American Health Care Act (The House ACA "Repeal and Replace" Plan)

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Background Reading and Structure of this Document

This document includes an analysis of the implications of the legislation for North Carolina. The analysis of the bill is divided into four sections: Medicaid reform (Sec. I), individual health insurance coverage (Sec. II), other provisions (Sec. III), and other parts of the ACA the bill leaves intact (Sec. IV). I also included information from the Congressional Budget Office (CBO) and Joint Committee on Taxation (JCT) on the impact of these provisions. In addition, I included a final section to this memo (Sec. V), which includes the overall CBO/JCT assessment of the impact of the bill on the federal deficit and health insurance coverage.

Most of the information comes from a reading of the bill (as introduced for markup in Committee), as well as some of the summaries written by others. Specifically, this analysis is based, in part, on Timothy Jost's analysis of the American Health Care Act in the Health Affairs blog: http://healthaffairs.org/blog/2017/03/07/examining-the-house-republican-aca-repeal-and-replace-legislation/; Sara Rosenbaum's analysis of the Medicaid provisions of the bill: http://healthaffairs.org/blog/2017/03/10/the-american-health-care-act-and-medicaid-changing-a-half-century-federal-state-partnership/; and the Kaiser Family Foundation summary that compares the ACA (current law) to the American Health Care Act: http://files.kff.org/attachment/Proposals-to-Replace-the-Affordable-Care-Act-Summary-of-the-American-Health-Care-Act. In addition, I also included a summary of the Congressional Budget Office (CBO) and Joint Committee on Taxation (JCT)'s analysis of the bill: https://www.cbo.gov/sites/default/files/115th-congress-2017-2018/costestimate/americanhealthcareact_0.pdf.

I. Medicaid Reform

The proposed legislation would: 1) Keep the state option for Medicaid expansion (but only allow new expansions for a limited period of time), and phase down and eventually eliminate the enhanced state match for the expanded coverage; 2) Provide financial incentives to states that choose not to expand Medicaid; 3) Change Medicaid to impose a per capita allotment on federal funding to states; and 4) Make other changes to the Medicaid eligibility process and coverage provisions.

1) Medicaid expansion

States have the option of expanding Medicaid to cover those with incomes up to 138% FPL up through December 31, 2019. Beginning in 2020, for states that expanded prior to December 31, 2019, the enhanced match rate will only continue to apply to individuals who were continuously covered by Medicaid before that date (with no more than a gap of one month). Otherwise, the federal match rate for the expansion population will decrease to the state's regular match rate. (In North Carolina, the federal match rate in FFY 2018 is 67.61%).[1] States would no longer have to provide essential health

[1] Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier. FY 2018. State Health Facts. Kaiser Family Foundation. http://kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

benefits to the expanded population (giving states more latitude to determine what services would be covered).

Notably, the bill does not change the list of mandatory or optional Medicaid benefits for the traditional Medicaid eligibles, so presumably, states will still be required to cover mandatory eligibles and services.

CBO/JCT analysis of this provision: CBO estimated that there would be 1 million fewer people on Medicaid in 2017, increasing to 14 million fewer by 2024. This is due to some states dropping their Medicaid expansion (in later years), and other states choosing not to expand (that would have absent the elimination of the enhanced match rate).

2) Provide financial incentives for states that chose not to expand coverage (Sec. 113, Sec. 115)

Under the ACA, Medicaid DSH funds are scheduled to be cut beginning in FY 2018. This bill would eliminate the DSH cuts for non-expansion states starting in FY 2018, and for expansion states beginning in FY 2020. (Expansion states would bear all of the scheduled cuts in FY 2018 and 2019.)

In addition, states that did not expand would be given additional funding to enhance payments to safety net providers (up to a capped amount, and subject to DSH-like hospital-specific limits). The federal government would appropriate $2B for calendar years 2018-2021.[2] States would be eligible for a share of that amount based on the percentage of all individuals below 138% in that state compared to all individuals below 138% in all the nonexpansion states. North Carolina accounts for about 8.6% of the total individuals below 138% in all nonexpansion states.[3] Thus, we could be eligible for an allotment of ~$172M/year.[4] (To put that in context, North Carolina is losing between $2.6B-$5B in federal funds by choosing not to expand Medicaid.[5]) Payments to providers could not exceed the providers' cost in providing services to Medicaid recipients and the uninsured. Importantly, there would be no non-federal share requirement for the safety net payments for CY 2018-2021, and the FMAP would be 95% in CY 2022.

CBO/JCT analysis of these provisions: CBO estimated that federal funding will increase by $31B over the next ten years by restoring DSH cuts to the non-expansion states in 2018-2019, and in all states (2020-

[2] There may be a technical problem in the legislation so funding may extend until calendar year 2022.

[3] US Census. Health Insurance Coverage Status and Type by Ratio of Income to Poverty Level in the Past 12 Months by Age. 2015 American Community Survey 1-Year Estimates. B27016. https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_15_1YR_B27016&prodType=table

[4] There were approximately 379,000 uninsured with incomes below 138% FPL out of 4,482,000 in 2016. Garfield R, Damico A. The Coverage Gap: Uninsured Poor Adults in States that Did Not Expand Medicaid. Kaiser Commission on Medicaid and the Uninsured. Oct. 2016. http://files.kff.org/attachment/Issue-Brief-The-Coverage-Gap-Uninsured-Poor-Adults-in-States-that-Do-Not-Expand-Medicaid.

[5] Ku L, et. al. The Economic and Employment Costs of Not Expanding Medicaid in North Carolina: A County-Level Analysis. Center for Health Policy Research, George Washington University prepared for the Cone Health Foundation, Kate B. Reynolds Charitable Trust. Dec. 2014. http://www.conehealthfoundation.com/app/files/public/4202/The-Economic-and-Employment-Costs-of-Not-Expanding-Medicaid-in-North-Carolina.pdf. Ku's analysis are based on the assumption that North Carolina expanded Medicaid in 2016, but that it took 3 years to reach full enrollment.

2025). In addition, CBO estimated $8B in new safety net funding to the states in the 2017-2026 time period.

3) Per capita allotment (Sec. 121)

Calculating the amount of the per capita allotment: States will be given an annual per capita allotment. Different per capita amounts will be determined for different eligibility categories, including: elderly, blind/disabled, children under age 19, expansion enrollees, and nonexpansion adults. The per capita allotment will be based on the sum of per capita calculations for each eligibility category based on a 2016 base year, inflated annually by the *medical component of the CPI* (urban consumers). If the state exceeds its per capita allotment, the federal government will recapture excess funding in the next fiscal year.

