Summary and Analysis of American Health Care Act

March 8, 2017

On Monday, March 6, 2017, House Republicans released two bills which constitute their first attempt at repealing and replacing the Affordable Care Act (ACA) since winning the White House and maintaining majorities in both the House and Senate in November. While several other draft bills and various policy proposals have leaked in the past few months, the March 6 bill, dubbed the American Health Care Act (AHCA), is the first to move to through the legislative process and make it to committee markup. As expected, Republicans are using the budget reconciliation process as a vehicle for ACA repeal, which means that the AHCA does not include some key issues that are important to health centers, like National Health Services Corps, Teaching Health Centers, or 330 funding. It does, however, propose to move the Medicaid program to a per-capita cap funding scenario and end the enhanced federal match rate for the Medicaid expansion starting in 2020. The Congressional Budget Office (CBO) has not yet issued an analysis of the bill's impact, but we know that it will vastly reduce federal investment in California's safety-net health care infrastructure.

Short and Simple: This bill, if enacted, would be devastating for California. A massive reduction in federal investment for Medi-Cal will result in millions losing coverage.

Quick Summary of Critical Issues

- Establishes a per capita cap for Medicaid based on 2016 Medicaid enrollees.
- Medicaid expansion states will no longer receive the enhanced federal match (FMAP) for newly eligible Medicaid enrollees after December 31, 2019. For persons enrolled before December 31, 2019, who do not experience a gap in coverage, states will continue to receive the enhanced rate.
- Tightens eligibility requirements for Medicaid after December 31, 2019, including provisions that require states to re-evaluate eligibility every 6 months, and removes the 5% income disregard used to prevent "churning" in and out of coverage for those whose incomes fluctuate on a month to month basis.
- Prohibits Medicaid and other federal funding to go to Planned Parenthood for one year. The one year funding, estimated to be $422 million, will be reallocated to Federally Qualified Health Centers.

Other Changes

- Repeals all taxes related to the ACA – prescriptions drugs, over-the-counter medications, health insurance premiums and medical devices – starting in 2018.
- Repeals the employer and individual mandates.
- Requires insurers to charge 30% extra to individuals who have a lapse in insurance coverage of more than 63 days, including those with pre-existing conditions.
- Repeals the Prevention and Public Health Fund.
- Repeals the Disproportionate Share Hospital (DSH) program cuts for non-expansion states immediately and for expansion states in 2020.
- Removes the enhanced match rate for Children's Health Insurance Program (CHIP).
- Repeals essential health benefit requirement for Medicaid plans, including maternity care and preventive services, starting after December 31, 2019.
- Allows insurers to charge up to 5 times as much for policies for older individuals (ACA says no more than 3 times as much) or allows states to set their own ratios.
- Provides $100 billion over 10 years to help states deal with very ill residents (establish high-risk pools) and stabilize insurance markets.

californiahealth+ advocates
ADVANCING THE MISSION OF COMMUNITY HEALTH CENTERS

(916) 503-9130
healthplusadvocates.org
1231 I Street, Suite 400, Sacramento, CA 95814

- Repeals exchange subsidies and replaces them with tax credits that vary by age and are phased out at certain income levels.
- Individuals cannot use tax credits to buy insurance that covers abortions but they can purchase separate policies out of pocket.
- Raises the limits on contributions to health savings accounts.
- Repeals the ten percent tax that the US Government requires tanning providers to collect on indoor tanning services.

Provisions kept from ACA

- Maintains guarantee of coverage for pre-existing conditions, but applies lapse in coverage penalties that apply to everyone.
- Allows individuals to stay on their parents' insurance until 26 years of age.
- Keeps the requirement that plans cannot set annual or lifetime limits on essential health benefits.
- Keeps the ACA's essential health benefits requirements for private insurance plans, but does remove actuarial value requirements and the 3-to-1 ratio for premium variation, and replaces with a 5-to-1 premium variation.

