



Health Policy Brief

State policy options in the American Health Care Act

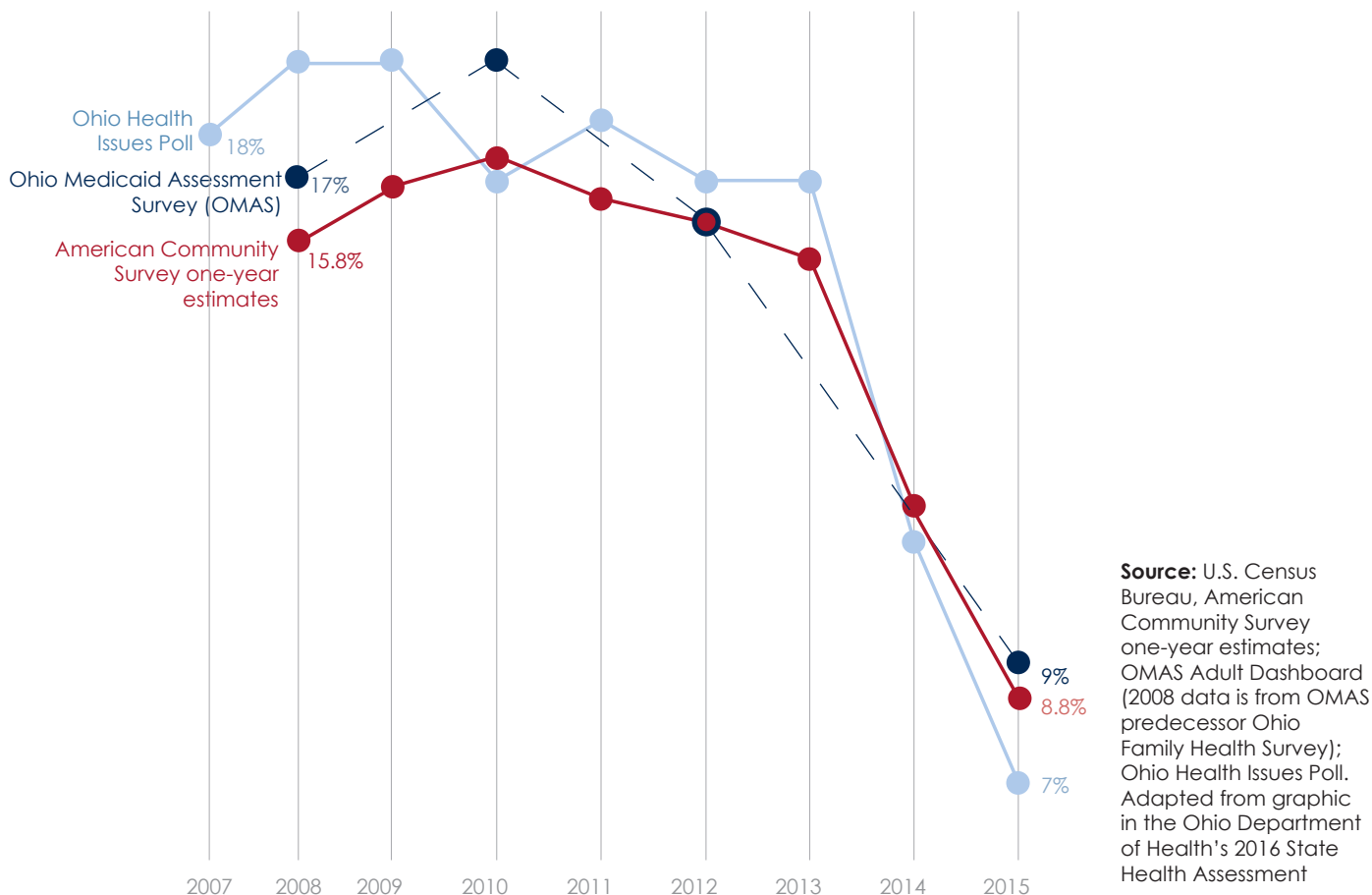
Overhauling the ACA

On May 4, 2017, the U.S. House of Representatives passed the American Health Care Act (AHCA) by a vote of 217-213. The bill aims to overhaul much of the Affordable Care Act (ACA).