In determining the per capita costs of each eligibility category, the federal government will look at total medical expenditures (eg, will not include administrative costs). In addition, certain costs will not be included in the estimate, including:

- *Certain categories of eligibles*, including: children covered on Medicaid through the CHIP program (in North Carolina, that would include children ages 1-6 with incomes between 100-133% FPL); people covered under Indian Health Services (in NC, Eastern Band of Cherokee Indians), Breast and Cervical Cancer eligible individuals, people receiving premium support (to purchase employer based coverage), or people eligible for partial benefits only, such as people eligible for Medicare cost sharing coverage only (Medicare Savings coverage) or undocumented immigrants receiving emergency services.
- *DSH payments.* For FY 2016, North Carolina's preliminary federal DSH allotment is $320,601,454, which translates into $584,963,000 in total DSH expenditures.[6]

The per capita allotment will include non-DSH supplemental payments (such as UPL and GME payments),[7] but the federal government will use a different process to add those costs into the per capita allotment. Essentially, the federal government will first determine the medical expenditures for each of the categories listed above for 2016. Then, the government will inflate the amount for each category by a percentage which is equal to the amount of the non-DSH supplemental payments as a proportion of overall state Medicaid expenditures. (In 2015, North Carolina spent 18.3% of its Medicaid expenditures on non-DSH supplemental payments.[8] Thus, the underlying per capita medical expenditures for each covered category will be inflated by 18.3%.) Finally, the government will inflate that per capita amount into 2019 dollars using the medical component of the CPI.

[6] 81 Fed. Reg. 74432, 74439 (Oct. 26, 2016).

[7] A non-DSH supplemental expenditures is "a payment to a provider under the State plan (or under a waiver of the plan that-(I) is not made under section 1923; (II) is not made with respect to a specific item or service for an individual; (III) is in addition to any payment made to the provider under the plan (or waiver) for any such item or service; and (IV) complies with the limits for additional payments to providers under the plan (or waiver) imposed pursuant to section 1902(a)(30)(A), including the regulations specifying upper payment limits under the State plan in part 447 of title 42, Code of Federal Regulations (or any successor regulations)." Sec. 121(d)(4).

[8] http://www.statenetwork.org/resource/data-points-to-consider-when-assessing-proposals-to-cap-federal-medicaid-funding-a-toolkit-for-states/. Table 5.

Impact of per capita allotments: Per capita allotments can hurt states in multiple ways. First, per capita formulas essentially lock a state into their 2016 base year spending. So, higher spending states will have higher per capita allotments, and lower spending states will have lower per capita allotments. This will makes it harder for states to increase provider payments or covered services. This could be particularly problematic if there is an economic downturn or a public health crisis. Without counting supplemental payments, North Carolina is a low spending state. Table 1 gives the FY 2011 per person spending by eligibility group (latest data available), national average, and the state's ranking (with 1 being the state with the highest per capita spending).

Table 1. Medicaid Spending Per Full Benefit Enrollee by Eligibility Group and State, FY 2011.

	Total		Children		Adults		Disabled		Aged	
	Amount	Rank	Amount	Rank	Amount	Rank	Amount	Rank	Amount	Rank
US	$6,502		$2,492		$4,141		$18,518		$17,522	
NC	$5,450	42	$2,355	30	$4,360	23	$15,060	41	$10,518	50

Manatt Data Points to Consider When Assessing Proposals to Cap Federal Medicaid Funding. A Toolkit for States. http://www.statenetwork.org/resource/data-points-to-consider-when-assessing-proposals-to-cap-federal-medicaid-funding-a-toolkit-for-states/. Table 8.

Second, the per capita allotments are only inflated by the medical component of the CPI. While that is better than the inflation rate applied to the tax credits available for the uninsured (discussed more fully below), it may still be less than actual growth in Medicaid spending, per eligibility group. For example, between FY 2000-2011, the Medical CPI was 4%. Table 2 shows the average annual growth in Medicaid spending and rank (with 1 being the state with the highest growth rate), by different eligibility categories (between FY 2000-2011). For North Carolina, the growth rate for children and for adults was well above the medical CPI. Nationally, the Congressional Budget Office and Joint Committee on Taxation estimated that state Medicaid expenditures would be expected to grow 4.4% per year between 2017-2026, but that the medical component of CPI will only grow 3.7%.[9]

Table 2. Growth in Medicaid Spending per Full Benefit Enrollee by Eligibility Group (FY 2000-2011)

	Total		Children		Adults		Disabled		Aged	
	Average Annual	Rank	Average Annual	Rank	Average Annual	Rank	Average Annual	Rank	Average Annual	Rank
US	6.9%		5.3%		5.6%		4.5%		3.7%	
NC	5.9%	35	6.0%	19	6.5%	31	3.3%	39	3.0%	37

Manatt Data Points to Consider When Assessing Proposals to Cap Federal Medicaid Funding. A Toolkit for States. http://www.statenetwork.org/resource/data-points-to-consider-when-assessing-proposals-to-cap-federal-medicaid-funding-a-toolkit-for-states/. Table 9.

Third, states have discretion in how they spend money, or which types of services they cut if their expenditures are likely to exceed the per capita allotment. As noted earlier, the per capita allotment is based on the per capita amount times the number of enrollees in each category. However, the states have flexibility to move actual expenditures among different categories as long as the total health spending does not exceed the total funding allocated to the state. Thus, a state may choose to limit services or provider payments in one category of eligibles if it looks like it may overspend its target. Note however, that the American Health Care Act does not provide additional flexibility beyond current

[9] Congressional Budget Office Cost Estimate. American Health Care Act. March 13, 2017. https://www.cbo.gov/sites/default/files/115th-congress-2017-2018/costestimate/americanhealthcareact_0.pdf.

law with respect to the non-expansion Medicaid population. Thus, states would be prohibited from cutting mandatory eligibles or services, and would need to meet other program requirements.

According to the Center on Budget and Policy Priorities, the American Health Care Act would shift $370 billion in Medicaid costs to the states over ten years *through their per capita allotment formula*.[10] This would particularly hit the states that expanded Medicaid (because of the decline in the federal match rate after 2019), but states would also experience losses for their traditional population as the CPI medical component does not fully match actual increases in Medicaid spending. In addition, the new funding formula would not factor in changes that occur as a result of breakthrough treatments (such as the medications for Hep C), or new public health emergencies.

Medicaid expansion: As noted earlier, states can still choose to expand Medicaid to all adults up to 138% until December 31, 2019. If North Carolina chooses to expand Medicaid it would receive a federal match rate of 95% in FY 2017, 94% in FY 2018, and 93% in FY 2019. Under the ACA, the federal match rate for expansion populations would have declined to 90% starting in FY 2020 and stay at that level thereafter. However, under the American Health Care Act, states that expanded Medicaid would no longer get an enhanced match rate effective 2020.

