How the AHCA Directly Impacts Significant Parts of the ACA

Executive Summary

Six weeks after pulling the American Health Care Act (AHCA) (H.R. 1628) from consideration, the House of Representatives passed an amended version of the bill on May 4, 2017, by a vote of 217 to 213. The legislation makes significant changes to some parts of the Patient Protection and Affordable Care Act (ACA) (P.L. 111-148), in particular repealing the employer and individual mandates; scaling back Medicaid expansion; and repealing many of the taxes included in the ACA. The House also passed H.R. 2192, which would eliminate provisions that exempt members of Congress and congressional staff from state waiver provisions, in response to criticisms that the AHCA would affect all Americans except those voting on the bill (see The AHCA strikes back, May 4, 2017).

The Senate is now considering the legislation, and is likely to make substantial changes to the AHCA, or even start from scratch on new legislation. Moderate Republican senators in particular are concerned about the changes to Medicaid coverage that roll back the ACA's expansion of the program. This White Paper will compare provisions of the AHCA with the ACA.

One thing to note at the outset is that the ACA as enacted in March 2010 included ten titles, while the AHCA makes significant changes to only three of the titles. Much of the ACA, especially related to the Medicare program and the training of various types of medical practitioners, therefore, would remain intact if the AHCA passes in its current form.

In addition, the Trump Administration has stated more than once that it sees the rollback of the ACA as occurring in three stages—(1) legislation to repeal or change ACA provisions that would allow the Senate to pass a bill with a bare majority under the budget reconciliation process; (2) administrative actions to provide patients with additional insurance options and give states more flexibility in Medicaid spending, and (3) legislation on Trump's other priorities including sale of health insurance across state lines and medical tort reform (see Is the American Health Care Act a 'critical first step' or unsupportable?, March 8, 2017).

ACA Title I—Quality Affordable Health Care for All Americans

Title I of the ACA includes the most contentious parts of the legislation, including private insurance market reforms, the individual and employer mandates, the description of the essential health benefits package, the establishment of a federal health insurance marketplace, premium tax...
credits for the purchase of health insurance, and Medicaid expansion.

Repeal of cost-sharing subsidy

**ACA.** Individuals who enroll in a qualified health plan through the federal health insurance marketplace may be eligible for cost-sharing reductions (i.e., subsidies) if their household income does not exceed 400 percent of the poverty line. The subsidies should decrease annual out-of-pocket limits and, for lower-income individuals, further increase a plan’s share of total allowed benefits costs. [ACA §1402.]

**AHCA.** ACA Sec. 1402 would be repealed in its entirety. [AHCA §131.]

Essential health benefits tiers

**ACA.** The essential health benefits package offered by qualified health benefit plans through the federal health insurance marketplace must include specific categories of benefits, meet certain cost-sharing standards, and provide certain levels of coverage (bronze, silver, and gold.) [ACA §1302.]

**AHCA.** Beginning in 2020, health plans no longer would be required to conform to these actuarial tiers. The practical effect of this change is that insurers could offer plans that are both more and less generous than plans currently available through the federal health insurance marketplace. [AHCA §134.]

Permissible age variation

**ACA.** Health insurance issuers may vary premium rates based on age, but only within a ratio of 3:1 for adults age 21 and over. The ACA put in place a single age band for individuals age 0 through 20; one-year age bands for individuals age 21 through 63; and a single age band for individuals age 64 and older. [ACA §1201.]

**AHCA.** The legislation would maintain the age bands but increase the ratio by which health insurance premiums may vary by age, from a 3:1 ratio to a 5:1 ratio. States would have the option to preempt the ratio. [AHCA §135.]

State waivers for insurance plans

**ACA.** The ACA established strict guidelines for health insurance plans regarding what essential health benefits needed to be covered and limiting the range of premiums that could be charged. [ACA §1201.]

**AHCA.** While the AHCA would maintain the essential health benefits outlined by the ACA, it also would provide a limited waiver for states for both the essential health benefits and community rating of premiums. States would have to attest that the purpose of the waiver would be to reduce premium costs, expand coverage, or maintain coverage for people with pre-existing conditions. [AHCA §136.]

Premium tax credit

**ACA.** Taxpayers with household income between 100 percent and 400 percent of the federal poverty line can qualify for a refundable health insurance premium assistance tax credit. Individuals are liable to pay back any excess credit they receive over the year, although the liability for certain low-income households is limited to an applicable dollar amount. [ACA §1004(c).]

**AHCA.** Taxpayers would be liable for the full amount of excess advance payments of the premium tax credit. [AHCA §201.] The credit also would be available for catastrophic qualified health plans and plans that are not offered through the federal health insurance exchange, but otherwise meet the requirements for qualified health plans. The credit could not be used for health plans that cover abortions. [AHCA §202.]

