American Hospital Association

Special Bulletin

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SUMMARY OF HOUSE PACKAGE TO REPEAL AND REPLACE PARTS OF THE ACA

On March 6, House Republican leaders unveiled a legislative package to repeal and replace parts of the Affordable Care Act (ACA). Taken together, the bills by the Republican leadership of the Energy & Commerce and Ways & Means committees – collectively called the American Health Care Act – would repeal the ACA's employer and individual mandates to purchase health coverage and replace the law's means-tested advance premium tax credits and cost-sharing reductions with tax credits that vary by age and income. The package also would end the ACA's Medicaid expansion, beginning in 2020, and transition the program to a per capita cap funding model. In addition, the package would repeal most of the law's taxes while maintaining, though delaying, the tax on high-value employer-sponsored health plans (or "Cadillac" tax).

Health care coverage is vitally important to working Americans and their families. In a letter to members of the House of Representatives today, we asked Congress to protect our patients, and find ways to maintain coverage for as many Americans as possible. We look forward to continuing to work with the Congress and the Administration on ACA reform, but we cannot support The American Health Care Act in its current form.

Highlights of the major provisions of the package follow.

COVERAGE INCENTIVES

The bill would reduce the individual and employer coverage mandate penalties to $0 beginning in 2016 and, instead, would, beginning in 2019, use penalties for failure to maintain coverage as the incentive to enroll in coverage. Insurers could assess a penalty on any individual who experienced 63 or more continuous days without coverage during a 12-month look-back period. The penalty could be up to 30 percent of the monthly price of the health plan premium and would be assessed on all monthly premium payments made during that coverage year (or the remainder of the year for partial-year enrollees).

MEDICAID EXPANSION

The package would end Medicaid's enhanced federal matching funds for future expansion populations as of Jan. 1, 2020. However, it would allow states to maintain

coverage for the existing expansion populations with the enhanced Federal Medical Assistance Percentage (FMAP) (set at 90 percent in 2020) as long as there is no break in an enrollee's eligibility after Dec. 31, 2019. After Jan. 1, 2020, a state would be permitted to expand coverage up to 133 percent of the federal poverty level (FPL), but would receive its standard FMAP, not the enhanced FMAP.

"Early" expansion states (those that expanded Medicaid prior to 2014) also could maintain coverage for their expansion populations, but their enhanced FMAP would be frozen at 80 percent in 2017 and after.

In addition, non-expansion states could expand, prior to Jan. 1, 2020, with the enhanced matching funds. The bill also would reduce the mandatory income eligibility threshold for children ages six to 19 from 133 to 100 percent FPL as of Jan. 1, 2020. States could instead cover these children through Children's Health Insurance Program (CHIP).

Repeals Essential Health Benefits for Expansion Population. The bill would repeal the ACA requirements that the benchmark benefit package for the Medicaid expansion population be equivalent to the ACA essential health benefits, as of Dec. 31, 2019.

***Per Capita-based Cap for Federal Medicaid Payments to States*.** The bill would replace the current federal Medicaid payment system with a per capita cap structure, as of Oct. 1, 2018 (fiscal year (FY) 2019).

- Each state would have a single overall per capita allotment that would be comprised of per capita allotments for five enrollee categories:
    - Elderly
    - Blind/disabled
    - Expansion adults
    - Children
    - Non-elderly/non-disabled adults

- The per capita allotments for FY 2019 would be based on the state's FY 2016 Medicaid expenditures for each enrollee category multiplied by the number of enrollees in the category, trended forward by the medical Consumer Price Index (CPI).

- Capped amounts for each enrollee category would be adjusted by the ratio of non-disproportionate share hospital (DSH) supplemental payments (such as upper payment limit payments) in FY 2016 to the total adjusted Medicaid expenditures in FY 2016.