If a state chooses to expand Medicaid after FY 2016, the per capita base rate for the expansion population will be based on the rate for the other nonelderly, nondisabled, non-expansion adult population. (On average, expansion states spent $4,513 per eligible in CY 2014.[11] As a point of comparison, in CY 2011, the average spending for traditional adults was $4,141 nationally.[12])

Data: To make this system work, the state must submit adequate enrollment and expenditure data to the federal government. If the state does not submit such data, the growth factor applied by the federal government to the per capita allotments will be reduce by 1 percentage point. However, to help states prepare for this new reporting requirement, the federal government will enhance the FMAP rates paid to the states to upgrade their reporting system. (Depending on the type of expenditure, the FMAP rates will be increased to 100% or 60%).

*CBO/JCT analysis of these provision*s: CBO/JCT estimates that Medicaid funding would be cut by $880B over the 2017-2026 time period (down 25% from what would have been expected under the ACA). This is due to both reductions in eligibles (due to some states dropping the expansion or choosing not to expand when the enhanced match rate is eliminated), and the effects of the per capita allotment. The American Health Care Act would result in 14 million fewer Medicaid enrollees (17% decline from what would have been anticipated under the ACA). As noted earlier, CBO estimated that the average annual per-enrollee increase in Medicaid expenditures (4.4%) would exceed the medical component of the CPI

[10] Park E, Aron-Dine A, Broaddus M. House Republican Health Plan Shifts $370B in Medicaid Costs to the States. March 8, 2017. Available at: http://www.cbpp.org/sites/default/files/atoms/files/3-8-17health.pdf.

[11] Snyder L, et. al. Medicaid Expansion Spending and Enrollment in Context: An Early Look at CMS Claims Data for 2014. Kaiser Commission on Medicaid and the Uninsured. Jan. 2016. http://files.kff.org/attachment/issue-brief-medicaid-expansion-spending-and-enrollment-in-context-an-early-look-at-cms-claims-data-for-2014.

[12] Manatt Data Points to Consider When Assessing Proposals to Cap Federal Medicaid Funding. A Toolkit for States. http://www.statenetwork.org/resource/data-points-to-consider-when-assessing-proposals-to-cap-federal-medicaid-funding-a-toolkit-for-states/. Table 8.

(3.7%) during the 2017-2026 period. "With less federal reimbursement for Medicaid, states would need to decide whether to commit more of their own resources to finance the program at current-law levels or whether to reduce spending by cutting payments to health care providers and health plans, eliminating optional services, restricting eligibility for enrollment, or (to the extent feasible) arriving at more efficient methods for delivering services."

4) Other Medicaid changes (Sec. 114, 116)

Some of the other proposed Medicaid changes have not received as much media attention. They are listed below:

- *Retroactive eligibility*: The bill would no longer guarantee retroactive eligibility. Under current law, Medicaid eligibility can start as much as 3 months prior to the date the individual applied for Medicaid. Under this bill, Medicaid coverage would begin in the month in which the individual applies. This could potentially have significant implications for providers who may no longer get paid for services provided during the retroactive period.
- *Presumptive eligibility*: Under the ACA, hospitals could elect to make presumptive eligibility determinations for all Medicaid eligibles. Under this new bill, hospitals may no longer conduct presumptive eligibility determinations after Jan. 1, 2020.
- *Coverage for immigrants*: Under current law (ACA), Medicaid agencies will enroll immigrants who meet all the other eligibility criteria while providing 90 days to provide the documents needed to prove citizenship or lawful immigrant status. Providers get reimbursed for the services provided during this 90 day window, regardless of whether the individual is ultimately determined to be Medicaid eligible. The American Health Care Act changes this policy, so that providers will no longer be paid until a person's citizenship or qualified legal immigrant status is determined.
- *Medicaid eligibility for children ages 6-19*: Medicaid income eligibility for children ages 6-19 will be reduced to 100% FPL (pre-ACA levels). Under the ACA, children ages 6-19 with incomes between 100-138% FPL were moved into Medicaid. This bill would move them back into CHIP. In North Carolina, these individuals are not guaranteed coverage, as CHIP is a capped allotment and not an entitlement program).
- *Other Medicaid eligibility changes*: States would be required to count lottery winnings or lump sum payments in Medicaid eligibility (thus potentially excluding people from coverage for certain lengths of time depending on the value of the winnings/lump sum). It would also prohibit Medicaid coverage to individuals who have home equity of more than $500,000. (In North Carolina, the current limit was $552,000 in 2015).[13] And, the bill would eliminate the enhanced match rate for the Community First Choice program for the frail elderly or people with disabilities (providing attendant services to people to help them remain in the home instead of moving to an institution).
- *Eligibility changes for the expansion population*: Currently, states must redetermine Medicaid eligibility for the expansion population on a yearly basis. Under this Act, states must redetermine Medicaid eligibility no less frequently than once every 6 months for the expansion populations. States will be given an increased FMAP rate if they choose to do redeterminations

[13] https://www2.ncdhhs.gov/info/olm/manuals/dma/abd/man/MA2242.PDF.

more frequently than once every 6 months (the administrative match would be increased from 50% to 55%). The more frequent redeterminations increases costs to the state (thus the increased federal match rate), and it may result in more people losing coverage as a result of having to go through the redetermination process more frequently. In addition, there will be an increased penalty for knowingly enrolling when the person's income doesn't meet the income limits.

CBO/JCT analysis of these provisions: CBO estimates that some of the other changes to Medicaid spending would reduce spending by $7B over 2017-2026.

II. CHANGES TO THE INDIVIDUAL INSURANCE COVERAGE REQUIREMENTS

As a broad summary, the Act keeps certain ACA insurance law protections (which probably could not be changed in a reconciliation bill), but makes other changes to insurance laws. It effectively repeals the individual and employer mandate starting this year. It maintains the premium tax credits (with some modifications) and the cost sharing subsidies based on income until 2020. Thereafter, uninsured individuals would be eligible for an age-related refundable tax credit to help them buy coverage in the private market. The Act prohibits insurers from discriminating against individuals based on health status, but people who do not stay continuously insured will be charged a 30% surcharge. The legislation also includes a Patient and State Stability Fund, to help states stabilize the insurance market and/or reduce the costs of coverage. The Act also removes existing limits on the amount of the advanceable premium tax that individuals are required to repay when they received more than they were entitled to throughout the year. It makes it easier for people to use health savings accounts or other savings options to pay for health care not covered through insurance, and prohibits any funding (including tax credits) to be used to pay for coverage that covers abortions (with limited exceptions).

General Insurance Law Protections

The American Health Care Act retains many of the ACA's insurance-related protections, including prohibitions on annual or lifetime limits, out-of-pocket maximums, and all of the essential health benefits in the individual and small group market. It also continues protections for people with preexisting conditions. The Act retains the Marketplace, but allows individuals to use their new premium tax credits to purchase insurance coverage on or off the Marketplace.

