The American Health Care Act of 2017 (AHCA): The Political Calculus Moving Forward and the Potential Impact on Medicaid, the Exchange and Individual Insurance Markets

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PROFESSIONAL

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On May 4, 2017, the House of Representatives passed by a margin of 217 - 213 the American Health Care Act (AHCA) to "repeal and replace" the Patient Protection and Accountable Care Act of 2010 (ACA). Introduced in the House on March 20, 2017, and without the benefit of Congressional Budget Office (CBO) analysis of its costs and the impact on insurance coverage, the bill was subject to only a few amendments. We now have a CBO estimate that shows 23 million people losing coverage by 2026–virtually unchanged from previous versions of the bill – and net savings of $119 billion over ten years, versus over $300 billion for the committee-reported version.

Having watched the painful process that embroiled the House for several weeks, the Senate is unlikely to repeat the House errors. The Senate wisely waited for the CBO analysis, which now gives them a ready basis for moving to draft their own version rather than merely building on the House version. Commenting on the CBO estimates, Senator Ted Cruz (R-TX), as quoted in the Washington Post, said that Senators are "not spending a great deal of time dwelling on one scoring estimate for a proposal that's not going to be the underlying bill."

While the process in the House resembled a race rather than well considered legislative process, Senate Republicans will hopefully be more deliberative. They have formed a leadership "working group" that will be informed by the CBO analysis. This is important since it also affects not only the estimates of costs and revenues, and coverage, but also whether some provisions in the House-passed bill run afoul of the Senate's budget reconciliation rules—particularly the Byrd rule. Waiting for the CBO analysis also provided the Senate with a couple of weeks of breathing room. If the Senate does choose to write their own bill, rather than work off of the House-passed bill, they can thank the House for their suggestions and use the leadership working group to provide a blueprint for a Senate alternative that can get to 51 votes (or 50 plus a tie-breaker vote from the Vice President, in his capacity as President of the U.S. Senate).

It is unprecedented to see a bill of this scale, affecting so much of the economy, with so few formal hearings and public input. Yet, it is all but a forgone conclusion that the Senate bill will not go through the "normal" Committee process. Any hearings will be a platform for criticism from the other side of the aisle. So, while it is possible there will be a process of some kind that allows the Senate to build the public case for some of the issues it wants to address, such as problems in the exchanges, it is also unlikely that development of a Senate bill will be a bottom-up process. Expect a lot of speeches on the Senate floor and other messaging opportunities to put a better light on the Senate's work product—in contrast to that of the House.

A more likely scenario is that the Senate working group takes the time to work through a Senate alternative. Before the bill is brought to the floor, both sides will consult with the Parliamentarian of the Senate to assure that provisions in the bill—as well as any expected floor amendments—are not subject to a point of order and struck from the bill, unless an amendment is able to muster 60 votes to be retained. Once that alternative is developed and Senate Republicans are confident they have the votes, the House bill could be brought to the floor and the Senate alternative would be an amendment in the nature of a

substitute. A reconciliation process on the Senate floor could then begin.

Under the reconciliation process—the allotted 20 hours of debate typically stretches into the better part of a week, and is capped by a "votearama" wherein amendments may be offered even though the clock has expired. The Budget Act as well as Senate rules set parameters for what is and is not "in order" to be debated and ultimately included in a final, Senate passed bill.

Thus far, Senate Republicans have been careful not to set self-imposed deadlines, preferring instead to work to build consensus and then move forward. In this case, that means 51 Republican yes votes, since it is unlikely that there will be any Democratic yes votes. While the working group is seeking consensus, the Senate will move on to other matters, including nominations, 2018 appropriations, user fee bills for FDA, and eventually the debt ceiling. One of the interesting questions is whether the focus on ACA repeal and replace will in the end result in the delay of many of President Trump's other policy goals, including taxes and infrastructure.