The premium assistance tax credit would be repealed for health coverage that begins after December 31, 2019. [AHCA§203.]

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**ACA Titles Not Affected By AHCA**

Title III—Improving the Quality and Efficiency of Health Care
Title V—Health Care Workforce
Title VI—Transparency and Program Integrity
Title VII—Improving Access to Innovative Medical Therapies
Title VIII—CLASS Act
Title X—Strengthening Quality Affordable Health Care for All Americans
Small business tax credit

**ACA.** An eligible small employer may claim a tax credit for premiums it pays toward health coverage for its employees. [ACA §1421.]

**AHCA.** The small business tax credit would be modified to: (1) prohibit the credit from being used for health plans that include coverage for abortions for taxable years beginning after December 31, 2017; and (2) repeal the credit for taxable years beginning after December 31, 2019. [AHCA §204.]

Individual mandate

**ACA.** The ACA’s individual mandate provision requires taxpayers to obtain health insurance coverage with minimum essential benefits or pay a penalty (unless they received an exemption from the penalty). “Essential health benefits” include ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative services, laboratory services, preventative and wellness services, and pediatric services. [ACA §1501.]

**AHCA.** The individual mandate would be repealed effective for months beginning after December 31, 2015. [AHCA §205.]

Employer mandate

**ACA.** Applicable large employers (generally, those averaging 50 or more full-time employees) are required to offer health insurance coverage to their employees or face a penalty. [ACA §1513.]

**AHCA.** The employer mandate would be repealed effective for months beginning after December 31, 2015. [AHCA §206.]

Medical device excise tax

**ACA.** The ACA imposes a 2.3 percent excise tax on manufacturers, producers and importers of certain medical devices; in 2015, Congress enacted a two-year moratorium on the tax. [ACA §1405.]

**AHCA.** The medical device excise tax would be repealed for medical device sales in calendar years beginning after December 31, 2017. [AHCA §211.]

Net investment income tax

**ACA.** One of the revenue raisers in the ACA is a 3.8 percent tax on the net investment income of individuals, estates, and trusts with incomes above specified amounts. [ACA §1402.]

**AHCA.** The tax would be repealed. [AHCA §251.]

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Both the individual and employer mandates would be repealed.

ACA Title II—Role of Public Programs

Title II of the ACA is focused on improved access to Medicaid, additional federal funding for the Children’s Health Insurance Program, Medicaid enrollment simplification, expansion of Medicaid services, new long-term care services, changes in Medicaid prescription drug coverage, and reductions in Medicaid disproportionate share hospital payments. The AHCA would make significant changes to the Medicaid program, specifically eliminating some of the Medicaid expansion benefits to states and reducing funding to states.

Medicaid expansion

**ACA.** Hospitals can make presumptive Medicaid eligibility determinations to provide children, pregnant women, and certain other populations medical assistance during a presumptive eligibility period. [ACA §2202.] States that choose to expand their Medicaid programs could do so to include Medicaid benefits to individuals with household incomes up to 133 percent of the federal poverty level (FPL). [ACA §2001.] State Medicaid programs had the option to offer community-based attendant services and support to Medicaid beneficiaries with disabilities who would otherwise require the level of care offered in a hospital, nursing facility, intermediate care facility for the mentally retarded, or an institution for mental diseases. [ACA §2401.]
States could limit the option for a participating-provider hospital to preliminarily determine an individual’s Medicaid eligibility for purposes of providing the individual with medical assistance during a presumptive eligibility period. The legislation would lower, from 133 percent to 100 percent of the official poverty line, the minimum family-income threshold that a state may use to determine the Medicaid eligibility of children between the ages of six and 19. In addition, the bill reduces the Federal Medical Assistance Percentage (FMAP) for Medicaid home- and community-based attendant services and supports. [AHCA §111.]

Beginning in 2020, the legislation would eliminate:

- the enhanced federal funding for Medicaid services furnished to adult enrollees made newly eligible for Medicaid under the ACA; and
- the expansion of Medicaid to cover such enrollees.

However, a state Medicaid program could continue to provide coverage, with federal funding support, to people enrolled in Medicaid prior to 2020 and who do not have any break in eligibility exceeding one month. Current federal support will remain at the 2017 funding level. Any alternative benefit plan offered by a state Medicaid program would not be required to provide specified essential health benefits beginning in 2020. [AHCA §112.]

Medicaid disproportionate share hospital payments

The Medicaid DSH payment reductions would stop in fiscal year (FY) 2018 to states that did not implement Medicaid expansion under the ACA, and beginning in FY 2020 with respect to other states. [AHCA §113.]

Medicaid income eligibility for nonelderly

States are required to use modified adjusted gross income to determine Medicaid eligibility for low-income families and the newly eligible, but not for individuals who receive Medicaid because of age, disability, or need for long-term care. [ACA §2002.]