The American Health Care Act removes the requirement that plans have at least a 60% actuarial value as well as the metal levels. Thus, insurers could begin to offer plans with a lower actuarial value, as long as they cover all the same mandated benefits and costs the individual no more than the maximum out-of-pocket limits. In addition, the Act changes the age-rating band. Under the ACA, insurers can charge older adults no more than 3 times what it charges younger adults. In contrast, in the American Health Care Act, insurers could charge no more than 5:1. (States have the option of adopting a different ratio). Presumably, the changes in the rating band will decrease the costs for younger adults, but increase the costs to older adults. However, as noted below, the tax credit for older adults is only two-times that of younger adults.

CBO/JCT analysis of these provisions: CBO/JCT estimated that average premium prices would increase between now and 2020 (because of the elimination of the individual mandate); but would decrease once insurers were allowed to offer plans with lower actuarial value and a 5:1 age rating band. This is

likely to lead to a different insured population mix, with more young adults and fewer older adults. CBO/JCT estimates that average premiums in the individual market would be 10% lower than estimates under the ACA, once these changes take effect. In its analysis CBO noted that the reduction in premium prices is due to the shift to less comprehensive plans (eg, plans with lower actuarial value), and the shift in the composition of the insured population.

CBO/JCT predicted that shopping would be harder because there would no longer be a requirement that insurers offer plans with standardized actuarial values (eg, bronze, silver, gold). In addition, people could use their subsidies to purchase plans on or off the Marketplace. Insurers could choose to offer their plans directly, rather than through the Marketplace, thus making comparison shopping more difficult.

Individual Mandate

The American Health Care Act effectively removes the individual mandate effective January 1, 2016 by reducing the amount of the penalty to $0 for failure to have creditable coverage. Without the mandate, some of the currently insured individuals may drop coverage, which on its own, could lead to market instability. However, states may be able to protect insurers from excessive risk through the Patient and State Stability Fund (discussed below). And, the bill includes a 30% penalty for failure to have continuous coverage (described below).

CBO/JCT analysis of this provision: CBO/JCT estimated a decline in nongroup coverage of 2 million (in 2017), increasing over time to 9 million fewer people covered by 2020. CBO noted that the repeal of the individual mandate would lead some people to drop coverage, and that the average health status for those remaining in the Marketplace would get worse. They also noted that insurers may have difficulty setting premiums initially, as changes in the individual mandate and new tax credits may lead to a different composition of insured individuals (both in the short-term and longer term).

While fewer people would have coverage initially, CBO did not think the Act would adversely impact market stability. In the short-term, funding from the Patient and State Stability Funds could be used to mitigate insurance losses.

Penalty for Failing to Have Continuous Coverage

Beginning in plan year 2019, anyone who failed to have continuous coverage will be charged a 30% premium surcharge for one year. Continuous coverage is defined as meaning that the individual did not have a gap in coverage of at least 63 days for any time in the last 12 months. For dependents who age out of their parents' health insurance, continuous coverage is defined as obtaining coverage in the next open enrollment period. This 30% penalty is intended to encourage people to stay continuously insured, but some commentators have suggested that it may discourage healthy individuals from enrolling into coverage once they lose continuous coverage. Presumably, sick individuals would be more willing to pay the 30% penalty, thus this provision could potentially lead to greater adverse selection into plans.

CBO/JCT analysis of this provision: CBO/JCT estimated that initially, more people will purchase coverage in 2018 to avoid the surcharge. But, over time, as people lose coverage, the healthy will be less likely to

reenroll and pay the 30% surcharge. Those with health problems would be less likely to be deterred by the premium surcharge, and thus more likely to enroll.

Employer Mandate

The American Health Care Act also removes the employer mandate effective January 1, 2016 by reducing the amount of the penalty to $0.

CBO/JCT analysis of this provision: CBO/JCT estimates that by 2026, 7 million fewer people would have employer based coverage. That is due to a combination of factors: fewer employees will purchase employer-sponsored insurance (ESI) if there is not a mandate to have coverage. In addition, fewer employers will offer coverage to their employees. Under the ACA, the premium tax credits are not available to employees with higher incomes making it less attractive to employers to drop coverage. Under the American Health Care Act, more employees would be eligible for tax subsidies thereby making it more likely that employer could drop coverage in favor of the tax credits. While some employers may choose to drop coverage, CBO/JCT recognized that many employers will continue to offer coverage, because ESI will likely to offer more comprehensive coverage than available in the non-group market; and shopping for coverage will be more difficult because of lack of standardization of plans and availability of insurance products in a common Marketplace (discussed previously).

Premium Tax Credits and Cost Sharing Subsidies

The Act repeals the ACA's income based premium tax credit and cost sharing subsidies as of Dec. 31, 2019. While the Act creates a new, more limited, premium tax credit, it does not provide for any form of cost sharing subsidies (unless states choose to use other funds for this purpose, discussed below). Under current law, eligible individuals with incomes between 100-400% FPL are eligible for an advanceable, refundable premium tax credit. Individuals are required to pay a certain percentage of their income on the premiums (based on a sliding scale, so lower income individuals pay a smaller percentage of their income than higher income individuals). In North Carolina, 90% of those who signed up for coverage through the Marketplace this year are receiving premium tax credit subsidies, and ~65% qualify for cost sharing subsidies.[14] The actual amount of the premium tax credit is calculated based on the second lowest cost silver plan (with a 70% actuarial value), minus the amount the individual is required to pay. Thus, the premium tax credit is based both on the person's income and the actual cost of a silver plan, and varies over time as premium costs change (or the person's income changes) and across different geographies (or rating areas). Under the ACA, the federal government pays a large portion of any increase in the premium costs for those who receive premium tax credits, since the amount individuals are required to pay is tied, in large part, to their income.

The Act modifies the ACA income-based premium tax credit for 2018 and 2019, to lower the amount that young individuals would be required to pay, and to increase the amount that wealthier older individuals would need to pay. See Table 3. In addition, the premium tax credit can be used to purchase a catastrophic plan. (Under the ACA, catastrophic plans are only available to individuals under age 30 or those for whom other plans would exceed 8% of their income.)

[14] Centers for Medicaid and Medicare Services. 2017 Marketplace Open Enrollment Period Public Use Files. Final State-Level Public Use File. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/Plan_Selection_ZIP.html.