Full Summary and CCHC Analysis

Medicaid Funding: Per Capita Cap

Starting in 2020, this bill would create a 'per capita cap' model for Medicaid funding, which would limit federal spending per-enrollee. The caps would be based on the costs per beneficiary in 2016, based on eligibility category (aged, blind and disabled, children, non-expansion adults, and expansion adults). The capped amount per beneficiary would grow annually based on the medical component of the Consumer Price Index (M-CPI). Any spending above the per capita cap would fall 100% onto the state.

Certain payments are held outside the Medicaid per capita cap. For example, Disproportionate Share Hospital (DSH) payments operate outside the caps, as well as Administrative payments. Certain populations are also funded outside the caps, including:

- Children covered under CHIP expansion;
- Individuals who receive medical assistance through an Indian Health Service Facility;
- Individuals receiving care under the Breast and Cervical Cancer Early Detection Program;
- Undocumented individuals receiving emergency Medi-Cal;
- Family Planning, Access, Care, and Treatment (FPACT);
- Medi-Medi dual eligibles;
- Tuberculosis services for individuals with TB

Health Center Analysis:

The Medicaid program began in 1965 as an entitlement – which is a commitment that federal and state funding is ensured regardless of cost and enrollment. The Republican bill would cap federal funding for Medicaid for the first time, essentially ending Medicaid's entitlement status. By delinking federal Medicaid funding from the actual cost of providing care to vulnerable Americans, Republicans are setting a dangerous precedent that makes the Medicaid program highly vulnerable to more cuts in the future.

Republicans promised that a per capita cap would come with enhanced flexibility for the states. Because this bill has to fit into the Budget Reconciliation rubric, it does not provide that flexibility. That may be addressed in future legislation or through regulations issued by HHS.

The Center on Budget and Policy Priorities estimates that Medicaid costs per beneficiary are expected to rise about .2 percentage points faster each year than the states' per capita capped amounts based on the M-CPI, meaning that this per capita cap proposal is not only a cap, but a cut to federal Medicaid funding to states, and the cut will grow each year. In addition, this cost-shift to states also includes any cost growth or demographic changes that the per-capita cap

wouldn't account for, such as an epidemic, new and expensive pharmaceuticals or treatments, or growth in spending as baby boomers age. As more of the costs are shifted to the state, states will have to either contribute much more of their own funding or cut eligibility, benefits, and provider payments to make up the difference.

Making Medicaid a per-capita cap would make the program highly vulnerable to cuts in the future. Once Medicaid funding is de-linked from actual Medicaid spending, there is no reason that future policymakers couldn't take more funding from the program – perhaps by lowering per-capita cap payments - to pay for other priorities.

Though it's not specified clearly in the bill, it's possible that a move from Federal Medical Assistance Percentages (FMAP) to a per-capita cap will also allow states to significantly change the way they run their Medicaid programs. The bill does not address how the federal requirements to make FQHC services available to Medicaid enrollees will be handled under the per-capita cap scenario, nor does it contemplate the federal requirement that states pay FQHCs their cost-based PPS rate.

Medicaid Expansion

The Republican bill makes even further reductions to the Medicaid program by ending the enhanced federal funding for new enrollment in the Medicaid expansion as of January 1, 2020. Traditionally, the federal government pays for between half and 70% of Medicaid costs based on a states' relative wealth. This is referred to as the Federal Medical Assistance Percentage (FMAP). California, as a relatively wealthy state, has historically had an FMAP of approximately 50%, which is very low compared to other states. This means that the federal government and the state of California usually split the costs of the Medi-Cal program about 50/50. Under the ACA, California (and other states who elected to expand Medicaid) received a much higher FMAP for the Medicaid expansion population. The Medicaid expansion FMAP started at 100% in 2014, (meaning that the federal government paid 100% of the cost of insuring the expansion population), and drops slowly over time until 2020 when the federal FMAP caps out at 90%. Under the ACA, the FMAP for the expansion population was supposed to stay at 90% permanently.