- Certain expenditures would be carved out of the cap, including Medicaid DSH payments; new safety-net payments for non-expansion states; 1115 Waiver spending such as for delivery system reform, uncompensated care pools or other

expenditures defined by the Secretary of Health and Human Services; Medicare cost sharing for dual-eligibles; and administrative costs.

- Populations excluded from the cap would be CHIP, the Indian Health Service, breast and cervical cancer treatment eligibles, immigrants otherwise not eligible for emergency Medicaid services, dual-eligibles receiving Medicare cost sharing, unauthorized aliens receiving Medicaid emergency department services, Medicaid family planning individuals and workers receiving assistance with employer-based premium costs.

- Annual future updates to the per capita cap allotment would be based on enrollment growth and the trend rate of the medical CPI.

- States that fail to report necessary expenditure and enrollment data for any quarter in a fiscal year after FY 2019 would have their cap growth factor reduced by one percentage point.

- CMS would be required to audit all state spending and enrollment data used for the development of the cap.

- States also would receive a temporary increase in FMAP for administrative spending to support improved data systems between October 2017 and October 2019.

- States that exceed their per capita allotment would be subject to recoupment of federal funds.

- It appears that states with 1115 and 1915 Waivers would be required to apply the same per capita limitations on expenditures as described in the bill.

***Medicaid DSH*.** For non-expansion states, the bill would immediately repeal the ACA Medicaid DSH cuts, currently slated to start in FY 2018. For expansion states, the bill would repeal the ACA DSH cuts beginning in FY 2020. Repeal of the DSH cuts would be permanent.

***New Safety-net Funding for Non-expansion States*.** The bill would provide $10 billion in safety-net funding to non-expansion states from 2018 through 2022. To draw down these funds, states would receive an enhanced FMAP of 100 percent in calendar year (CY) 2018 through CY 2021, and 95 percent in CY 2022. Distribution of the $10 billion pool among states 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. Payments would be made directly to states and states would determine eligible providers and payment amounts. Provider payment amounts could not exceed the cost of care provided to Medicaid and uninsured patients. Eligible providers could include any provider serving the Medicaid

population, including hospitals, clinics and physicians. Any non-expansion state that chooses to expand its program would no longer be eligible for the safety-net funding program. This funding would be excluded from the per capita cap calculations.

***Eligibility and Eligibility Redetermination Changes*.**

- **Hospital Presumptive Eligibility:** The bill would repeal the requirement that states allow hospitals to make presumptive eligibility determinations.
- **Limit Retroactive Eligibility:** Beginning Oct. 1, 2017, the bill would limit retroactive coverage of Medicaid benefits to only one month prior to the date of the eligibility application, rather than the current three-month period.
- **Citizenship or Legal Resident Documentation:** Beginning Oct.1, 2017, individuals applying for Medicaid would be required to present documentation of citizenship or legal status before coverage can begin.
- **Redeterminations for Medicaid Expansion Populations:** The bill would require Medicaid expansion states, beginning Oct. 1, 2017, to re-determine expansion enrollee eligibility every six months. Civil monetary penalties would be assessed for anyone deliberately defrauding the program. States would receive from Oct. 1, 2017 to Dec. 31, 2019 a temporary 5 percentage point FMAP increase to help defray costs for complying with this new requirement.

***Community Health Center Program*.** The bill would increase Community Health Center funds for Federally Qualified Health Centers by $422 million in FY 2018.

PATIENT AND STATE STABILITY FUND

The bill would make $100 billion available to states over a nine-year period (2018-2026) to implement high-risk pools, establish premium stabilization programs, make payments to providers, and assist individuals with premiums and cost-sharing, among other potential uses. To be eligible for the funding, states must contribute to the cost, with the state share growing from as low as 7 percent in 2018 to 50 percent in 2026. In states that do not choose to apply for funding, the federal government would operate a reinsurance program that would share in the cost of claims between $50,000 and $350,000 with insurers. However, states also would be required to contribute toward this program.

