll tax for high earners, fees on insurers, prescription drugs and medical device manufacturers, and others.

Flexible Savings Account (FSA) and Health Savings Account (HSA) Provisions

- The ACA limited the amount an employer or individual could contribute to Flexible Savings Accounts (FSAs) to $2,500. This limitation is removed under the AHCA and the contribution per year is increased to at least $6,500 (self) and $13,100 (family).
- Under the ACA, the tax on HSA distributions that are not used for qualified medical expenses was increased from 10 to 20 percent. The AHCA lowers this back to 10 percent.
- New under the AHCA, a beneficiary may use HSA withdrawals for qualified medical expenses incurred before the establishment of the HSA in certain circumstances.

The Prevention and Public Health Fund

- The Prevention and Public Health Fund (PPHF) was established under the ACA as an appropriation for a public health initiative to be administered by the Department of Health and Human Services (HHS).
- The AHCA repeals PPHF appropriations starting in FY 2019.

Patient and State Stability Fund

- New under the AHCA, this fund provides resources to states to implement programs that provide financial assistance to high-risk individuals that do not have coverage, establish premium stabilization programs, make payments to providers, and assist individuals with premiums and cost-sharing, among other things.
- The fund makes $100 billion available over nine-years (2018-2026) for eligible states that apply and contribute to the cost.

Community Health Center Program

- The AHCA would increase 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

- This provision of the AHCA, often being referred to as the "Planned Parenthood Provision," imposes a one-year freeze on mandatory funding to certain designated providers or *prohibited entities*. The funding impacted includes Medicaid, CHIP, Maternal and Child Health Services Block Grants, and Social Services Block Grants.
- *Prohibited entities* include certain non-profits, community providers primarily engaged in family planning/reproductive health services; entities that provide abortions (with some exceptions); or an entity that received over $350 million in federal and state Medicaid dollars in fiscal year 2014.