



H.R. 1628, the American Health Care Act Legislative Summary

On March 20, the U.S. House of Representatives released H.R. 1628, the American Health Care Act (AHCA), legislation that repeals major elements of the Patient Protection and Affordable Care Act (PPACA), commonly referred to as “Obamacare,” and implements numerous new conservative health care policies. A lack of consensus among House Republicans forced Speaker Paul Ryan (R-WI) to indefinitely delay a March 24th vote on passage of H.R. 1628.

The AHCA simply lacked the votes needed for passage. No House Democrats were expected to vote in favor of the legislation. House Republican leadership preferred to pass the bill in March so it could then be considered in the U.S. Senate under budget reconciliation, an arcane parliamentary procedure that prohibits a Senate filibuster and allows select bills to be passed with a simple majority vote. Prior to the cancellation of the vote, Speaker Ryan and Senate Majority Leader Mitch McConnell (R-KY) were committed to passing H.R. 1628 no later than April 7, 2017.

The American College of Radiology (ACR) is pleased that the AHCA currently does not repeal PPACA provisions requiring private insurance companies to cover the cost of life saving cancer screening services, such as mammograms, low-dose CT screens for lung cancer, and CT Colonographies for colon cancer, without any form of patient cost sharing (i.e. co-pays, co-insurance, or deductibles). ACR also supports House Republicans’ decision to retain the Essential Health Benefit (EHB) program for insurance policies sold in the individual market. The AHCA, however, does repeal EHB requirements within the Medicaid program.

H.R. 1628 consists of five major policy components, specifically the elimination of many existing PPACA taxes, the creation of new health care tax credits to assist individuals purchase health insurance, expanded access to health savings accounts (HSAs), state innovation grants to help cover beneficiaries with pre-existing conditions, and Medicaid reform.

Repealed PPACA Taxes

The AHCA successfully repeals many taxes enacted via PPACA. First and foremost, H.R. 1628 immediately zeroes out any financial penalties for noncompliance with the individual or employer mandates. No individual or business will be subjected to *government imposed* fines for failing to either obtain or provide insurance coverage. In place of the individual mandate, H.R. 1628 allows insurers to assess a 30 percent premium increase on individuals who fail to retain continuous health care coverage, defined as a break in coverage of more than 63 days. This policy concept is designed to coax Americans to both purchase and retain health insurance when healthy.

Other unpopular levies slated to be terminated include: the small business tax credit, the over-the-counter medication tax; the 2.3 percent medical device tax; increased taxes assessed to non-qualified medical expenses paid via an HSA; existing limitations on financial contributions to flexible savings accounts (FSAs); existing limitations on tax deduction for employers who offer sufficient prescription drug coverage to their employees via the Retiree Drug Subsidy; higher adjusted gross income percentage threshold for medical expense itemized deductions; the 0.9 percent Medicare payroll tax assessed to “high earners;” existing limitations on maximum contributions to HSAs; prohibitions on both spouses making “catch-up” HSA contributions; the 10 percent tanning tax; the 3.8 percent tax assessed to certain net investments for high earners; the health insurance tax or annual fee assessed to health insurance issuers; the tax on brand manufacturer prescription medications; and existing limitations on tax deductions associated with remuneration for insurance executives.

In an attempt to placate the more conservative wing of the Republican Party, President Trump and Speaker Ryan tweaked H.R. 1628 to make the repeal of all PPACA taxes effective in 2017 rather than 2018. In addition, the controversial Cadillac tax, or a 40 percent excise tax on high-cost employer-sponsored health coverage, will be delayed for an additional year until 2026.

Health Care Tax Credits

A new section of the tax code that offers universal, refundable tax credits primarily based on age, rather than income, is a key pillar of the AHCA’s commitment to granting all individuals the opportunity to obtain access to quality health coverage.

Under PPACA, only poorer individuals or families that meet certain income thresholds are eligible for subsidies to purchase prescriptive insurance policies through the exchanges. The subsidies are given directly to the insurance companies. Beneficiaries who fail to buy policies that meet all Obamacare requirements via the exchanges are ineligible for the subsidies. House Republicans traditionally viewed Obamacare’s insurance subsidies as expensive, inefficient and highly rigid.