The AHCA was introduced on March 6. In order to gain enough votes to ensure passage in the U.S. House, several key amendments were added to give states more flexibility to remove or modify provisions of the ACA. The bill is now under consideration in the U.S. Senate. It is unclear whether the House-passed legislation will move through the Senate and, if so, how much of the original language will remain.

An analysis of the AHCA by the non-partisan Congressional Budget Office (CBO), released May 24, projected that the law would reduce the deficit by \$119 billion and would, on average, lower health insurance premiums. However, the analysis predicts that premiums would increase for older Americans and those with health conditions and would lead to 23 million more Americans without health insurance coverage over the next 10 years (the uninsured rate has dropped significantly since the passage of the ACA, see figure 1). The CBO also concluded that, while the individual health insurance market would remain stable in most of the nation, "about one-sixth of the population resides in areas in which the nongroup market would start to become unstable beginning in 2020."¹

Figure 1. **Uninsured adults.** Percent of 18-64 year olds in Ohio without health insurance (2009-2015)



Although the AHCA is sometimes referred to as a bill to “repeal and replace” the ACA, it leaves many of the decisions to alter the 2010 health reform law in the hands of states. States would be able to apply for a number of waivers under the AHCA. The law also changes the U.S. Department of Health and Human Services’ approval process to allow waivers to be approved automatically unless they are found, within 60 days, to be noncompliant with requirements outlined in the AHCA.

Given the considerable flexibility in the AHCA for states, Ohio policymakers will have additional policy options available to them if the current bill is signed into law. This publication highlights some of the areas in which Ohio policymakers will encounter new decision points.

Health coverage landscape in Ohio

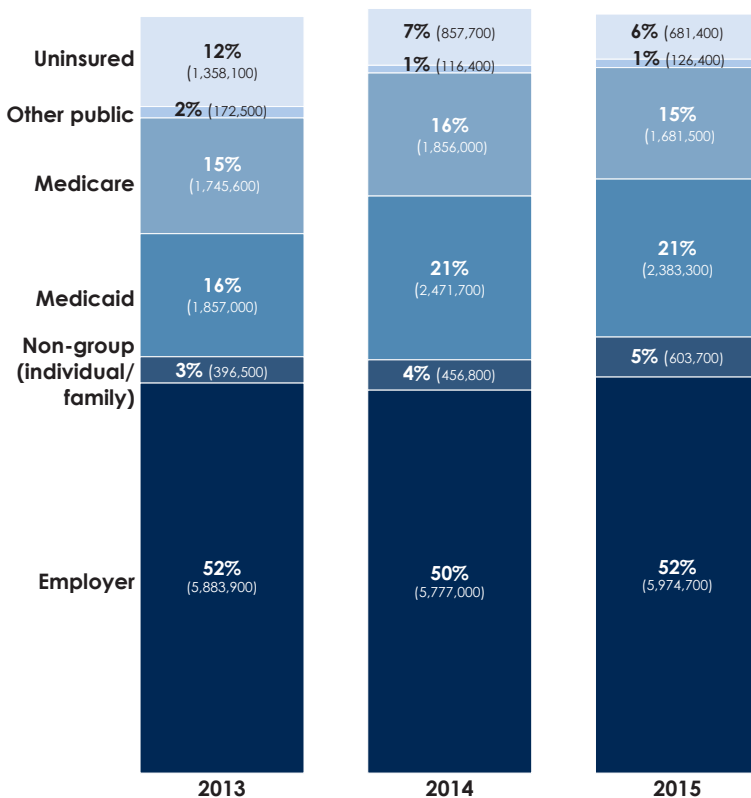
In 2015, the majority of the state’s population — more than 5.9 million Ohioans (52 percent) — had private health insurance coverage through their employer (see figure 2). About 4.2 million Ohioans (36.6 percent) had public health insurance coverage through