No less frequently than every six months, states would have to redetermine the eligibility of adult enrollees made newly eligible for Medicaid by the ACA. The bill would temporarily increase by 5 percent federal payments for expenditures that are attributable to meeting this requirement. In addition, the bill would increase the civil penalty for improperly filing certain Medicaid claims related to Medicaid expansion. [AHCA §116.]

ACA Title IV—Prevention of Chronic Disease and Improving Public Health

ACA Title IV contains almost 30 provisions related to disease prevention, public health services, and increasing access to preventative health care.

A Prevention and Public Health Investment Fund is established to provide an expanded and sustained national investment in prevention and public health programs to improve health and help restrain the growth in private and public sector health care costs. [ACA §4002.]

This bill would eliminate funding after FY 2018 for the Fund; funds that are unobligated at the end of FY 2018 would be rescinded. [AHCA §101.]

ACA Title IX—Revenue Provisions

ACA Title IX included several new taxes or changes in existing taxes, designed to fund a portion of the expanded health coverage provided under the law.

A 40 percent excise tax would have been imposed on health coverage providers to the extent that the aggregate value of employer-sponsored health coverage for an employee exceeds
a threshold amount. This is the tax on so-called “Cadillac” health plans. The original tax would have been imposed starting in 2018; legislation in 2015 pushed the start of the tax to 2020. [ACA §9001.]

**AHCA.** Implementation of the “Cadillac” tax would be further delayed until 2025. [AHCA §207.]

### Over-the-counter medication

**ACA.** Generally, expenses for health flexible spending accounts (FSAs) incurred for a medicine or drug are treated as a reimbursement for a medical expense only if the medicine or drug is a prescribed drug or insulin. [ACA §9003.]

**AHCA.** Under the legislation, tax-favored health savings accounts (HSAs), Archer Medical Savings Accounts (MSAs), health flexible spending arrangements (FSAs), and health reimbursement arrangements could be used to purchase over-the-counter medicine that is not prescribed by a physician. [AHCA §208.]

### Tax on HSA and Archer MSA distributions

**ACA.** The additional tax on distributions from HSAs and Archer MSAs not used for qualified medical expenses is increased to 20 percent of the amount of the distribution included in gross income. [ACA §9004.]

**AHCA.** The legislation would repeal the increase in the tax on distributions from HSAs and Archer MSAs that are not used for qualified medical expenses. It would reduce the tax on HSA distributions from 20 percent to 10 percent and reduce the tax for Archer MSAs from 20 percent to 15 percent to return the taxes to the levels that existed prior to the ACA. [AHCA §209.]

### Contributions to FSAs

**ACA.** Health FSAs offered as a part of a cafeteria plan must limit contributions through salary reductions to $2,500. [ACA §9005.]

**AHCA.** The legislation would repeal the limitation on FSA salary reduction contributions. [AHCA §210.]

### Part D subsidy

**ACA.** The rule that allows an employer, as a plan sponsor, to disregard the value of any qualified retiree prescription drug plan subsidy in calculating the employer’s business deduction for retiree prescription drug costs was repealed. [ACA §9012.]

**AHCA.** Employers who provide Medicare-eligible retirees with qualified prescription drug coverage and receive federal subsidies for prescription drug plans would be able to claim a deduction for the expenses without reducing the deduction by the amount of the subsidy. [AHCA §212.]

### Medical care deduction

**ACA.** For tax years beginning after December 31, 2012, the threshold to claim an itemized deduction for unreimbursed medical expenses is increased from 7.5 percent of adjusted gross income (AGI) to 10 percent of AGI for regular income tax purposes. [ACA §9013.]

**AHCA.** The increase in the income threshold used to determine whether an individual may claim an itemized deduction for unreimbursed medical expenses would be repealed. All taxpayers would be able to claim an itemized deduction for unreimbursed expenses medical expenses that exceed 7.5 percent of adjusted gross income. [AHCA §213.]

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<th>Individuals</th>
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<td>Mandate: Taxpayers must either maintain coverage or pay a penalty unless exempt</td>
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<td>Incentive: Beginning in 2019, taxpayers who go longer than a certain number of days in the prior 12 months without continuous coverage may be charged a penalty of a certain percentage of their premium for the first 12 months of coverage</td>
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<th>Employers</th>
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<td>Mandate: Large employers must either provide affordable, minimum value coverage or pay a penalty</td>
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Medicare tax increase

**ACA.** An additional 0.9 percent Medicare tax was imposed on the wages and self-employment income of certain high-income taxpayers received for tax years beginning after December 31, 2012. [ACA §9015.]