Under the Republican bill, starting in 2020, states would receive only their regular FMAP for those who newly enroll or re-enroll in the Medicaid expansion, meaning that California would have to cover 50% of the cost of these beneficiaries, rather than just 10%. States could continue to receive the enhanced match for people who are already enrolled as of January 1, 2020, and who don't experience a gap in coverage of more than one month. For those who enroll after January 1, 2020, or drop out of coverage and try to re-enroll after that date, the state will no longer receive the enhanced FMAP for that individual and will receive only their usual 50% FMAP. The bill also tightens eligibility requirements, thereby increasing the likelihood that beneficiaries will fall out of coverage with the enhanced FMAP and be eligible only for regular FMAP coverage.

Health Center Analysis:
Currently, California receives a 95% FMAP, which is set to ratchet down to 90% by 2020. If the entire Medi-Cal expansion population were to pull down only a 50% FMAP, California would potentially spend an additional $10 billion per year to continue to provide coverage at current levels to the full expansion. It is unlikely under the current Brown Administration that California will elect to maintain Medi-Cal up to 138% Federal Poverty Level (FPL), in addition to further cuts to benefits, eligibility, and provider reimbursement rates. Reductions in Medi-Cal will have a negative impact on health centers bottom line, and an even greater impact on patients as they will be left without the comprehensive coverage provided through Medi-Cal.

The ACA has had an incredible impact on FQHCs in California. Since 2012, 1.2 million more CCHC patients are covered by Medi-Cal, largely due to the Medi-Cal expansion and easing of enrollment processes. A recent Capital Link report has estimated that rolling back the Medicaid Expansion will contribute to a 42% decline in patients, and 1.5 million fewer FQHC patients covered by Medi-Cal.

Additional Medicaid Eligibility and Plan Changes

The Republican bill proposes revisions to Medicaid eligibility which make it more difficult for individuals to get into Medicaid, and easier to fall out of coverage. This ensures that after January 1, 2020, more and more beneficiaries over time will fall out of coverage with enhanced FMAP and either lose coverage entirely or be re-enrolled at the lower FMAP, presumably with severely curtailed benefits. The new eligibility restrictions include:

- A requirement that states who have implemented the Medicaid expansion re-determine eligibility for Medicaid every 6 months.
  - *In California, renewals (eligibility redeterminations) are only required one time per year for an individual to remain on Medicaid. Between renewal periods, individuals are expected to notify Medi-Cal of any changes that may impact their eligibility (for example, a change in household size). Because renewals require action on the part of the beneficiary, this change is likely to cause more beneficiaries coverage to lapse, pushing them out of the 90% FMAP and onto 50% FMAP if and when they re-enroll.*
- The bill repeals states' expanded authority to make presumptive eligibility determination for the Medi-Cal expansion population. States would still be allowed to make presumptive eligibility determinations for children, pregnant women, and breast cancer and cervical patients.
  - *Through the Hospital Presumptive Eligibility (HPE) Program, qualified hospitals are all able to provide temporary, no Share of Cost Medi-Cal benefits during a presumptive period to individuals determined eligible on the basis of preliminary patient information. Hospitals, for example, are able to treat patients under presumptive eligibility and bill Medi-Cal even when the patient has not gone through the MC eligibility process. This bill will eliminate the Hospital Presumptive Eligibility program for the expansion population, which is bad for patients and providers. With the real-time determination, during the PE eligibility window, patients can more easily access care and providers can more easily get reimbursed for that care. Hospitals are likely to see an increase in bad debt, and patients will experience more barriers to access, especially when transitioning out of the hospital.*
- Limits the effective date for retroactive coverage of Medicaid benefits to the month in which the applicant applied starting October 2017.
  - *Under the ACA, individuals who incurred medical expenses in any of the three months (90 days) prior to the month of Medi-Cal application could apply for coverage for those months. With a rolling back of retroactive coverage, patients and providers will suffer as bills go unpaid and debts grow.*
- Requires Medicaid applicants to provide documentation of citizenship and lawful presence before obtaining coverage.
  - *Currently, the law allows applicants a "reasonable opportunity" period to provide documentation of citizenship or immigration status, during which time the individual is enrolled in Medicaid. With this change, applicants will be unable to enroll until after they've provided their documentation, creating a barrier and potentially a long delay before Medicaid benefits are realized. Whole households may simply choose not to apply.*
- Would repeal the authority for states to elect to substitute a higher home equity limit that is above the statutory minimum in law, applicable 180 days after enactment of this legislation.
- Re-calculate the way in which lottery winnings are counted as income for purposes of MAGI determination. Any lottery winnings above $80,000 would be counted over multiple months, even if paid in a single month, to prevent a recent winner from getting back on Medicaid after the month of their payout. A hardship exemption could be considered by the Secretary of HHS.
  - *These are both additional examples of tightening eligibility in hopes of rolling beneficiaries off of 90% FMAP and onto 50% FMAP.*
- The bill reverts mandatory Medicaid income eligibility level for children back to 100% FPL. States could cover this population in their CHIP programs.
  - *The bill reverts mandatory Medicaid income eligibility level for children back to 100% FPL. For school-aged children (6-18 yrs) and their families this will have the most significant impact as many states will likely chose to undo cost-sharing and benefit protections that were put in place as a result of the ACA. States could cover this population in their CHIP programs, but that may come with the reduction of benefits and an increase in cost-sharing.*