Table 3. Current and Revised Percentage of Income Used to Calculate Premium Tax Credits (Revised effective 2018, 2019)

	ACA	Revised Percentage of Income used to Calculate Premium Tax Credit (2018, 2019)				
	Existing Law (2017)	Up to Age 29	Age 30-39	Age 40-49	Age 50-59	Age 60+
Up to 133%	**2.03%**	2%	2%	2%	2%	2%
133-150%	**3.05-4.07%**	3-4%	3-4%	3-4%	3-4%	3-4%
150-200%	**4.07-6.41%**	4-4.3%	4-5.3%	4-6.3%	4-7.3%	4-8.3%
200-250%	**6.41-8.18%**	4.3%	5.3-5.9%	6.3-8.05%	7.3-9%	8.3-10%
250-300%	**8.18-9.66%**	4.3%	5.9%	8.05-8.35%	9-10.5%	10-11.5%
300-400%	**9.66%**	4.3%	5.9%	8.35%	10.5%	11.5%

Note: the premium tax credit ranges in any cell is the minimum and maximum amount a person would have to pay depending on their income. Thus, someone with an income of 150% would pay 4.07% of their income under existing ACA provisions for the second lowest cost silver plan. A person with income at 200% FPL would pay 6.41% of their income in premiums for the second lowest cost silver plan. Someone with income in between 150-200% would be a proportionate share.

Age-Related Tax Credits

Beginning 2020, the ACA's mechanism to fund private health insurance coverage will be repealed, to be replaced by a refundable, advanceable tax credit that only varies by age. Individuals who do not have access to employer sponsored insurance, Medicaid, CHIP, Medicare, Tricare, Peace Corps, Department of Defense, or enrolled in VA benefits are eligible for the tax credit. (Note: the ACA's requirement that employer sponsored insurance be "affordable" is removed, so as long as employees have access to coverage they are ineligible for the age-related tax credits.) The amount of the tax credit is listed in Table 4:

Table 4. American Health Care Act Annualized Tax Credit

Age	Annual Tax Credit
<30	$2,000
30-39	$2,500
40-49	$3,000
50-59	$3,500
60 or older	$4,000

No family can obtain more than $14,000 in tax credits. The amount of the tax credit is based on the five oldest individuals in the household. Tax credits start phasing out once the modified gross income reaches $75,000 for an individual or $150,000 for married couples, filing jointly. The amount of the tax credit would be increased on an annual basis by a CPI+1%, which is lower than the medical component

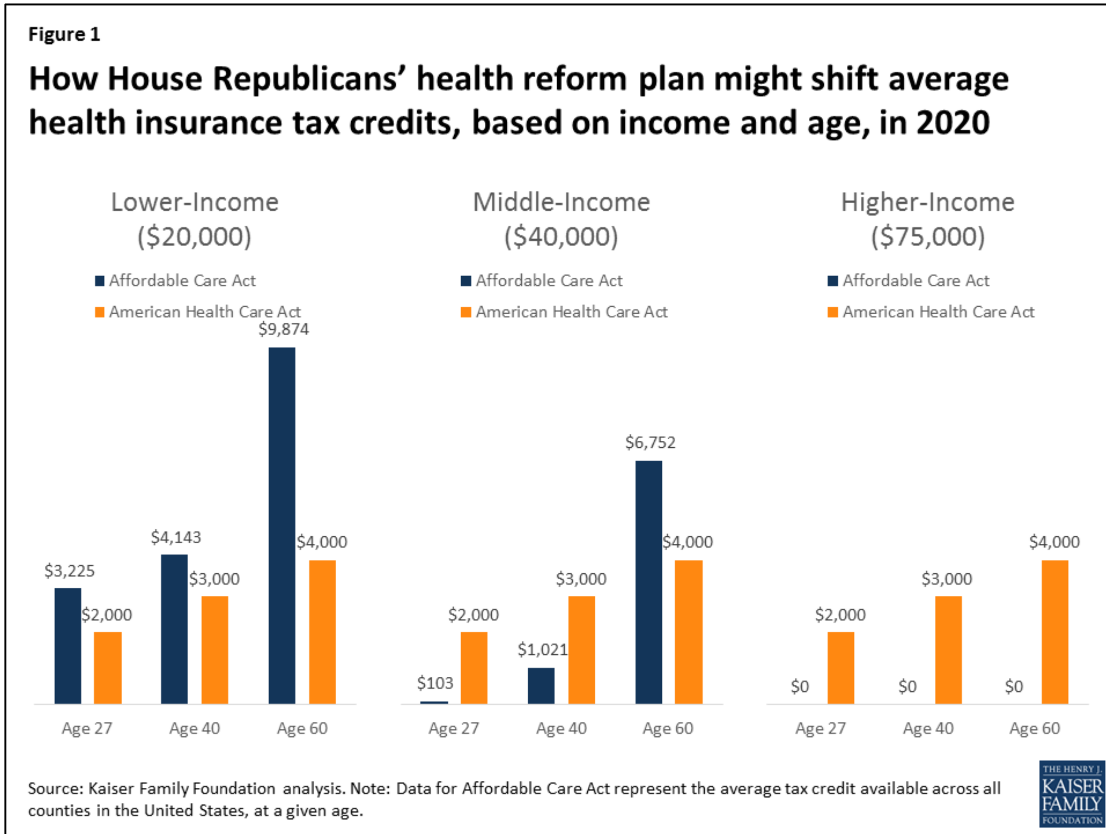
of the CPI.[15] Over time, the tax credit is likely to cover less and less of the cost of premiums, as the average growth rate in private health insurance premiums has historically increased much faster than the medical component of the CPI or CPI +1%.[16] Individuals can use these funds to purchase compliant health insurance on or off the Marketplace, unsubsidized COBRA coverage, or short term, non-renewable policies (but not grandfathered or grandmothered plans). If the amount of the tax credit exceeds the premium amount, the excess would be contributed to a Health Savings Account. (Note: short-term non-renewable policies can charge people based on preexisting health status and can use medical underwriting. This can lead to market segmentation, with healthier people purchasing short-term non-renewable policies.)

To put this into context, the tax credit would enable a 21 year old in Orange County in 2016 to buy the lowest cost catastrophic plan (which costs ~$2,175/year). This plan has a $7,150 deductible (which is the out-of-pocket limit). The lowest cost bronze plan (a high deductible plan with an actuarial value of 60%) would cost ~$3,500/year, requiring this younger individual to pay $1,500 more in premiums in addition to the $2,000 tax credit. The lowest cost bronze plan for a 64 year old would be ~$10,600/year; requiring this older adult to pay $6,600/year more in premiums to purchase a high deductible plan (in addition to the $4,000 tax credit). Presumably, with a 5:1 age rating band, the costs of insurance for a young adult will be further reduced; but likewise, it is likely to be increased for an older adult. This has significant implications for providers, as older uninsured adults may have much more difficulty paying for robust health insurance coverage. People generally are more likely to use health services when they age. Thus, providers are more likely to incur uncompensated care costs if these individuals remain uninsured or purchase plans with low actuarial value and thus face high out-of-pocket costs.