SHORT-TERM TRANSITIONAL POLICIES

The bill would take several steps to stabilize the Health Insurance Marketplaces for 2018 and 2019, and expand consumer choice of health plans. The bill would increase the permissible age-rating bands for qualified health plans to 5:1 from 3:1 and give states the authority to select the range for their state. The amount of the advanced premium tax credit (APTC) authorized by the ACA also would be modified based on age, with younger enrollees receiving a larger APTC than older enrollees in the same income bracket. Also, individuals and families would be eligible to receive a tax credit if

enrolled in a plan sold on the non-Health Insurance Marketplace individual market, with some limitations. For example, consumers would not be permitted to apply the tax credit toward grandfathered and grandmothered plans. In addition, consumers who enroll in off-Marketplace plans must wait to receive the tax credit at annual tax filing.

Repeal of the APTC, Cost-sharing Reductions (CSRs) and Small Business Health Care Tax Credit

Beginning in 2020, APTCs and CSRs for individuals and health care tax credits for eligible small businesses would no longer be available.

Refundable Tax Credits for Health Insurance Coverage

Beginning in 2020, the federal government would make available age-based, advanced, refundable tax credits to individuals without another source of coverage. The value of the tax credit would start at $2,000 annually for individuals under age 30 and increase by $500 with each decade of age to a maximum of $4,000 annually for individuals over age 60. Families claiming tax credits for multiple family members would be capped at a maximum tax credit of $14,000 annually. The amounts would be updated by the CPI plus 1 percent.

The amount of the tax credit begins to phase out for higher income individuals at the rate of $100 for every $1,000 over a certain income threshold ($75,000 for an individual; $150,000 for joint filers). Higher-income individuals and families may reach a point of income where they no longer qualify for a tax credit. This amount will vary based on a person's age or the number and age of the family members. Because older individuals receive higher tax credits, they would be able to reach higher income levels before the credit is fully phased out, compared to younger populations. Similarly, families that qualify for a larger tax credit due to the age or number of family members will take longer to hit the maximum income threshold than families receiving a smaller tax credit.

Repeal of the Metal Tier Requirements (Actuarial Value)

Beginning in 2020, the metal tiers for health plans (i.e., bronze, silver, gold and platinum) and the corresponding actuarial value requirements – or how much of the cost of coverage is the responsibility of the health plan – would be repealed, enabling insurers to sell a broader range of plans with different benefit and cost-sharing structures. Presumably, this will enable insurers to offer lower cost plans.

Changes to Health Savings Accounts (HSAs)

The bill would incentivize the use of HSAs by increasing the maximum amount an individual could contribute to his or her HSA to align with limits on deductibles and co-pays, allowing more flexibility for catch-up contributions. It also increases the allowable uses of HSA dollars. HSAs would continue to be linked to enrollment in high-deductible health plans.

CADILLAC TAX DELAY

The bill would delay the excise tax on certain high-value plans, known as the “Cadillac” tax, until 2025. The bill would not otherwise tax employer health coverage.

REPEAL OF THE ACA TAXES

The bill would repeal most taxes authorized by the ACA for 2018 and beyond, including the increase in the Medicare payroll tax for high earners, as well as fees on insurers, prescription drugs and medical device manufacturers, among others.

WHAT THE BILL DOES NOT DO

The provisions within the legislation must meet the reconciliation rules, and, therefore, a number of policies that have been discussed are not included in the bill. Proposed changes that are not addressed by the legislation include changes to consumer protections such as guarantee issue, limits on deductibles and cost sharing, coverage of pre-existing conditions and prohibition on annual and lifetime benefit and cost limits. The bill also does not address other features included in previous Republican proposals, such as selling insurance across state lines and establishing individual and small business purchasing pools. Finally, the bill does not appropriate funds for the CSRs through 2019 nor make any changes to the delivery system and payment reform components of the ACA. The bill does not restore the hospital market basket reductions or Medicare DSH cuts used to help fund the ACA coverage expansions.