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American Health Care Act: Key Provisions and Implications, June 2017 Update

In March 2017, House Republicans unveiled the American Health Care Act (AHCA), their proposal to replace the Affordable Care Act (ACA). On May 4, the U.S. House of Representatives passed AHCA by a vote of 217-213. On May 24, the U.S. Congressional Budget Office projected that under the House-passed version of AHCA, 14 million more Americans would be uninsured in 2018 than under current law, with the number of additional uninsured rising to 23 million by 2026. In addition, CBO estimated that average individual market premiums would increase by 20% in 2018 compared to under current law, while average premiums after 2020 could decrease depending on states' decisions to apply for several waivers proposed in AHCA.[1] The following summarizes key AHCA provisions and who is primarily affected.

Provision	*American Health Care Act (AHCA)*	Who is Primarily Affected
Replace the ACA's Individual Mandate with a Continuous Coverage Requirement	Enrollees who experience a lapse in coverage longer than 63 days would pay 30% higher premiums for one year upon re-enrolling in individual coverage.	Individual market enrollees and those that experience spells of uninsurance would be most affected. There were an estimated 533,000 enrollees in Michigan's individual market in 2016.[2] There is considerable churning of coverage within the individual market. Our latest survey shows that 5% of those with individual market coverage had spells of uninsurance within the past year.[3] In addition to these individuals, about 519,000 people in Michigan were uninsured in 2015 but had household incomes that could have qualified them for ACA tax credits.[4] In 2017, the average annual premium for the second-lowest cost silver plan in Michigan was $2,736 (before tax credits). A 30% continuous coverage surcharge would increase that annual premium to $3,557.[5]
Change Tax Credits from those based on income and premium cost in the ACA to based on age and allow the tax credits to be used on or off Exchange	Proposed annual tax credit structure: • **20-29**: $2,000 • **30-39:** $2,500 • **40-49:** $3,000 • **50-59:** $3,500 • **60 and older:** $4,000 Family limit of $14,000 Credits phase out at income levels of $75, 000-$115,000 Adjusted annually by CPI plus 1%	In 2016, about 275,000 Michigan residents (87.9% of exchange enrollees in the state) received an ACA premium tax credit.[6] Average ACA tax credits were projected to be $3,375 in 2020 compared to an average expected tax credit of $2,946 under AHCA.[7] AHCA tax credits are expected to be 13% lower than average ACA tax credits.
Repeal Cost-Sharing Reduction Subsidies	The ACA includes cost sharing subsidies for those at 250% of poverty or less. AHCA would repeal these subsidies in 2020.	In 2016, about 165,000 Michigan residents (52.6% of exchange enrollees in the state) received cost-sharing reduction subsidies through the ACA.[8]
Widen Age Rating Bands	The ACA allows plans to vary rates between the youngest and oldest from 1:3. AHCA would allow rate bands of 1:5. Starting in 2018, states could apply for waivers to expand age bands beyond this ratio (see State Waivers below).	25% of enrollees in Michigan's Health Insurance Marketplace in 2016, approximately 86,000 individuals, were ages 18-34. 29% of enrollees, approximately 100,000 individuals, were ages 55-64.[9]
Freeze Medicaid Expansion	Allow Medicaid expansion to continue in states that have already expanded the program with enhanced federal matching rate until 2020 (90%). In 2020, the enhanced federal matching rate continues indefinitely for expansion enrollees covered on December 31, 2019, who do not have a lapse in coverage for longer than 1 month. All others would receive the traditional federal matching rate (65.15% for Michigan in 2016).	As of December 2016, there were about 1,800,000 "traditional" Medicaid enrollees and about 649,000 Healthy Michigan Plan enrollees.[10] Michigan and most states would be likely to stop covering the expansion population over time under this provision.
Shift Medicaid from funding based on the cost of coverage to Per-Capita limit or block grant	AHCA's original language would shift the entire Medicaid program to a per-capita cap system in 2020. Under a per-capita cap system, states would receive a fixed per-enrollee payment for different enrollment groups based on FY2016 expenses and payments would grow with medical inflation (medical inflation plus one percentage point for elderly, blind, and disabled populations). The March 23 manager's amendment allows states to choose a block grant system, rather than a per-capita cap, for children and non-disabled, non-elderly adults.	In FY2015, Michigan Medicaid expenditures were $15.9 billion, of which the federal share was $11.6 billion.[11] Starting in 2020, the rates of increase in federal funding would be limited to medical inflation (plus one percentage point for elderly, blind and disabled) and enrollment but would not take account of changes in technology. For example, in March 2016, the state's Medicaid program began covering the specialty drug Sovaldi to treat Hepatitis C.[12] The cost of a typical course of Sovaldi treatment is around $84,000 per person,[13] which would not be included in the base cost. This provision would transfer considerable costs to states over time.[14]
State Waivers (MacArthur Amendment)	Allow states to apply for three types of waivers: • **Starting in 2018**, widen age bands for the individual and small group market beyond the 5:1 ratio proposed in AHCA. • **Starting in 2019**, opt out of community rating requirements, allowing insurers to underwrite policies for certain individuals based on health status if the state is operating a program under	According to the CBO, approximately one-third of the population are expected to live in a state that would use these waivers to make moderate changes to EHBs and allow limited use of medical underwriting. In these states, average premiums in 2026 would be 20% lower than under current law, with young, healthy people receiving the largest premium reductions. Approximately one-sixth of the

