PCG Memorandum on the American Health Care Act

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Addendum (3.23.2017)

On March 20, 2017, the House released a Manager's Amendment to the American Health Care Act (AHCA). Many of the changes are either technical in nature or alter the implementation timeline. However, there are several significant changes in the amendment, most notably:

- Adding an option and incentives for states to impose work requirements on certain Medicaid recipients
- Adding an option for states to receive block grants in lieu of per capita allotments (except for elderly and disabled populations). Block grant amounts would not adjust for increased enrollment but states may be incentivized to pursue the greater flexibility in administering Medicaid programs that block grants offer.
- Eliminating the option that any amount that the tax credits exceed premiums for those receiving the credit be deposited into HSAs.

The House is set to vote on the AHCA this week. PCG will provide a comprehensive update of this summary to reflect the bill that passes the House.

Executive Summary

The American Health Care Act ("the bill") was filed in the House of Representatives on March 6, 2017. The bill is a compilation of budget reconciliation packages from the House Energy & Commerce Committee and the House Ways & Means Committee, in follow-up to the budget resolution adopted in January.

As outlined in greater detail below, the bill does not repeal the Affordable Care Act (ACA) in full, but rather proposes changes primarily focused on the ACA's insurance affordability, Medicaid expansion, coverage requirement and revenue provisions. It also proposes changes to Medicaid funding more generally. On the other hand, the bill largely leaves the ACA's insurance consumer protections (such as guaranteed availability, extended dependent coverage, cost-sharing limits, and prohibitions on pre-existing coverage exclusions and lifetime and annual caps) largely untouched and does not propose changes to: Exchanges, open enrollment and special enrollment period rules, 1332 State Innovation Waiver, non-discrimination rules, reforms related to quality of care and delivery system reform, Medicare, or CHIP. The administration has said that action through budget reconciliation will be followed-up with changes through administrative actions and non-budget legislation.

While informative as a starting point for the official debate in Congress over repeal of the ACA, the bill is likely to change throughout the upcoming legislative process. The bill is being considered in House Committees – beginning this week – before moving to the House floor and then over to the Senate. The bill will face challenges during this process. Nearly unanimous Republican support will be needed for passage, which will be challenged by divisions over Medicaid expansion and tax credits. Additionally, it appears that certain provisions do not directly impact the Federal budget (such as the continuous coverage penalties, elimination of actuarial value requirements and coverage levels, and the change to age-rating) and, therefore, could run afoul of Senate rules for budget reconciliation. Finally, no "score" from the Congressional Budget Office has yet been released to outline the cost of the bill and how it will be paid for.

PCG subject matter experts have created a comprehensive overview of this initial legislative proposal. Please contact us for more information.

Energy and Commerce Committee Provisions

Federal Funding

Prevention and Public Health Fund

The bill would repeal the ACA's Prevention and Public Health Fund as of Fiscal Year 2019, resulting in a loss of $3 billion in state and local public health funding over five years.

The Community Health Center Program

The bill proposes to increase funding for community health centers. In 2017, the increase would be $422 million.

Federal Payments and Hyde Amendment

The bill would impose a one-year freeze on federal payments to certain non-profit organizations offering any abortion services not meeting Hyde Amendment restrictions.

Medicaid

Medicaid Program Changes

The bill would repeal certain Medicaid provisions:
- Would limit Medicaid presumptive eligibility determinations to children, pregnant women, and women with breast or cervical cancer.
- Would revise a pre-ACA requirement that states offer Medicaid eligibility to certain children in families with incomes under 133% of the Federal poverty level (FPL), dropping the income threshold to 100% of the FPL.
- Would repeal the six-percentage point increase in the Federal Medical Assistance Percentage (FMAP) rate for community-based attendant services under the ACA's Community First Choice Option.

Repeal of Medicaid Expansion

The bill proposes to significantly limit the ACA Medicaid Expansion:
- Would repeal the state option under the ACA to expand Medicaid eligibility to certain adults, as of December 31, 2019, for states that have not already expanded
- In expansion states, the bill would freeze reductions to the enhanced FMAP rates for the ACA Medicaid expansion population (adults not eligible for Medicaid under pre-ACA requirements) as of 2017. However, starting in 2020, only existing enrollees without breaks in coverage would be eligible for the enhanced match rate. New applicants after December 31, 2019 and re-applicants who have had a break in eligibility after December 31, 2019 would qualify for regular FMAP rates.
- Would curtail an ACA provision designed to provide equivalent financial assistance to several states, such as Massachusetts, which implemented Medicaid eligibility expansion before 2014
- Would repeal as of December 31, 2019 an ACA requirement that state Medicaid agencies cover "essential health benefits" as defined under the ACA