The new tax credits are based on age only, and are not adjusted based on a person's income or geography. This benefits wealthier individuals with incomes above 400% FPL (who are not currently eligible for a premium tax credit), and some younger, middle-income individuals. However, it will significantly reduce tax credits for lower-income individuals. See Figure 1.

[15] The average annual increase in the CPI between 2000-2011 was 2.5% (or 3.5% when adding the 1%). According to an analysis by Manatt consultants, the average annual increase in the medical component of the CPI was 4.0% during that time period.

[16] Between 2000-2011, the medical component of the CPI increased 4% while private health insurance premiums per enrollee increased 6.7% annually. Clemans-Cope L, Holahan J, Garfield R. Medicaid Spending Growth Compared to Other Payers: A Look at the Evidence. Kaiser Commission on Medicaid and the Uninsured. April 2016. Issue Brief.

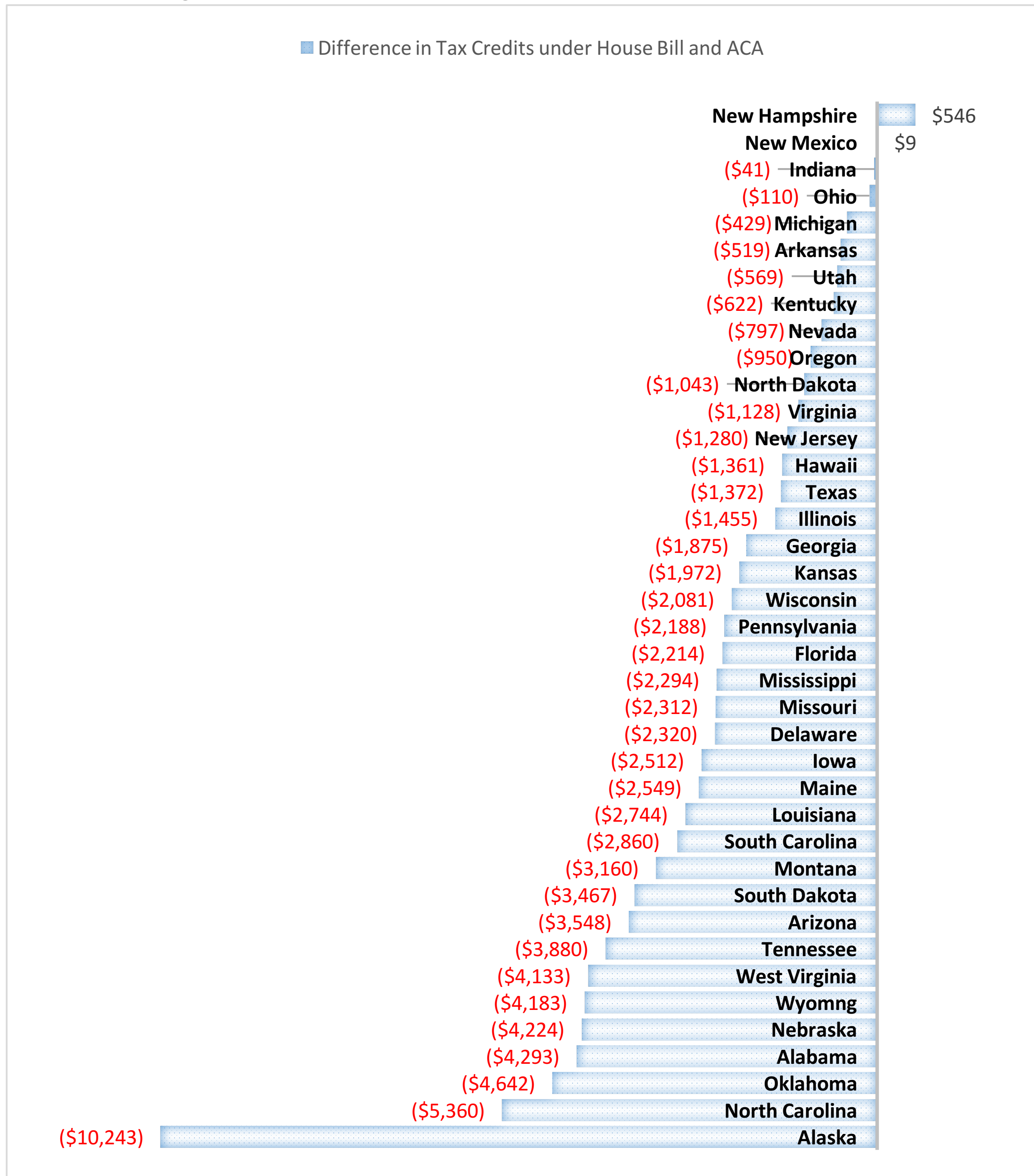


Cox C, et. Al. How Affordable Care Act Repeal and Replace Plans Might Shift Health Insurance Tax Credits. Kaiser Family Foundation. March 8, 2017. Available at: http://kff.org/health-reform/issue-brief/how-affordable-care-act-repeal-and-replace-plans-might-shift-health-insurance-tax-credits/.

More importantly for North Carolina, because these tax credits are not adjusted for geography and so do not take differences in premiums into account, North Carolina stands to lose more than most states. According to an analysis by the Center for Budget and Policy Priorities (Figure 2), North Carolinians would experience the second largest loss in average tax credits (-$5,360); second only to Alaska (-$10,243).[17] This is because North Carolina had amongst the highest premiums in the Marketplace in the country.

[17] Aron-Dine A, Straw T. House Tax Credits Would Make Health Insurance Far Less Affordable in high-Cost States. Center on Budget and Policy Priorities. March 9, 2017. http://www.cbpp.org/research/health/house-tax-credits-would-make-health-insurance-far-less-affordable-in-high-cost.

Figure 2. The Difference Between the Tax Credits Available in the American Health Care Act and Those Available Through the ACA



Center for Budget and Policy Priorities. House Tax Credits Would Make Health Insurance Far Less Affordable in high-Cost States. Center on Budget and Policy Priorities. March 9, 2017. http://www.cbpp.org/research/health/house-tax-credits-would-make-health-insurance-far-less-affordable-in-high-cost.

Further, it is important to highlight that one way the American Health Care Act is expected to lower health premium costs is by reducing the actuarial value of the plan below the 60% threshold set by the ACA. Thus, insurers are likely to offer plans covering even less of the costs of coverage, leading to

greater out-of-pocket costs for most individuals. As noted earlier, CBO estimated that the average premium would decline by 10%, given the fact that insurers are likely to offer less generous plans, and the composition of the nongroup market would shift towards younger adults. But a recent Brookings analysis determined that the average premium would actually increase by 13% under the American Health Care Act if coverage and the composition of enrollees were similar to existing law.[18]

Wealthier individuals may be able to contribute to a Health Savings Account (HSA) to help pay for these higher out-of-pocket costs (discussed more fully below). However, lower-income individuals will be unlikely to have the resources to contribute to a HSA. And unlike the ACA, there are no cost-sharing subsidies available to help lower-income individuals pay for the out-of-pocket costs for their barebones plans.