Currently, under the ACA's maintenance of effort protections, states cannot make reductions in children's eligibility through 2019. In California, the upper income for determining eligibility for children is 266% FPL. In 2013, California transitioned all children from its separate CHIP program into Medi-Cal. Depending on age – 0 -1 year, 1-5 years, and 6-18 years – Medi-Cal and CHIP FPL thresholds vary. For Medi-Cal, these thresholds are higher than 100% FPL across the board. With a significant reduction in federal funding to support the Medicaid population, the state will be hard-pressed to maintain current levels of coverage and benefits for millions of children. This may not only impact CHIP and/or Medicaid funded children, but children, such as undocumented children, that the state is providing coverage to through state-only funds. If the state chose to roll back eligibility for Medi-Cal children, they would likely make similar eligibility adjustments to children newly covered through 2015 state legislation. We are working with our children advocacy partners to better understand the full range of implications of this proposed change.

- The bill repeals the requirement that state Medicaid plans provide the same "essential health benefits" (EHB) that are required by plans on exchanges.
    - *This will allow states to provide "thin" benefit packages that no longer cover the full breadth of services used by Medi-Cal beneficiaries. For states like California who, under the proposal, will see a big jump in the cost of Medi-Cal come 2020, this will allow them to reduce benefit packages as a cost-saving structure and beneficiaries will be at risk for purchasing coverage that will not cover the services they expect or will dramatically limit the providers they can see.*

Individual Mandate

Probably one of the most controversial parts of the ACA, the individual mandate requires every person in the United States to acquire health insurance coverage that meets a minimum standard or pay a penalty. The mandate is meant to ensure that Americans don't wait until they become sick to get insurance coverage, resulting in a high percentage of the insurance market consisting of sick people, leading to skyrocketing costs. This bill repeals the individual mandate only to replace it with a "continuous coverage requirement." The Republican bill attempts to incentivize people into maintaining coverage through a 30% surcharge added onto premium costs if they had a lapse in coverage for more than 63 continuous days, and then try to re-enroll. In that sense, Republicans would replace a penalty for not having insurance with a new penalty for allowing insurance to lapse. Another difference between the penalty and the surcharge is that the penalty was assessed like a tax and went to help pay for other parts of the ACA; the surcharge goes to the insurance companies. The repeal of the individual mandate would be retroactive for years beginning with 2016.