Medicaid, Medicare or other government programs.² Six percent of Ohioans were uninsured in 2015 and 5 percent (more than 600,000) had individual coverage, including 238,000 in Ohio’s federally run ACA individual marketplace.³

The number of uninsured Ohioans decreased by half from 2013 to 2015, falling from about 1.4 million Ohioans in 2013 to 681,400 in 2015.⁴ This drop in the number of uninsured Ohioans was largely due to the extension of Medicaid eligibility under the ACA. Beginning Jan. 1, 2014, Medicaid coverage in Ohio was expanded to adults between ages 19 and 64 with incomes less than 133 percent of the federal poverty level (FPL) and who are not eligible under other categories. As of February 2017, about 723,000 Ohioans were enrolled in the new eligibility group known as Group VIII.⁵ In state fiscal year (SFY) 2016, Ohio Medicaid’s average monthly enrollment was 3.04 million Ohioans.⁶

To learn more about health insurance coverage in Ohio, see HPIO’s [Private Health Insurance Basics](#) and [Ohio Medicaid Basics 2017](#).

Figure 2. Health insurance coverage for Ohioans, 2013-2015



Note: Enrollees in the Affordable Care Act health insurance marketplace are included in the non-group (individual/family) coverage category
Source: Census Bureau’s March Supplement to the Current Population Survey, as compiled by the Kaiser Commission on Medicaid and the Uninsured

State flexibility and/or decision points in the private health insurance market

While the AHCA retains the insurance market reforms of the ACA, the new law would provide states with more flexibility to alter the private health insurance market.

Patient and State Stability Fund

The AHCA calls for \$100 billion in federal funds over nine years to be placed in a new Patient and State Stability Fund. The fund could be used by states to assist high-risk individuals, stabilize private insurance premiums, promote access to preventive services or to provide cost-sharing subsidies. The funds could also be used by states for maternity coverage and newborn care, mental health and substance use disorder services or other services that are currently included as required “essential health benefits” in individual plans under the ACA but could be waived under the AHCA (see essential health benefits section).

In addition to the \$100 billion in the stability fund, the AHCA also allocates \$15 billion over nine years to a new Federal Invisible Risk Sharing Program (FIRSP). Under the program, insurers would identify enrollees in advance who are likely to incur large claims and enroll them in a high-risk pool funded by insurers and supplemented with federal funds. The pool would then pay all claims for the identified individuals beyond a set threshold. A primary difference between invisible risk-sharing and other forms of reinsurance is that insurers are required to preselect enrollees who are likely to have high claims.

Pre-existing conditions

The AHCA retains the ACA’s prohibition on excluding individuals with pre-existing conditions from accessing coverage. However, states that use Patient Stability Fund grants for high-risk pools or reinsurance, or that participate in the FIRSP, could allow insurers to charge higher premiums to people with pre-existing conditions who do not maintain continuous coverage. Lapse in coverage is defined as 63 consecutive days during the previous 12 months.

Shortly before the passage of the AHCA in the U.S. House, an amendment was added

to allocate \$8 billion to states over six years to fund high-risk pools or directly subsidize premiums or cost-sharing for high-cost individuals.

According to analysis from consulting firm Avalere Health, there are currently more than 2.2 million people with pre-existing conditions in the individual market.⁷ The new funding called for in the AHCA, according to the analysis, would be sufficient to help just 110,000 people nationally in a high-risk pool, or 5 percent of those with pre-existing conditions.⁸

The CBO projects that, “over time, it would become more difficult for less healthy people (including people with pre-existing medical conditions) in [states that obtain waivers to modify both essential health benefits and community rating] to purchase insurance because their premiums would continue to increase rapidly.”⁹

Essential health benefits (EHBs)