CBO/JCT analysis of this provision: CBO/JCT projected that the tax credit subsidies under the American Health Care Act would be, on average, about 60% of what was available under the ACA. Some people will find coverage more affordable, while others would find coverage less affordable. In general, lower-income people would have lower premium tax credits than they receive under the ACA; and they would pay more in out-of-pocket costs (because of the elimination of the cost-sharing subsidies). However, those with higher incomes (eg, those with incomes above 400%, but below the premium tax credit ceiling) would receive a higher tax credit. In addition, older adults would be adversely affected because their tax credit is only two-times what younger adults get ($4,000 vs. $2,000), but insurers could charge premiums that are five times higher than the same premium for a younger adult. Thus, CBO/JCT assumes that the composition of the individual marketplace will change, with a larger proportion of younger adults and fewer older adults enrolling.

In addition, the Patient and State Stability funds can continue to provide reinsurance to insurers for high-cost claims, thereby helping support insurer stability.

Patient and State Stability Fund

The Act would appropriate $15B in FY 2018-2019, then $10B for each year (FY 2020-2026) to states to help them stabilize the insurance market, help certain high cost individuals pay for services, or to promote access to preventive, vision, mental health or substance abuse services.

States will be allocated a part of this fund based on two mechanisms: 85% will be based on the states' incurred claims compared to all claims (based on the annual required MLR reporting); and 15% will be based on the percentage of uninsured below 100% FPL compared to the total of all uninsured <100% in qualifying states. States will be able to use the funding for any of the following purposes:

- Help high risk individuals to buy health insurance through the individual market (by providing financial assistance){Note: can continue to use the Marketplace, or state can create new mechanism)
- Provide incentives "to appropriate entities to enter into arrangements with the State to help stabilize premiums for health insurance coverage in the individual market"

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[18] Fiedler M, Adler L. How Will the House GOP Health Care Bill Affect Individual Market Premiums? Brookings Institute. March 16, 2017. https://www.brookings.edu/blog/up-front/2017/03/16/how-will-the-house-gop-health-care-bill-affect-individual-market-premiums/.

- Reduce the cost to provide health insurance coverage in the individual and small group market to people projected to have high costs
- Promote insurer participation in the individual and small group market and increase health insurance options
- Promote access to preventive services, vision, dental, mental health and substance abuse services
- Provide payments to health care providers to provide services
- Help people enrolled in insurance coverage reduce out-of-pocket costs

Notably, states have 45 days after the passage of the legislation to decide how to use their allocations. If a state does not make an election, the funds will be used to provide reinsurance to insurers for claims between $50,000-$350,000. Thereafter, states can change how they will use their funding by submitting a plan no later than March 31st.

States must provide matching funds to qualify for this funding. The amount of the matching fund varies, depending on whether the state actively applies for funding or it is allocated funding based on the default reinsurance model:

- To qualify for the payments based on state application, states must contribute 7% of the amount allocated in 2020, 14% in 2021, 21% in 2022, 28% in 2023, 35% in 2024, 42% in 2025, and 50% in 2026.
- To qualify for the default reinsurance payments (eg, if the state doesn't apply for the funding), states must contribute 10% of the amount in 2020, 20% in 2021, 30% in 2022, 40% in 2023, 50% in 2024-2026.

Repayment of Excess Premium Tax Credits

Under existing law, the IRS reconciles the amount of premium tax credit that the individual was entitled to receive compared to that which the individual did receive throughout the year. People are required to pay back any amount they received that was in excess of the amount they were due, up to a maximum payback amount (Table 5). The American Health Care Act removes the ceiling on the amount an individual must pay back.

Table 5. ACA Maximum Premium Tax Repayment (2016)

Income as Percent of Federal Poverty Limits	Annual income for an individual (2016)	Repayment limit for single individuals	Annual income for a family of four	Repayment limits for married taxpayers filing jointly
Less than 200% FPL	<$23,760	$300	<$48,600	$600
At least 200% but less than 300%	$23,760 to less than $35,640	$750	$48,600 to less than $72,900	$1,500
At least 300% but less than 400%	$35,640 to less than $47,520	$1,250	$72,900 to less than $97,200	$2,500
400% and above	$47,520 and higher	No limit, must repay full amount	$97,200 and higher	No limit, must repay full amount

IRS. Premium Tax Credit: Claiming the Credit and Reconciling Advance Credit Payments. https://www.irs.gov/affordable-care-act/individuals-and-families/premium-tax-credit-claiming-the-credit-and-reconciling-advance-credit-payments. 2016 Federal Poverty Guidelines: https://www.federalregister.gov/articles/2016/01/25/2016-01450/annual-update-of-the-hhs-poverty-guidelines.

CBO/JCT analysis of this provision. CBO/JCT estimated that the federal government will recapture $4.9B in additional tax revenues between 2018-2020 through the elimination of the cap on premium tax repayments.

Expansion of Health Care Savings Options

As noted earlier, insurers are likely to offer high deductible health plans in order to make their health insurance premiums more affordable. The bill makes it easier for people to invest in health savings accounts, and to use those funds in ways not currently allowed. For example, the legislation would increase the amount that individuals could contribute to their HSA up to the limit on out-of-pocket cost sharing under qualified high deductible health plans. If an individual had any excess premium tax credits that they deposited into the HSA, this would not count towards the limit. Both spouses over age 55 can make up to $1,000 catch up contributions to their HSAs. In addition, the Act reduces the penalty for withdrawing funds from the HSA to use for nonqualified expenses from the current rate of 20% to 10%. HSAs tend to favor higher income individuals, as they are more likely to have the financial ability to contribute to an HSA, and receive higher tax benefits from their contributions into an HSA. According to the Center for Budget and Policy Priorities, 70% of those who contribute to HSAs have family incomes of more than $100,000.[19]

CBO/JCT analysis of this provision: The JCT estimated that the changes to the HSA provisions would lead to $19.2B in reduced federal revenues.

Abortion Restrictions

The bill prohibits the new tax credits to be used to purchase insurance that covers abortions (except when the life of the mother is at risk, or in cases of rape or incest).

III. OTHER PROVISIONS OF THE AMERICAN HEALTH CARE ACT

Elimination of the Prevention and Public Health Trust Fund

The bill eliminates the Prevention and Public Health Trust Fund effective FY 2019 and any unobligated funds reverts to the federal government (Sec. 101).

CBO/JCT analysis of this provision: The repeal of the Prevention and Public Health Trust Fund will reduce federal spending by $9B over the 2017-2026 time frame.