Provision	*American Health Care Act (AHCA)*	Who is Primarily Affected
	AHCA's Patient and State Stability Fund. This would only apply to individuals with a lapse in coverage greater than 63 days. Individuals who maintain continuous coverage cannot be underwritten based on health status. • **Starting in 2020**, determine essential health benefits for the individual and small group market.	population are expected to live in a state that would make substantial changes to market regulations through both EHB and community rating waivers. In these states, premiums would be medically underwritten and plans would cover a narrower set of benefits than under current law, potentially resulting in out-of-pocket increases for less healthy people. Premiums would be lower for younger, healthier individuals. Less healthy people would experience very high premiums; over time, it would become difficult for them to purchase coverage. The changes made under these waivers could cause individual markets in these states to become unstable after 2020.[15] The community rating waiver may have impacts on the large group market in addition to the small group and individual markets. Under the ACA, large employer plans are prohibited from imposing annual or lifetime limits on essential health benefits. Current regulations allow large employer plans to adopt any state's definition of essential health benefits (since all states must meet federal standards for essential benefits). Under AHCA, if a state received a waiver to determine essential health benefits and narrowly defined EHBs or chose to eliminate them altogether, employer plans could impose lifetime and annual limits on a wide range of benefits.[16]
Patient and State Stability Fund	AHCA initially provided $100 billion over nine years to establish the Patient and State Stability Fund (PSSF). States could use these funds for a variety of purposes to stabilize insurance markets, including establishing high-risk pools. After subsequent amendments, total funding for the PSSF increased to $138 billion. • The March 23 manager's amendment allocated $15 billion to the PSSF. These funds are earmarked for maternity coverage, newborn care, and behavioral health. • The Palmer/Schweikert Amendment allocated $15 billion to the PSSF to create a federal "invisible risk sharing program" covering claims over $10,000 for individuals with certain health conditions (to be determined by the CMS Administrator). • The Upton Amendment allocated $8 billion from 2018-2023 for people with pre-existing conditions in states that have received a waiver to opt out of community rating requirements. These funds would be used to lower premiums and out-of-pocket costs for individuals purchasing coverage on the individual market and who have had a lapse in coverage longer than 63 days.	According to Avalere, states with high medical costs and high individual market enrollment would receive the highest levels of funding. States with low insurer participation in their health insurance marketplace and/or a recent increase in uninsured residents below 100% FPL would also receive additional funds.[17] The CBO estimates that these funds would help lower premiums and encourage insurer participation in the individual market.[18] Prior to the ACA's insurance market reforms, states relied on high-risk pools to provide access to coverage for individuals with pre-existing conditions. In 2011, approximately 226,000 individuals were enrolled in coverage through high-risk pools in 35 states, with total claims of $2.5 billion.[19] Premiums were 125-200% of average premiums in the individual market.[20] 33 states had maximum lifetime limits on coverage, 6 states had annual limits, and 14 states had plans with annual deductibles of $10,000 or more.[21] The Commonwealth Fund estimated that the federal government would need to provide $178 billion per year to adequately fund high risk pools if 13.7 million people were enrolled.[22] Conservative analysts James Capretta and Tom Miller in 2010 that a high-risk pool covering 4 million individuals would require $15 to $20 billion in federal funding annually.[23] A recent analysis from Avalere estimated that 600,000 individuals with pre-existing conditions could have coverage if states allocated all $123 billion in non-earmarked PSSF funds toward establishing high risk pools.[24]

Essential Health Benefits Under the ACA	Common Pre-Existing Conditions Prior to the ACA
The ACA requires insurers in the individual and small group markets to provide coverage for ten categories of Essential Health Benefits: 1. Ambulatory services 2. Emergency services 3. Hospitalization 4. Maternity and newborn services 5. Mental health and substance use disorder services 6. Prescription drugs 7. Rehabilitative and habilitative services and devices 8. Laboratory services 9. Preventive and wellness services, and chronic disease management 10. Pediatric services, including pediatric dental and vision services	Prior to the implementation of the ACA's community rating requirements, insurers could decline coverage or charge more to individuals with certain pre-existing conditions. According to the Kaiser Family Foundation, commonly declinable conditions in the pre-ACA individual market included:[25] • Cancer • Crohn's disease • Diabetes • Heart disease • HIV/AIDS • Pregnancy • Severe mental illness • Severe obesity • Stroke • Substance use, with recent treatment

ENDNOTES

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