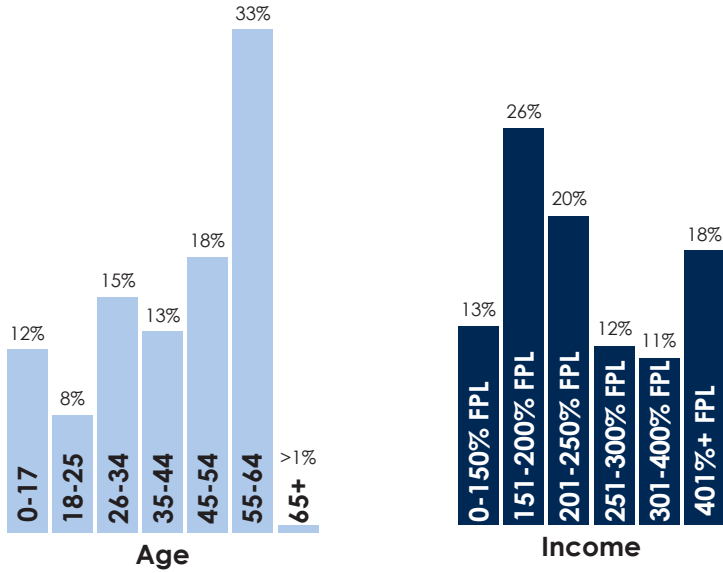
The ACA requires that most small group and individual health insurance plans offer a comprehensive package of covered items and services known as “essential health benefits,” which include:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

Starting in 2020, the AHCA would allow states to apply for a waiver to redefine essential health benefits in the individual and/or small-group market(s).

Many critics of the ACA suggest that essential health benefit requirements create a barrier to lowering the cost of premiums, particularly for healthy, non-pregnant individuals. By tailoring plans more closely to the needs of

Figure 3. Ohio marketplace enrollees, by age and income (2017)



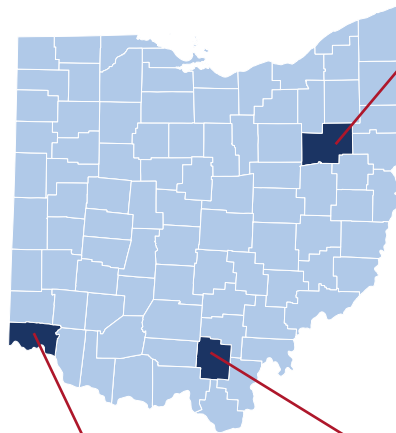
Key takeaway
As seen in figure 3, Ohioans who are older and have lower incomes are more likely to enroll in the ACA marketplace than other population groups. As figure 4 illustrates, these groups are more likely to see increases in premiums under AHCA.

Source: Centers for Medicare and Medicaid Services

Figure 4. Monthly premium changes from ACA to AHCA

To the right are estimates of the potential change in the average monthly premium for a silver-level plan from the ACA to the AHCA in three Ohio counties. ACA premiums were calculated using data about plans offered on Ohio's ACA marketplace for plan year 2017 and the ACA's 3:1 age rating curve and income-based tax credit formula. AHCA premiums were calculated using the same data and the AHCA's 5:1 age rating curve and age-based tax credit formula that would go into effect beginning in 2020. The estimates do not reflect potential premium changes resulting from waivers, including waivers of EHB and pre-existing condition protections.

Calculations for additional counties are available at www.hpio.net



Stark County
Unique issuers: 6
Silver plans offered: 30
Marketplace enrollment: 7,722 (2.1% of county population)
Percent receiving tax credits: 77% (5,937)
Percent receiving cost sharing subsidies: 56% (4,356)

		Annual income		
		\$20k	\$40k	\$60k
Age	27	-\$125	-\$216	-\$216
	40	-\$135	-\$265	-\$265
	64	+\$265	+\$22	-\$147

Hamilton County
Unique issuers: 6
Silver plans offered: 30
Marketplace enrollment: 18,481 (2.3% of county population)
Percent receiving tax credits: 65% (11,921)
Percent receiving cost-sharing subsidies: 42% (7,762)