[19] Huang C. House Republicans' ACA Repeal Plan Would Mean Big Tax Cuts for Wealthy, Insurers, Drug Companies. Center on Budget and Policy Priorities. March 8, 2017. Available at: http://www.cbpp.org/research/federal-tax/house-republicans-aca-repeal-plan-would-mean-big-tax-cuts-for-wealthy-insurers#_ftn7.

Planned Parenthood

The Act would prohibit any federal funding (CHIP, Medicaid, or block grant funding) to be used to support Planned Parenthood for one year after the date of enactment (Sec. 103).

CBO/JCT analysis of this provision: CBO estimated both savings of $178M from the elimination of funding to Planned Parenthood in 2017 (or $234 over 2017-2026), as well as additional Medicaid costs of $21M from increased pregnancies and additional coverage of children in 2017 (or $77M over 2017-2026). Thus, there will be a net cut of $156M in direct spending over 2017-2026 due to this one year cessation of funding to Planned Parenthood.

Other Funding Changes

The bill also provides $422M in additional funding to Community Health Centers in FY 2017 (Sec. 102).

Repeal of ACA Taxes and Fees

The Act repeals some of the new taxes or fees that the ACA included effective January 1, 2018, including but not limited to:

- Increased Medicare payroll tax for high earners
- Taxes on pharmaceutical manufacturers
- Tax on tanning beds
- Tax on health insurers
- Excise tax on sale of medical devices

In addition, the Cadillac tax on high-cost employer sponsored insurance is delayed until 2025.

There were other provisions that will have an impact on the federal budget, including repealing the annual limit on contributions to flexible spending accounts, and repealing the annual limits on business expense deductions that insurers can take for salaries in excess of $1 million.

CBO/JCT analysis of this provision: The JCT estimates that the repeal of some of the ACA's taxes and fees would reduce federal revenues by $592B over 2017-2026.

IV. ACA Provisions Left Intact

There are certain provisions of the ACA which the bill leaves intact, including sections related to insurance coverage, provider payment cuts, and changes intended to move towards value-based payments.

ACA Provisions Related to Insurance Coverage

As noted earlier, the American Health Care Act maintains protections for people with preexisting conditions (except for insurance sold through short-term policies), prohibitions on annual and lifetime limits, and maintains the limits on annual out-of-pocket costs. It also continues coverage for dependents up to age 26 on their parents' plan, maintains coverage for the essential health benefits, and for clinical preventive services with no cost sharing. It retains the Marketplace (but will not require individuals to purchase coverage through the Marketplace, starting in 2020). The Act also prohibits gender rating. Notably, the bill is silent on sale of insurance coverage across state lines. The continuity of certain

provisions that were part of the ACA may be due to the fact that this bill must meet the restrictions put on Budget Reconciliation bills (eg, limited to provisions that affect the federal budget).

Of importance to the navigator and assister community, the American Health Care Act does not repeal the provisions related to navigators or assisters. But, on the other hand, it also does not provide funding to continue their work.

ACA Provisions Related to Provider Payments

The American Health Care Act retains some of the other ACA cuts related to provider payments (except those specifically noted above), such as the reductions to the annual market basket updates and cuts to Medicare Advantage plans.

ACA Provisions Related to Quality and Delivery System Reform

The bill does not change any of the provisions related to quality (such as the penalties for excess hospital readmissions or hospital acquired conditions). Nor does it affect the provisions related to payment and delivery reform (such as the move towards ACOs, bundled payments, or patient centered medical homes), or cut funding to the Centers for Medicare and Medicaid Innovations (CMMI). No changes were made in the community benefit requirements nonprofit hospitals must meet to retain their tax exempt status.

V. CBO AND JCT ANALYSIS OF THE AMERICAN HEALTH CARE ACT

The Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) released their review of the American Health Care Act on March 13, 2017.[20] This section describes the CBO/JCT estimates of the overall impact of the legislation on the federal deficit and insurance coverage.

Federal Deficit

The CBO/JCT estimated that the American Health Care Act would reduce federal deficits by $337 billion over 2017-2026. This is largely due to reductions in Medicaid spending due to 14 million fewer people having Medicaid coverage ($880B), reductions to the premium tax credits and elimination of the cost sharing subsidies ($673B), and the elimination of the small business tax credit ($70B). The net savings are reduced by the cost of the new tax credits ($361B), reduction in the penalties paid by individuals and employers ($210B), funding to the new Patient and State Stability Fund ($80B),[21] and increased Medicare DSH payments due to increases in the uninsured ($43B).

Numbers of Uninsured

The CBO/JCT estimated that the numbers of uninsured would rise considerably. In 2018, there would be 14 million more people who would be uninsured (from removing the penalties for the individual mandate and reductions in Medicaid). That would grow to 24 million more uninsured by 2026 (due, in large part, to reductions in Medicaid enrollment). By 2026, the total number of uninsured is likely to grow to 52 million people (up from the 28 million that was predicted under the ACA). See Table 6

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[20] Congressional Budget Office Cost Estimate. American Health Care Act. March 13, 2017. https://www.cbo.gov/sites/default/files/115th-congress-2017-2018/costestimate/americanhealthcareact_0.pdf.

[21] The American Health Care Act provides $100B in funding for the Patient and State Stability Fund which runs past 2026. Only $80B would be in the 2018-2026 time period (which was the focus of the CBO/JCT analysis.

CBO/JCT also estimated that the drop in coverage is likely to be greater among older people with lower incomes.

Table 6. CBO/JCT Estimate of the Impact of the American Health Care Act on Health Insurance Coverage for the Nonelderly (2017-2026)

Table 5 - EFFECTS OF THE AHCA ON HEALTH INSURANCE COVERAGE FOR PEOPLE UNDER AGE 65

(Millions of people, by calendar year)

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Total Population Under Age 65	273	274	275	276	276	277	278	279	279	280
Uninsured Under Current Law	26	26	27	27	27	27	27	28	28	28
Change in Coverage Under the AHCA										
Medicaid[a]	-1	-5	-6	-9	-12	-13	-13	-14	-14	-14
Nongroup coverage, including marketplaces[b]	-2	-6	-7	-9	-8	-8	-6	-5	-4	-2
Employment-based coverage	-1	-2	-2	-2	-2	-2	-3	-5	-5	-7
Other coverage[c]	*	*	*	-1	-1	-1	-1	-1	-1	-1
Uninsured	4	14	16	21	23	23	23	24	24	24
Uninsured Under the AHCA	31	41	43	48	50	50	51	51	51	52
Percentage of the Population Under Age 65 With Insurance Under the AHCA										
Including all U.S. residents	89	85	84	83	82	82	82	82	82	81
Excluding unauthorized immigrants	91	87	87	85	84	84	84	84	84	84

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.