**AHCA.** This additional tax would be repealed. [AHCA §214.]

Tax on prescription medication

**ACA.** The law imposed an annual fee on manufacturers and importers of branded prescription drugs. [ACA §9008.]

**AHCA.** This annual fee would be repealed. [AHCA §221.]

Health insurance tax

**ACA.** Starting in 2014, health insurers that meet certain criteria must pay a fee based on the amount of health insurance premiums collected. Insurers also must annually provide a report to the Treasury Department detailing health insurance premiums collected. [ACA §9010.]

**AHCA.** This annual fee would be repealed. [AHCA §222.]

Tanning tax

**ACA.** A 10 percent excise tax is imposed on amounts paid for indoor tanning services (whether paid by insurance or otherwise) performed on or after July 1, 2010. [ACA §9017.]

**AHCA.** This tax would be repealed. [AHCA §231.]

Remuneration by insurance providers

**ACA.** The deduction for employee remuneration paid by certain health insurance providers is limited. The limitation applies to certain individuals who are paid in excess of $500,000 in tax years beginning after December 31, 2012. [ACA §9014.]

**AHCA.** The section would repeal a provision that prohibits certain health insurance providers from deducting remuneration paid to an officer, director, or employee in excess of $500,000. [AHCA §241.]

AHCA provisions unrelated to the ACA

The AHCA also included provisions unrelated to the ACA that would impact insurance coverage and the Medicaid program.

Lottery winners

A substantial part of the bill specifies how, beginning in 2020, a state must treat qualified lottery winnings and lump-sum income for purposes of determining an individual’s income-based eligibility for Medicaid.

Retroactive Medicaid coverage

Under current law, a state Medicaid program must provide coverage for up to three months prior to an individual’s application for benefits if the individual would have been eligible for benefits during that period. The bill would eliminate this requirement and, instead, specifies that coverage would begin in the month during which the individual applies for benefits.

Immigration status

The bill would allow a state to delay or deny an individual’s initial eligibility for Medicaid benefits without providing a reasonable opportunity to submit evidence of a satisfactory immigration status or pending official verification of such status. A state that elects to provide a reasonable period for an individual to provide such evidence would not receive payment for amounts expended on the individual’s medical assistance during that period.

Home equity and long-term care

In addition, the bill would disallow a state from using, for purposes of determining Medicaid eligibility for long-term care assistance, a home equity limit that exceeds the statutory minimum. [AHCA §114.]

Community health centers

The bill would amend the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)
(P.L. 114-10) to increase funding for community health centers. [AHCA §102.]

Planned Parenthood

For one year, certain federal funds would not be made available to states for payments to certain family planning providers (e.g., Planned Parenthood Federation of America). [AHCA §103.]

Cap on Medicaid spending

The bill would establish limits on federal funding for state Medicaid programs beginning in FY 2020. Specifically, the bill establishes targeted spending caps for each state, using a formula based on the state's FY 2016 medical assistance expenditures in each enrollee category:

1. the elderly;
2. the blind and disabled;
3. children;
4. adults made newly eligible for Medicaid by the ACA; and
5. all other enrollees. [AHCA §121.]

Coverage for high-risk individuals

The bill would establish the Patient and State Stability Fund to provide funding to states through 2026. The money would be used to:

1. provide financial assistance to high-risk individuals so they may enroll in health insurance;
2. stabilize health insurance premiums;
3. promote participation and increase options in the health insurance market;
4. pay providers for services; and
5. provide financial assistance to enrollees to reduce out-of-pocket costs.

To receive the funding, states must provide matching funds at a rate that grows from 7 percent in 2020 to 50 percent in 2026. [AHCA §132.]

Continuous health insurance coverage

Health insurers would be required to increase premiums by 30 percent for one year for enrollees in the individual or small group market who had a break in coverage of more than 62 days in the previous year. [AHCA §133.]

Conclusion

The AHCA was passed by the House without any report from the Congressional Budget Office (CBO) on the cost of coverage implications of the legislation, though a score on the House version will be available the week of May 22, 2017. A CBO report for the version of the AHCA that was pulled without a vote in March 2017 indicated that the legislation would reduce federal deficits by about $150 billion over 10 years, but that 14 million people would lose health coverage in 2018. By 2026, there would be 52 million uninsured people, compared to a projected 28 million people under the ACA. The AHCA as passed by the House did not repeal some of the more significant ACA insurance reforms, such as the requirement that health plans must cover preexisting conditions; guarantee availability and renewability of coverage; cover adult children up to age 26; and cap out-of-pocket expenditures. It also did not address the majority of the ACA, as summarized in the box on pg. 3, in particular with regard to Medicare payments to providers and changes in how health care professionals are trained. What the AHCA does do is set a base from which the Senate can start work. Early indications are that senators will either make changes to the AHCA or start from scratch, either of which means that sometime this summer or fall a conference committee may be established to come up with final language to change the ACA.