In terms of the substance of the bill in the Senate, Senators Alexander, Portman, Cassidy, Collins, and others have publicly expressed concerns with the House bill. In particular, they are concerned with the abrupt discontinuation of Medicaid coverage, and watering down of protections on pre-existing conditions. One of the most significant policy changes in the House bill that has received very little public scrutiny is the Medicaid per capita caps. Because Senators represent entire states instead of local districts, the state-by-state impact of the Medicaid policies likely is going to be subject to much greater scrutiny and will be central to achieving (or failing to achieve) the necessary 51 votes.

Medicaid Changes and the AHCA

The AHCA envisions a number of significant changes to the way that states may operate their Medicaid programs. These changes cover many aspects of the Medicaid programs, including changes to: (1) the structure of federal/state shared funding; (2) eligibility and enrollment changes; and (3) provider payments, among other areas.

Federal/State Shared Funding

State Financing: One of the most fundamental changes in the AHCA is how it would restructure the way that Medicaid is financed as a whole. Under the per capita cap structure in section 121, states that expended more than a calculated target of expenditures each year would have the federal share of that overage withheld from the state's federal financial participation in the following year. The target would be calculated by multiplying a per capita cap for one of five enrollee groups (elderly, blind and disabled, children, expansion adults and other adults) by the number of enrollees in that category for the year. The per capita cap for each of the groups is based on 2016 costs per beneficiary in that group, and is adjusted based on the growth in the medical care component of the consumer price index for all urban consumers and to account for certain types of non-DSH and other supplemental payments. Amendments to H.R. 1628 in committee fine-tune the way in which these non-DSH and other supplemental payments are accounted for in the per capita cap formula.

New York Per Capita Cap Provision: The bill would reduce the per capita cap by the amount of expenditures required by political subdivisions of a state that are unreimbursed by the state, effective fiscal year 2020. This provision was drafted to address a specific issue in the State of New York.

Block Grant Option: The bill also allows a state the option to receive block grants for non-expansion adults, or non-expansion adults and children for a period of ten years starting fiscal year 2020. This option may only be exercised by submitting and receiving approval for a plan to CMS. Under this option, a state could set eligibility conditions, with some exceptions, and would have greater flexibility in establishing benefits, so long as they continued to provide hospital care, surgical care and treatment, medical care and treatment, obstetrical and prenatal care and treatment, prescribed drugs, medicines and prosthetic devices, other medical supplies and services, and health care for children under 18 years of age. The initial block grant amount would be based on the per capita amounts for these groups multiplied by the number of enrollees in each of these groups, and would be increased based on the growth in the consumer price index (CPI_U medical) for all urban consumers for future years. Funds leftover at the end of a fiscal year could be rolled over to future years as long as the state

continues to opt for the block grant option. Upon the expiration of the block grant option, the state would revert back to the per capita cap funding structure.

Eligibility and Enrollment

Medicaid Expansion: With respect to the expansion, section 112 would eliminate the mandate that states expand Medicaid to childless adults up to 133% of FPL, but creates two optional categories for expansion enrollees and grandfathered expansion enrollees (enrolled as of December 31, 2019 without a break in enrollment). It would eliminate states' option to expand Medicaid to childless adults above 133% of the federal poverty line and receive enhanced Federal Medical Assistance Percentages (FMAP) for such enrollees, effective December 31, 2017. It would repeal the enhanced FMAP for expansion enrollees, reverting back to the state's traditional FMAP, effective January 1, 2020, but the enhanced FMAP would continue to be available for grandfathered expansion enrollees. It also limits the expansion state enhanced match transition period to 80%, which was the amount applicable to calendar year 2017.

Eligibility Redeterminations: Section 116 requires states to redetermine the eligibility for expansion enrollees every 6 months. It would also increase the civil monetary penalty by up to $20,000 per claim for certain claims in which: (1) the expansion enrollee was knowingly enrolled after October 1, 2017, but knowingly did not meet the income threshold; or (2) the claim was for an item or service furnished to an expansion enrollee whose enrollment was not made on the basis of the individual meeting the income threshold. It would also enhance FMAP by 5% for state expenditures for these redeterminations.

