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American Health Care Act Passes House: What Does It Mean?

As we predicted on March 6, 2017, though not without a detour, the U.S. House of Representatives has passed a bill to repeal and replace key portions of the Affordable Care Act (ACA) and to alter the structure of Medicaid financing. The bill, the American Health Care Act (AHCA), is much the same as the bill that was pulled for lack of votes on March 23. The main difference is the insertion of language meant to placate members of the further-right Freedom Caucus by making it optional for states to enforce key ACA provisions, such as essential health benefits and community rating. With those provisions seen by moderates as too extreme, another amendment was added to increase funding for people in those opt-out states who would be funneled to high-risk pools.

The House bill now moves to the Senate, which could either consider and perhaps modify it or draft entirely new legislation. Our appraisal is that the House bill is highly unlikely to receive a warm reception in the Senate. Indeed, in the Senate, any legislation that cannot meet the parliamentarian's criteria for passage under budget reconciliation rules—which we believe to be true of portions of the House bill—will need at least eight Democrats to sign on to escape a filibuster. It is too soon to describe the contours of a bill that could pass the Senate, though we imagine that the bill would "revise and rebrand," rather than "repeal and replace," the ACA.

The AHCA's major provisions are as follows:

Mandates, exchange plans, and subsidies: All these ACA features are effectively repealed. The tax penalty for not having qualifying coverage is replaced by permitting insurers to charge 30 percent more for one year to anyone applying for insurance who has been uninsured for at least two months.

The ACA subsidies are replaced by tax credits—between $2,000 and $4,000, scaled by age, not income—to buy private insurance. For the majority of enrollees, these amounts are significantly lower than the ACA's premium subsidies and cost-sharing reductions for low-income participants. The credits also phase out when income exceeds $75,000 per individual or $150,000 for joint filers.

Private plans would neither have to offer the full array of benefits nor meet a minimum actuarial value. People who buy high-deductible plans would be able to fund tax-advantaged health savings accounts (HSAs). Limits on tax deductibility would be higher than under current law.

State opt-out: While the bill preserves some ACA features such as guaranteed issue, essential health benefits, and modified community rating, it allows individual states to opt out of these requirements. States that choose that route—something that no one is predicting will happen just yet—would be required to show that they've established high-risk pools or other programs to provide coverage for people who are displaced from the regular insurance market. Some federal funding is to be furnished to support these high-risk pools, though it has not been determined that the amounts allotted by the AHCA would cover the costs.

Pre-existing conditions, community rating, and high-risk individuals: Even in states that opt out of these ACA insurance regulations, people with pre-existing conditions would still retain some protection against being dropped if they maintain continuous coverage. They would not, however, be protected from insurer medical underwriting wherein their health conditions are factored into premium rates and/or some services are excluded from coverage. Additionally, these enrollees would be subject to the AHCA's increase in the ACA's age rating limit from 3:1 to 5:1, which applies across all states, regardless of waiver status.

For people who might fall through the cracks, the bill offers "state innovation grants" of no defined amount to support high-risk pools and other measures that states could design. There would be a default reinsurance fund for states that fail to accept grants.

Taxes: Almost all of the taxes imposed by the ACA would be eliminated, including those imposed on high-income earners to help fund Medicare. The implementation of the excise tax on high-value health benefit plans (the "Cadillac tax") is delayed until 2026.

Medicaid expansion: As of December 31, 2017, no new states could expand and receive the enhanced federal matching percentage. States that already expanded could continue to cover non-disabled adults over 100 percent of the federal poverty level with enhanced federal funding only for already-enrolled individuals who do not have a break

in enrollment. Disproportionate share hospital (DSH) funds removed by the ACA would be restored.

Medicaid work requirement: States that want to institute a work requirement as a condition of Medicaid eligibility could do so as of October 1, 2017. The requirement could not be imposed on disabled, elderly, or pregnant persons. Eleven activities, such as community service and participation in vocational education, would qualify.

Medicaid funding: Medicaid's longstanding funding structure would change, starting in 2019, from open-ended entitlement to fixed per-capita allotments to each state, distinct for each of four eligibility categories. Trending from the base year is proposed at Medical CPI for children and non-disabled adults, and at Medical CPI plus 1 percentage point for the aged and disabled. These rates are below the Centers for Medicare & Medicaid Services' estimates of Medicaid cost growth, so states would see less federal contribution over time. States could opt for fixed-dollar block grants for their non-disabled, non-aged populations in return for some added flexibility.

Planned Parenthood and abortion coverage: Unrelated to any ACA provision, the AHCA cuts off Medicaid payments to Planned Parenthood and other abortion providers for one year and prohibits the use of federal tax credits to pay for insurance that covers abortion services.

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Should this bill become law, it will significantly alter the health care coverage landscape. The Congressional Budget Office (CBO) did not score the bill after the most recent amendments were made, but the new provisions are unlikely to materially change CBO's projection that 24 million people will lose coverage by 2026.

The mix of people covered and the nature and costs of coverage would shift as well. Most notably, older individuals having chronic conditions that are costly to treat will face less complete coverage and/or higher premiums. Younger and healthier people may find individual coverage premiums more affordable, though those with low incomes will not enjoy subsidies as generous as the ACA's.

Health care providers generally will not be enthusiastic about this bill. Patients will be exposed to higher costs for coverage and more services that coverage will not apply to, which will increase the burden of uncompensated care. Providers could also experience declining demand for services that are subject to consumer price sensitivity. Medicaid reimbursements—already the lowest of any third party payer—may go down over time.

Health insurers may have mixed sentiments. All insurers will be glad to see the ACA's health insurer fee (approximately 3 percent of premiums) disappear. Insurers that tried to succeed in the ACA marketplaces could enjoy some underwriting success in the new individual market. Those insurers that offer Medicaid managed care products will likely see growth in states shifting populations to capitated programs, though compression in rates is probable, and states may in the long term reduce Medicaid eligibility levels in response to reduced federal contributions.

As noted, the Senate will now take up its own process. The Senate is under no obligation to adopt the House bill—and we have reason to believe that the leadership will actually start with a blank sheet of paper. Once the Senate is done, the two bodies will need to attempt reconciliation. We will, of course, track all developments and offer our insights when something happens that is worth remarking upon.

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