The 30% surcharge penalty would be greater for older people since premiums may vary with age. The Republican bill allows a 5-to-1 variation in premium cost, meaning that older (and ostensibly more expensive) enrollees can pay up to 5 times more than younger ones. Under the ACA, premium variation is limited to three-to-one, so under the GOP plan we would likely see younger people see their premium rates lower a little, while older Americans see their costs rise. This is complicated by the bill's changes to actuarial value requirements, which allow that plans no longer have to meet ACA standards that require plans to offer benefit packages with actuarial values of 60%-90%, based on metal level. The repeal of the actuarial values (AV) levels would allow plans to be sold with AVs of less than 60 percent, although the maximum out-of-pocket limit in the ACA is retained so insurers would not be able to sell plans less generous than the current catastrophic plans. They would also be able to sell plans with AVs of more than 90 percent, and anything in between.

Health Center Analysis:

It seems unlikely that the "continuous coverage requirement" will work as effectively as the individual mandate in ensuring that the young and healthy maintain coverage. If the young and healthy don't see a point in maintaining coverage, health insurance premiums will likely rise considerably as the risk pools skew towards sicker and older patients

who utilize more and more expensive health care. For those who are expensively or catastrophically ill, a 30% surcharge is a small price to pay, but for those who are not catastrophically ill, a surcharge may be a disincentive to enroll.

A typical American purchasing coverage under the GOP plan may not see an immediate jump in premium rates, even with a skewed risk pool, because under this plan they will be able to buy coverage that is significantly less comprehensive than the coverage they were required to maintain under the ACA. While the premiums may not look as high, the out of pocket costs of buying coverage that does not have at least a 60% AV will come later. The Republican plan attempts to address this issue through expanding the use of health savings accounts and maintaining annual and lifetime limits created under the ACA, but enrollees may still purchase plans that leave them with enormous out of pocket costs and limited coverage. Clinics who care for these patients should be prepared for a rise in accounts receivable and bad debt. In general, clinics should be prepared to see the number of uninsured patients rise, especially among the low income that are currently receiving subsidies for Covered California. Those who keep commercial insurance will likely be older and sicker than the general population.

Subsidies to Buy Insurance

For those over 133% FPL who are ineligible for the Medicaid expansion, the ACA offers income-based subsidies to buy full scope insurance plans on Health Benefit Exchange Marketplaces, which is known here as Covered California. Subsidies in the form of advance tax credits are available for individuals and families up to 400% FPL, with greater subsidies for those with lower incomes. The tax credits under the ACA can only be used to buy plans on Exchanges like Covered California, and those plans must be full-service plans that offer all essential health benefits and meet actuarial value requirements. This bill repeals the ACA's income-based tax credits after 2019 and replaces them with new Advance Premium Tax Credits which differ from those in the ACA in several important ways.

Starting in 2018, the Republican plan offers Advance Premium Tax Credits which can be used to purchase off-exchange plans and catastrophic plans – basically, plans with much 'thinner' benefits than those offered through the ACA's Exchanges. Plans purchased with tax credits cannot cover abortions, but may cover infections, injuries, diseases or disorders caused by abortions. Individuals with tax credits may purchase separate abortion coverage out of pocket. The tax credit is refundable and advanceable on a monthly basis to pay for individual market premiums.

The amount of the tax credit that each consumer is eligible for will change under the Republican proposal as well. Rather than being based solely on income, the Republican Advance Premium Tax Credits will vary based on age as well as percentage of federal poverty level. The amount of tax credit is set at the lesser of the actual amount paid for coverage for individuals or families for the year (up to $14,000 or 5 family members), or $2,000 for an individual under 30, $2500 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. The tax credit begins to phase out when a taxpayer's modified adjusted gross income reaches $75,000 ($150,000 for joint filers), and phases out slowly above that income level.