Reduction of Eligibility for Children between Ages 6 and 19: Section 111 would limit Medicaid eligibility to children in this category to those with family incomes under 100% of the federal poverty line.

Work Requirements: Section 117 allows states to apply work requirements for certain adults. Such a work requirement could encompass a variety of work activities. Exceptions include: (1) pregnant women during pregnancy and through the 60 days after her pregnancy ends; (2) individuals under 19 years of age; (3) an individual who is the only parent/caretaker for a child under the age of 6 or with disabilities; and (4) an individual who is either married or the head of a household under 20 years of age who maintains satisfactory attendance at a secondary school or equivalent or participates in education directly related to employment. This section would enhance the FMAP by 5% for activities to implement such a work requirement.

Presumptive Eligibility: Section 111 would sunset the hospital presumptive eligibility program and presumptive eligibility for expansion individuals, effective January 1, 2020.

Retroactive Eligibility: Section 114 would make eligibility effective the first day of the month in which the application for Medicaid was made, instead of retroactive to the third month before the month in which such application was made, effective for applications made on or after October 1, 2017.

Other Eligibility Changes: Permits states to consider lottery winnings as income in determining eligibility. Permits states to require proof of citizenship or nationality for aliens declaring to be a citizen or national of the United States. Repeals the exception for states to exclude homes valued at $750,000 or less, and applies a limit of $500,000 or less, effective 180 days after enactment.

Provider Payments

Safety Net Funding for Non-Expansion States: Section 115 would create a safety net funding mechanism for non-expansion states with 100% FMAP for calendar years 2018-2021, and then 95% in 2022. Limits the funding to $2 billion per year and payments to providers may not exceed the costs of providing health care services to Medicaid and uninsured patients. States would be disqualified for such safety net funding if they adopt expansion.

Elimination of Medicaid DSH Reductions: Section 113 would sunset the Medicaid DSH cuts enacted by ACA, starting fiscal year 2020, and would not apply the DSH reductions to non-expansion states.

Other Provisions

Repeal of the Essential Health Benefits Baseline for Alternative Benchmark Packages: Section 112 would repeal the ACA requirement that states establishing alternative benchmark packages for Medicaid include at least the essential health benefits.

Home and Community Based Services: Section 111 would eliminate the 6% increase to federal matching percentage for home and community based services, effective January 1, 2020.

Exchange and Individual Insurance Markets – Katrina Pagonis

Although the AHCA would not repeal and replace the majority of the ACA, if enacted in its current form, it would have a significant impact on the Exchanges and individual market. The outlook for the AHCA in the Senate, however, is uncertain in part because a number of provisions that impact the Exchanges and individual markets are unlikely to have the budgetary impact required for reconciliation legislation like the AHCA. Provisions that are extraneous or merely incidental to the federal budget could be stricken under the Byrd rule, meaning that the Senate would either need a filibuster proof majority to adopt such provisions, or would need to exercise the "nuclear option" of eliminating the filibuster for legislation.

AHCA provisions that are likely to have an adequate budgetary impact to pass muster under the Byrd rule include the following:

- Elimination of the Individual and Employer Mandate Penalties. The AHCA eliminates the penalty for failing to maintain minimum essential coverage and the excise tax on large employers that fail to offer affordable, minimum value coverage to their full-time employees. The AHCA mirrors the repeal-and-replace legislation vetoed by President Obama in January 2016 by reducing the penalties to $0, while technically leaving the mandates in place, thereby withstanding a challenge under the Senate's rules for reconciliation legislation. The Congressional Budget Office concluded that the version of the AHCA passed by the House would result in 14 million people dropping or losing coverage in 2018, largely as a result of the elimination of the individual mandate penalty.
- Subsidies. The AHCA would eliminate cost-sharing reduction payments after December 31, 2019 and would modify the ACA's premium assistance tax credits. The premium assistance tax credits would continue to be refundable, advanceable tax credits, but in 2018, they would be available to individuals purchasing qualifying individual market coverage whether or not the individual enrolled through the Exchange (or Marketplace). In 2018, the amount of the subsidies would increase for younger individuals and decrease for older individuals earning more than 150 percent of the federal poverty level. Then, in 2019, the subsidy would convert to age-adjusted, fixed-dollar tax credits rather than means tested subsidies. For example, a 45-year-old individual would only be eligible for a $250 per month credit regardless of his or her income and the actual cost of health insurance in his or her marketplace.
- Patient and State Stability Fund. The AHCA would make $138 billion available to states to address potential coverage gaps resulting from the repeal of cost-sharing reduction payments, changes to the premium assistance tax credits, and the potential state waiver of certain ACA market protections like the essential health benefits coverage mandate and the prohibition against varying premiums based on preexisting conditions.

Other AHCA provisions, however, have a high risk of being stricken under a Byrd rule challenge in the Senate because they lack the budgetary nexus required for reconciliation legislation. These provisions largely focus on repealing or altering the ACA's individual market reforms.

- Penalty for Breaks in Coverage. In lieu of the individual mandate, the AHCA includes a continuous coverage provision that would require insurers on the individual market to apply a 30 percent premium surcharge on enrollees after a break in coverage. The CBO estimated that approximately 1 million individuals would take up coverage in 2018 to avoid the penalty, but that roughly 2 million fewer people would purchase coverage in most subsequent years because of the premium surcharge. The AHCA's continuous coverage penalty is paid as a surcharge to insurers rather than as a tax or penalty to the government; therefore, it is unclear whether it has a sufficient budgetary impact to be passed under the Senate's rules for reconciliation legislation.

- Preexisting Conditions. The AHCA includes amendments introduced by Representative Tom MacArthur (R-NJ), which would permit states to waive some of the ACA's protections for individuals with preexisting conditions. The ACA includes three key protections relating to preexisting conditions: (1) the guaranteed issue provision prohibits insurers from denying coverage on the basis of health status, (2) the prohibition on preexisting condition exclusions prohibits insurers from limiting or excluding benefits based on the presence of a condition before the effective date of coverage, and (3) the modified community rating provision prevents insurers from varying premiums based on any factor other than age, geographic rating region, tobacco use, and self-only or family coverage. As amended, the AHCA would permit states to obtain a waiver replacing the 30 percent premium penalty for a break in coverage with health status-based underwriting for individual market enrollees that failed to maintain continuous coverage.
- Essential Health Benefits. The MacArthur amendments to the AHCA would also allow states to opt out of the ACA's definition of essential health benefits for purposes of individual and small group coverage mandates. If enacted, this provision would effectively allow a state to exclude some categories of benefits from the definition of essential health benefits (e.g., mental health and substance abuse benefits, maternity care, prescription drugs). There is some uncertainty as to whether such state waivers would also impact broader group market protections against lifetime and annual limits on the dollar amount of essential health benefits and excessive out-of-pocket spending limits for essential health benefits.
- Age Bands and Premiums. The AHCA would permit insurers to generally charge five times more for older enrollees than for younger ones, an increase from the 3-to-1 age band limit under current law. The CBO has estimated that by 2026, this broader age band would increase premiums by 20 to 25 percent for a 64-year-old enrollee, but reduce it by a similar amount for a 21-year-old enrollee. The AHCA would also permit a state to establish wider age bands under a waiver.
- "Skinny" Plans and Actuarial Value Rules. The AHCA would eliminate the ACA's requirement that non-grandfathered individual and small group plans fit within a metal tier (platinum, gold, silver, or bronze coverage), potentially opening the door for insurers to offer plans with higher deductibles and copayments in states that have not separately adopted minimum actuarial value requirements.

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