Safety Net Funding for Non-Expansion States

The bill proposes providing an additional $10 billion over five years to non-expansion states in order to enhance funding for safety net providers.
- Safety net providers would include, but would not be limited to, hospitals meeting Medicaid Disproportionate Share Hospital qualification criteria.
- Medicaid Federal financial participation would be available at a special FMAP rate for state payment

adjustments to such providers up to their cost of uncompensated care for uninsured persons:
  - 100% FMAP for 2018 through 2021
  - 95% FMAP for 2022

Elimination of Disproportionate Share Hospital Cuts

The bill would reverse ACA reductions in Federal allotments to states for Disproportionate Share Hospital (DSH) payment adjustments (subsidies related to the hospitals' cost of uncompensated care for uninsured patients):
- For non-expansion states, in 2018
- For expansion states, in 2020

Reducing Medicaid Costs

The bill proposes to limit Medicaid by:
- Limiting retroactive effective dates for Medicaid eligibility to the month of the application, beginning October 1, 2017
- Requiring individuals to provide documentation as to citizenship or legal residency before obtaining Medicaid eligibility
- Imposing new limits on home equity for purposes of determining Medicaid eligibility for persons who remain subject to asset limits

Increased Frequency of Medicaid Eligibility Redeterminations

The bill would require Medicaid expansion states to re-determine eligibility of Medicaid expansion enrollees every six months, beginning October 1, 2017.

Medicaid Funding: Per Capita Allotments

The bill proposes per capita caps on Federal Medicaid payments to states, beginning October 1, 2019. Federal payments to states would be made per enrollee, rather than as a match of actual expenditures.
- There would be separate per capita caps for the aged, blind, disabled, children, Medicaid expansion adults, and non-expansion adults.
- The Centers for Medicare and Medicaid Services (CMS) would calculate each state's caps for each of the above Medicaid eligibility categories based on each state's expenditures as reported to CMS for Fiscal Year 2016.
  - Fiscal Year 2016 expenditures per capita would then be adjusted for inflation using the medical care component of the consumer price index (M-CPI).
- Medicaid administrative costs, DSH, partial benefit enrollees, and other specified items would not be part of the CMS calculation.

Private Insurance

Cost-Sharing Reductions

The bill proposes to repeal the ACA cost-sharing reductions (and associated payments to issuers) effective December 31, 2019.

Patient and State Stability Fund

The bill proposes to create a fund to be administered by CMS to provide funding to all states and the District of Columbia.
- States can apply for funds to be used to:
  - Provide financial assistance to help high-risk individuals without employer-sponsored insurance to enroll in coverage in the individual market (supporting new or existing mechanisms)
  - Provide incentives for an entity to enter into an arrangement with the state to stabilize premiums

    - for the individual market
    - Reduce the cost of providing health insurance coverage in the individual and small group markets for those with high utilization
    - Promote participation in the individual and small group markets and increase health insurance options in such markets
    - Promote access to preventive services, dental services (preventive or medically necessary), vision services (preventive or medically necessary), and / or mental health and substance use disorder services
    - Provide payments to health care providers for specified health care services
- This could include state-run market stabilization mechanisms, targeted state-based subsidies, or high risk pools.
- Funding would be available from 2018 through 2026. States would be required to apply initially and then could continue programs without any required renewals.
    - Applications would be deemed approved if not denied within 60 days.
- In states that did not apply for a state-run program, CMS, in consultation with the state Insurance Department, would use the funding to create a reinsurance fund for individual market insurers. The fund would pay 75% of claims between $50,000 and $350,000.
- $15 billion would be allocated nationwide for each of the first two years and $10 billion dollars per year thereafter.
    - It is not clear if funds could be used for program administration.
    - Distributions to states would be based on the state's relative share of national incurred claims, changes in uninsured rates for low-income residents, and the number of issuers in the individual Marketplace.
    - States would be required to contribute a state share to fund either the state-designed program (starting at 7% in 2020 and ramping up to 50% in 2026) or the Federal reinsurance payments in the state (starting at 10% in 2020 and ramping up to 50% in 2024 and thereafter).

Continuous Coverage Incentive

The bill proposes a continuous coverage "incentive" in place of the ACA individual coverage requirement. (Note: This provision does not seemingly directly impact the Federal budget and, as such, may not meet Senate requirements for inclusion in a reconciliation bill).