In lieu of the current process, effective 2020, the AHCA creates refundable and advanceable tax credits, or monthly government payments to beneficiaries to help offset insurance premiums costs. Traditional refundable tax credits require individuals to wait until they file their taxes the following year before they receive a government payment. Advanceable tax credits, however, would be immediately available to all American citizens and qualified aliens who are not offered insurance coverage either through a government program (e.g. Medicare/Medicaid) or employer-sponsored care. The schedule of tax credits is as follows:

- Under Age 30: \$2,000 tax credit
- Between 30 and 39: \$2,500 tax credit
- Between 40 and 49: \$3,000 tax credit
- Between 50 and 59: \$3,500 tax credit
- Over age 60: \$4,000 tax credit

The tax credits are capped at \$14,000 for a family and adjusted for inflation at the rate of Consumer Price Index (CPI) plus 1 percent. Credits are also available in full for individuals making \$75,000 or less OR for families making \$150,000 or less. Overall, the tax credits are means-tested and are phased out by \$100 for every \$1,000 in income higher than those thresholds.

H.R. 1628 permits the tax payments to be used to purchase any eligible plan approved by a state and sold in their individual insurance market. Qualified plans include catastrophic coverage which is currently barred under Obamacare. The tax credit can also be used to keep children on a parent's health insurance plan up until age 26.

Finally, a last minute change to the AHCA would establish a reserve fund of at least \$75 billion over 10 years for more generous tax credits that would be given to Americans between the ages of 50 and 64. In a peculiar legislative maneuver, H.R. 1628 does not outline the specifics of this higher tax credit. Instead, the legislation instructs the Senate to outline the structure of this expanded tax credit for this particular age bracket.

Expanded Access to HSAs

The AHCA also authorizes expanded HSAs to ensure equal access to more affordable health insurance policies. HSAs allow individuals and employers to contribute to a tax-preferred account up to specific financial threshold as long as they utilize a high-deductible health plan as their primary form of insurance coverage. Under PPACA, the maximum amount that can be contributed in 2017 to an HSA by both a beneficiary and employer is \$3,400 for an individual and \$6,750 for a family. H.R. 1628 increases the maximum HSA contribution amounts to \$6,500 and \$13,100 for individuals and families, respectively.

State Innovation Grants

H.R. 1628 also provides \$25 billion in funding over a nine year period to create a Patient and State Stability Fund principally to help states resuscitate dormant high-risk pools that were the primary manner in which individuals with pre-existing medical conditions purchased health insurance prior to PPACA. Although the legislative language is quite broad, it appears that States are also permitted to tap into the funds in order to reduce patients' out-of-pocket costs (co-payments, coinsurance, premiums, and deductibles), stabilize and reduce the cost of health insurance the individual and small group insurance markets, promote participation in individual and small group market, provide payments (directly or indirectly) to health providers for the provision of select health care services as specified by the Administrator of the Centers for Medicare and Medicaid Services (CMS), and promote access to preventive services including cancer screens, as well we as dental, vision, mental health and substance abuse care.

The ACR appreciates House lawmakers permitting states to use the Patient and State Stability Fund to help ensure patients retain access to preventive services, such as annual cancer screens performed by radiologists.

Medicaid Reform

H.R. 1628 also makes extensive changes to PPACA's Medicaid expansion policy. Medicaid, an entitlement program that provides health care to lower income Americans, pregnant mothers, children, blind or disabled individuals, and impoverished elderly citizens, is traditionally administered by the states while the cost is divided evenly between the state and federal government.

In an attempt to lower the total number of the uninsured, Obamacare required all states to expand Medicaid coverage for *any* "able-bodied" American with incomes up to 138 percent of the federal poverty level. In return for requiring coverage of a larger percentage of lower income Americans, the federal government is mandated to reimburse states for 90-95 percent of the cost of these new Medicaid beneficiaries. Ultimately, the Supreme Court ruled in *NFIB v. Sebelius* that tying the enhanced federal funding to a mandatory expansion of Medicaid coverage was unconstitutionally coercive to the states. As a result, states were given the option of expanding Medicaid and 32 states ultimately passed legislation to cover more able-bodied Americans up to the statutory federal poverty level limits.