		Annual income		
		\$20k	\$40k	\$60k
Age	27	-\$103	-\$218	-\$218
	40	-\$109	-\$266	-\$266
	64	+\$330	+\$87	-\$149

Jackson County
Unique issuers: 1
Silver plans offered: 11
Marketplace enrollment: 467 (1.4% of county population)
Percent receiving tax credits: 94% (440)
Percent receiving cost sharing subsidies: 43% (203)

		Annual income		
		\$20k	\$40k	\$60k
Age	27	+\$33	-\$209	-\$248
	40	+\$73	-\$170	-\$288
	64	+\$898	+\$655	-\$57

Green indicates lower premiums under AHCA
Red indicates higher premiums under AHCA

Source: HPIO analysis of "2017 QHP Landscape Individual Market Medical" from data.healthcare.gov. Adjustments to premiums prices based on AHCA's 5:1 age rating curve were made using estimates from a Milliman research report.¹²

individual enrollees, health insurers could offer less expensive plan options with fewer benefits. Prior to passage of the ACA, for example, 62 percent of people enrolled in an individual plan did not have coverage for maternity services, 34 percent did not have coverage for substance abuse services, 18 percent did not have coverage for mental health services and 9 percent did not have coverage for prescription drugs.¹⁰

With healthier consumers likely attracted to lower-cost plan options with fewer benefits, people with health conditions who need more services covered would likely pay more for that coverage. According to the CBO analysis of the AHCA:

Although premiums would decline, on average, in states that chose to narrow the scope of EHBs, some people enrolled in nongroup insurance would experience substantial increases in what they would spend on health care. People living in states modifying the EHBs who used services or benefits no longer included in the EHBs would experience substantial increases in out-of-pocket spending on health care or would choose to forgo the services.¹¹

Age rating

The AHCA repeals the ACA's age-rating requirement. Under current law, premiums for older enrollees in the individual market can be no more than three times that of younger enrollees. Ohioans who are older or have lower incomes are more likely to enroll in ACA individual market plans (see figure 3). The AHCA would allow older enrollees to be charged up to five times more, and gives states the option to set their own ratios beginning in 2018. As a result, the cost of health insurance premiums for young adults would likely decrease while the cost for older individuals would increase (see figure 4).

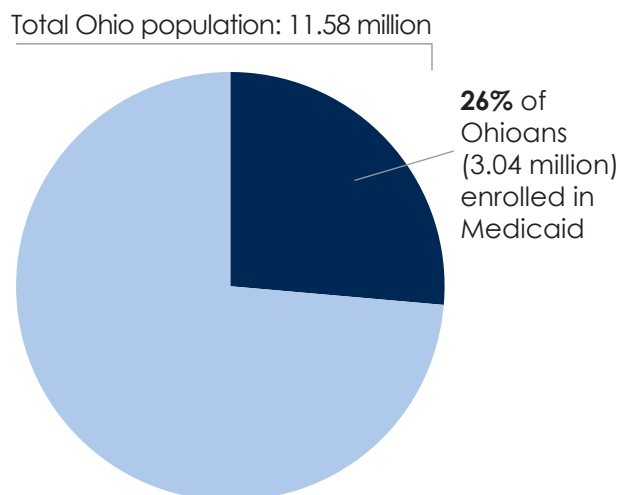
Changes in Medicaid

The AHCA, as passed by the House, would fundamentally change the Medicaid program, which provides coverage to about one in four Ohioans (see figure 5). Changes to the federal reimbursement structure would provide less federal funding than is provided under current law. To address anticipated reductions in federal funds, states would be granted greater decision-making authority related to receiving program funding and determining eligibility.