- Beginning in 2019 for enrollments through open enrollment and in 2018 for enrollments through a special enrollment period, individuals would face a 30% surcharge on premiums if they have not had continuous coverage over the prior 12 months (with no breaks of 63 or more continuous days). As a percentage of premiums, this surcharge would be higher for older individuals.
- Those aging out of extended dependent coverage would only face the penalty if they did not enroll during the first available open enrollment period.

Actuarial Value and Coverage Levels

The bill proposes to eliminate the metal coverage levels (Platinum, Gold, Silver, Bronze) and actuarial value requirements for health plans. (Note: This provision does not seemingly directly impact the Federal budget and, as such, may not meet Senate requirements for inclusion in a reconciliation bill).

Premium Rating

The bill proposes to allow the Secretary of the Department of Health and Human Services to expand age rating to 5:1 (from the current maximum ratio of 3:1) and to allow states to set their own ratio as of January 1, 2018. (Note: This provision does not seemingly directly impact the Federal budget and, as such, may not meet Senate requirements for inclusion in a reconciliation bill).

Ways and Means Committee Provisions

Private Insurance

Individual Tax Credits

The bill proposes to repeal the ACA premium tax credits as of December 31, 2017 and to make changes to how they would be administered until that time.

- The bill would remove the cap on advance premium tax credits (APTC) reconciliation amounts (the amounts individuals who receive advance payments that exceed the amount that they are ultimately eligible for at year-end have to repay) for 2018 and 2019.
- The bill would allow premium tax credits to be used to purchase coverage off-Exchange and catastrophic plans (advance payments would not be available for off-Exchange coverage).
- The bill would prohibit use of premium tax credits for plans that include abortion coverage other than to save the life of the mother or in cases of rape or incest.
- The bill proposes to adjust the percentage of income that those who are eligible for tax credits are required to contribute toward premiums (including by age-rating those amounts).for 2019.

Starting in 2020 the existing premium tax credits would be replaced with new tax credits under the bill, which individuals who are not eligible for subsidized group coverage or public coverage could use to purchase insurance on the individual market or unsubsidized COBRA.

- The new tax credits would be a flat amount per year based on age (and not coverage costs or income):
  - Under 30 years old: $2,000
  - Between 30 and 40 years old: $2,500
  - Between 40 and 50 years old: $3,000
  - Between 50 and 60 years old: $3,500
  - Over 60 years old: $4,000
  - (Note that the tax credits would be age-rated on a 2:1 scale, compared to the 5:1 scale that is proposed for premium age-rating)
  - Tax credits for families would be based only on the five oldest members of the family and capped at $14,000.
- The new tax credits would be advanceable and refundable, with the system for advance payments to be established by the Department of Health and Human Services, piggy-backing as much as possible off the current system.
- To the extent the credits exceed the cost of premiums, individuals would only receive that excess if they request it to be deposited in a Health Savings Account.
- The tax credits could not be used to purchase transitional (grandfathered or grandmothered) coverage or plans that include abortion coverage other than to save the life of the mother or in cases of rape or incest.

Small Business Tax Credit

The small business tax credit would be repealed after 2019. Prior to the repeal, the tax credits could no longer be used for plans that cover abortions other than to save the life of the mother or in cases of rape or incest.

Coverage Requirements

The individual and employer coverage requirement penalties would be zeroed out as of December 31, 2015.

Health Savings Accounts

The bill proposes a number of changes to expand the use of Health Savings Accounts (HSAs) and similar mechanisms as of December 31, 2017:

- Allowing HSAs, Archer Medical Savings Accounts (MSAs), Flexible Spending Accounts (FSAs) and Health Reimbursement Accounts (HRAs) to reimburse for over-the-counter drugs

- Repealing the increase of the tax on HSA and Archer MSA funds used to reimburse unincludable expenses
- Repealing the limitation on contributions to FSAs
- Increasing the limitation on contributions to HSAs to match the maximum deductible and out-of-pocket limits for High-Deductible Health Plans
- Allowing spouses to make catch up contributions to the same HSA
- Allowing HSAs to reimburse expenses incurred up to 60 days prior to the account being established

Revenue Provisions

The bill proposes to repeal ACA revenue provision as of December 31, 2017:

- The limitation on tax deductions of compensation for insurance executives
- The tanning tax
- The tax on brand name drugs
- The insurer tax
- The net investment income tax
- The medical device tax
- The increase in the income threshold for deducting medical care expenses from personal income tax
- The Medicare tax increase for individuals with high incomes
- The reduction of the employer deduction for expenses allocable to retiree drug costs

The bill also delays the so-called “Cadillac tax” on high-cost insurance plans until 2025.

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