Even though the Republican plan's Advance Premium Tax Credits do not require consumers to purchase plans on Exchanges, the plans that provide coverage for tax credits must file returns identifying their plans as qualified health plans (QHPs) and providing benefit, cost, and coverage information to the federal government. Under the Republican proposal, Americans can only qualify for the tax credit if they are enrolled in a qualified health plan, not eligible for employer coverage or government programs, are citizens or qualified aliens, and are not incarcerated other than pending disposition of charges.

Health Center Analysis:
California stands to lose under this proposal. Unlike the ACA, the Republican plan's tax credits are not adjusted to reflect geographic differences in health care and premium costs, so consumers in California's relatively high-priced markets would end up paying more of their income toward their premiums than consumers in other areas.

Further, the poor and the elderly will be much worse off under the Republican Premium Tax Credits than those available under the ACA. Even though the tax credits vary by age and income, at the most, the elderly only receive twice what the young receive in tax credits. However, the premium cost for elderly can be as high as 5 times more than the young. The two-for-on age adjustment in the tax credits falls far short of making up for the 5 to 1 ratio allowed in premium variation.

Finally, Covered California is a flagship Exchange created under the ACA which offers standardized benefit designs and consumer protections that are not available in the individual market. If the Republican plan allows individuals to purchase 'thin' and catastrophic plans on the individual market, we will likely see a move out of Covered California's robust full-coverage plans and toward plans with cheaper premiums and less generous benefits. This could dismantle Covered California while strengthening the off-Exchange market.

Planned Parenthood

The bill proposes a one-year freeze on mandatory funding to Planned Parenthood from Medicaid, CHIP, Maternal and Child Health Services Block grants, and Social Services Block Grants.

Health Center Analysis:
Planned Parenthood serves a vital role in the safety net, ensuring access to reproductive care for millions of women nationwide through a network of approximately 700 health centers. This bill blocks about $500 million in federal funding for Planned Parenthood, endangering a provider that offers a range of services to women beyond abortion.

FQHC Funding

FQHCs would receive $422 million in additional funding in 2017 under the legislation. This funding comes from what is currently Planned Parenthood funding.

Health Center Analysis:
It is CPCA's position that health centers cannot absorb the patients or offer the services of Planned Parenthood – they are an irreplaceable part of the safety net. While the destruction of the ACA does require additional investment in health centers, taking the funding of another essential provider is not the way to do it.

Patient And State Stability Fund For Reinsurance

The GOP plan creates a "Patient and State Stability Fund" and appropriates $15 billion per year for 2018 and 2019, and $10 billion per year each year until 2026, for a total of $100 billion. The funds require a 7% state match. States can use these funds for a variety of programs, including:

- Assisting high-risk individuals in purchasing coverage or reducing the cost of coverage for high risk enrollees;
- Providing reinsurance to stabilize individual market insurance premiums;
- Promoting participation and health insurance options in the individual and small group markets;
- Promoting preventive, dental, vision, and behavioral health services;
- Contracting with providers for the provision of services, and
- Reducing out of pocket costs.

States must apply for the funding, but applications will be automatically approved if not denied within 60 days. Once a program is approved it will remain approved for all subsequent years until 2026. The funding will be allocated among that states based on national incurred claims, reported medical loss ratios, increases in uninsured individuals under 100% FPL during the time of the ACA, and states with fewer than three QHPs.

Health Center Analysis:
California is likely to receive a larger portion of funds under this program than any other state, but there's no way to slice $15 billion 50 ways that gives California enough money to even come close to providing financial stability or patient relief with an individual insurance market as big as ours. California's Medicaid spending in 2015 was approximately $85.5

billion, Covered California subsidies equaled approximately $5 billion, and with a $2.5 trillion economy, whatever comes to California from this fund will be a negligible amount. Our best bet for a stabilized health care sector in California is to try to keep as many elements of the ACA as possible alive in the individual market. California might try to retain guaranteed issue requirements, a 3-to-1 ratio for premium variation, and other ACA market stabilization techniques so that we don't have to depend on this small and likely ineffectual fund for market stability.