Per-capita caps and block grants

The AHCA would replace the current Medicaid financing structure, known as Federal Medical Assistance Percentage (FMAP), with a per-capita

Figure 5. **Estimated percent of Ohioans enrolled in Medicaid, SFY 2016**



Sources: Ohio Department of Medicaid caseload report (February 2017); HPIO analysis based on American Community Survey 5-year population estimate (2015).

cap and a state option for block grants. The AHCA caps federal Medicaid spending for each state using a formula that considers the state's average per member per month cost for providing services to people in five Medicaid-eligible populations (elderly, blind and disabled, children, Group VIII adults and others) and the number of people enrolled in each population. Each year, the cap is increased based on the medical care component of the consumer price index for urban consumers (CPI-M). If a state requires more federal funding than allowed by the per-capita cap formula in a given year, that state's federal Medicaid funding would be reduced during the following year.

States may lose significant federal funding under this arrangement if the cost of providing Medicaid covered services grows faster than CPI-M. To balance the state budget, Ohio policymakers could change eligibility requirements, cut covered services and reduce provider payments and/or raise additional revenue to cover shortfalls.

The AHCA also gives states an option to receive block-grant funding for specific populations. States that choose block-grant funding would receive an initial annual allotment based on per capita medical expenditures, with grants increasing in subsequent years.¹³ Unlike the per-capita cap, block grants would be adjusted annually by the consumer price index, not CPI-M, and would not account for changes in enrollment. Federal funding for block grants would be provided at the Children's Health Insurance Program enhanced FMAP rate.¹⁴

States that choose the block grant option could rollover unused funds into the next year as long as they continue the block grant option. These states would also be given additional flexibility to manage enrollment, determine eligibility and set limits on covered services.

Expansion funding

The AHCA does not repeal Medicaid expansion, but it does phase out the Group VIII enhanced FMAP provided under the ACA. The Group VIII enhanced match was 100 percent during calendar years 2014-2016 and decreases to 90 percent by 2020. Under the AHCA, states that extend Medicaid eligibility after March 1, 2017, would not be eligible for the enhanced FMAP. Ohio and other states that expanded Medicaid eligibility prior to March 1, 2017, would receive enhanced FMAP for people that enroll before Dec. 31, 2019. After that date, Ohio would receive the regular FMAP for people who enroll or re-enroll after more than a one-month lapse in coverage.

Eliminating the enhanced FMAP for Group VIII adults would increase states' costs for providing coverage to this population. Some states that expanded Medicaid under the ACA's enhanced match may choose not to maintain coverage because of the higher state share.

Work requirement

The AHCA proposes several changes to Medicaid eligibility criteria and incentivizes states to implement administrative changes.

One such change is an incentive for states to implement work requirements for non-disabled, non-pregnant adults. The AHCA provides an additional 5 percent reimbursement for administrative costs associated with implementing a work requirement. Under the AHCA's work requirement, states could require non-disabled, non-pregnant adults to be employed or participate in a qualifying work or educational activity to be eligible for Medicaid.

Other insurance market changes

Individual mandate

The AHCA essentially repeals the ACA individual mandate by eliminating the tax penalty (\$695 or 2.5 percent of household income, whichever is higher) for not having coverage, retroactive

to Jan. 1, 2016. In place of the ACA's individual mandate, the new law imposes a penalty of 30 percent of premium cost for anyone enrolling in an individual plan after a lapse in continuous coverage. The late enrollment penalty applies to any individual who had a lapse of coverage of 63 consecutive days during the previous 12 months.

Cost-sharing reductions

Under the AHCA, the ACA cost-sharing reduction program — which reduces out-of-pocket costs for deductibles, copayments and coinsurance for marketplace health plan enrollees with incomes between 100 percent and 250 percent FPL — would be repealed effective Jan. 1, 2020.