H.R. 1628 ends the enhanced federal matching funding for all states that have not expanded their Medicaid program as of March 1, 2017. Although states are still permitted to expand Medicaid to able-bodied adults, they would only receive the traditional federal matching rate for this particular expansion population. Another late change to the AHCA prohibits states from expanding Medicaid to able-bodied adults with incomes *over* 133 percent of the federal poverty level, effective Dec. 31, 2017.

Despite these new restrictions, H.R. 1628 does permit some continued flexibility and expanded funding for states that previously chose to expand Medicaid coverage. Enrollees in states that elected to expand Medicaid coverage will receive a "grandfather status" and continue to receive the enhanced federal matching level so long as they do not incur a break in Medicaid coverage for more than 63 days. Because adult Medicaid recipients generally cycle on and off Medicaid as their incomes fluctuate, over time, this provision is designed to gradually phase out the enhanced federal matching rates.

Most importantly, the AHCA includes sweeping policy changes that transform Medicaid from its traditional practice of providing states with open-ended monetary resources to cover the cost of all beneficiaries to a program that only grants states fixed amounts of funding from the federal government regardless of enrollment numbers. Starting in 2020, the legislation grants states the option to pursue either per-capita funding caps or block grants to cover Medicaid costs.

Under per-capita caps, specific dollar amounts are calculated from mathematical formulas for each Medicaid beneficiary and this amount is paid to the state on an annual basis. If Medicaid expenses exceed a state's per capita allotment, the state is responsible for covering the excess costs. The per capita payment is indexed for inflation and is based on the average amount for beneficiaries in one of five enrollment categories: 1) the elderly; 2) blind and disabled individuals; 3) children; 4) adult expansion enrollees; and 5) all other enrollees (pregnant women).

The states' Medicaid population for Fiscal Year 2016 would serve as the "baseline" for calculating the per-capita amounts. The amount of the per-capita caps would be calculated based on average state

spending on each of the five subpopulations. That amount would then be used to calculate the federal matching rate for individuals in each subpopulation. As the composition of a state's Medicaid beneficiary population changes from year-to-year, the number of individuals in each enrollment category will change and the average cost against which matching funds are provided would change correspondingly.

In lieu of the per capita cap, states can also elect to receive a Medicaid block grant, or lump sum payments with minimal federal restrictions on how the funding should be used. H.R. 1628, however, stipulates that block grants would only apply to adults and children, thus the elderly, blind, disabled, and able bodied populations would be explicitly excluded from the policy. States must apply for the block grant funding and explicitly state how they will deliver care which must include: 1) hospital care; 2) surgical care and treatment; 3) medical care and treatment; 4) obstetrical and prenatal care/treatment; 5) prescription drugs and prosthetics; 6) other medical supplies; and 7) health care for children.

Funding for the block grant in the first year is based on a state's federal Medicaid match rate, its enrollment in the prior year, and per beneficiary spending. The block grant is increased each year based on inflation, yet it does not adjust the funding based on growing enrollment.

In addition, H.R. 1628 permits states, effective Oct. 1, 2017, to impose limited working requirements on "non-disabled, non-elderly, non-pregnant" Medicaid beneficiaries. States are authorized to determine the length of the work requirements and, in turn, the federal government provides a 5 percent increase in Medicaid matching funds to help implement this new policy.

Next Steps

It is unclear at this time whether H.R. 1628 will pass the House and Senate in its current form. In the House, many moderate and conservative members are concerned about the bill's tax credits and Medicaid reforms. Numerous moderate Senators have also expressed strong reservations regarding the AHCA's Medicaid reforms and its potential impact on the declining number of Americans who will retain access to health insurance in comparison to PPACA. If it successfully passes the House, Majority Leader Mitch McConnell (R-KY) will then try and pass it through the Senate.