Under the current law, insurers must offer silver plans with reduced patient cost-sharing (e.g., deductibles and copays) to ACA individual marketplace enrollees with lower incomes. To compensate for the added cost to insurers of the reduced cost-sharing, the ACA calls for the federal government to make payments directly to insurance companies, though a federal court case questions whether there is statutory authority for the federal government to pay these subsidies.¹⁵ The CBO estimates the cost of these payments at \$7 billion in fiscal year 2017, rising to \$10 billion in 2018 and \$16 billion by 2027.¹⁶

Of the 238,000 Ohioans who selected a plan through the ACA individual marketplace for 2017, 45 percent were eligible for cost-sharing subsidies.¹⁷

Actuarial rating of plans

The AHCA repeals the actuarial value standards established by the ACA, which created the bronze, silver, gold and platinum levels for health plans. Actuarial value is the percentage a health plan will pay towards covered medical expenses, based on a standard population. Repealing these standards would provide insurers with flexibility to design plans with a wide array of cost-sharing arrangements offered in the individual and small group markets.

Tax credits

The ACA created premium tax credits for individuals and families who earn between 100 percent and 400 percent FPL and purchase coverage through the ACA individual marketplace. The amount of the tax credit

is based on income level and the cost of coverage in an individual's area.

The AHCA creates a new tax credit formula in 2018 that increases the amount of tax credits for younger adults and reduces credits for older adults. It also allows for credits to apply toward coverage sold outside of the ACA individual marketplace and for catastrophic plans.

In 2020, the AHCA would completely replace the income-based tax credits with flat tax credits adjusted solely for age, with credits phased out at incomes between \$75,000 and \$115,000.

Unlike the ACA, geographic differences in the cost of health care are not considered. The proposed annual tax credit amount — which is capped at \$14,000 for up to five people in a family — is:

- \$2,000 per individual up to age 29
- \$2,500 per individual age 30-39
- \$3,000 per individual age 40-49
- \$3,500 per individual age 50-59
- \$4,000 per individual age 60 and older

Of the 238,000 Ohioans who selected a plan through the ACA individual marketplace for 2016, 74.5 percent were eligible for advanced premium tax credits.¹⁸

Conclusion

While the passage of the AHCA by the U.S. House was a significant development in federal health policy, the legislation still must be approved by the U.S. Senate. If it wins approval in the U.S. Senate, the AHCA could face a complicated reconciliation process between what could be two significantly different pieces of legislation from the House and Senate.

Although a firm timeline for Senate action on the AHCA remains unclear, Senate Majority Whip John Cornyn, R-Texas, estimated that a vote on a final bill could occur in June or July.¹⁹

In spite of the uncertainty surrounding the legislation, Ohio policymakers should carefully consider the changes and new decision points created by the AHCA. Given the considerable latitude in the AHCA for states to waive or alter components of the ACA, Ohio policymakers will have to weigh the potential impact of state policy choices on the health of Ohioans and state spending.

Notes

1. "H.R. 1628, American Health Care Act of 2017," Congressional Budget Office. May 2017.
2. Data from the Census Bureau's March Supplement to the Current Population Survey, as compiled by the Kaiser Commission on Medicaid and the Uninsured. "Health Insurance Coverage of the Whole Population." Kaiser Family Foundation. Accessed September 16, 2016. <http://kff.org/other/state-indicator/total-population/>
3. 2017 Open Enrollment Period Final Enrollment Report, Centers for Medicare and Medicaid Services (CMS), Department of Health and Human Services (HHS), March 15, 2017.
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8. Ibid.
9. "H.R. 1628, American Health Care Act of 2017," Congressional Budget Office. May 2017.
10. "Essential Health Benefits: Individual Market Coverage," Office of the Assistant Secretary for Planning and Evaluation, 2011. <https://aspe.hhs.gov/basic-report/essential-health-benefits-individual-market-coverage>
11. "H.R. 1628, American Health Care Act of 2017," Congressional Budget Office. May 2017.
12. Fontana, Joanne, Thomas Murawski and Sean Hilton. Impact of Changing ACA Age Rating Structure: An analysis of premiums and enrollment by age band. Milliman, 2017.
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18. Ibid.
19. "McConnell steps into Obamacare firing line," Politico, May 21, 2017. <http://www.politico.com/story/2017/05/21/mcconnell-obamacare-senate-repeal-238627>

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