
Health Law Daily Wrap Up

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The American Health Care Act (AHCA) would reduce federal deficits by $337 billion over the 2017 to 2016 period, in part because 24 million people who would have been insured under the Patient Protection and Affordable Care Act (ACA) (P.L. 111-148) would be uninsured under the ACHA by 2026, the Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) predict. The CBO and the JCT determined that the AHCA would entail costs resulting from repealing changes made to the Internal Revenue Code (IRC) and the establishment of a new tax credit for health insurance. However, those costs would be more than offset by reductions in outlays for Medicaid and the elimination of subsidies for nongroup health insurance (CBO Report, March 13, 2017).

Medicaid. Under the ACA, the federal matching rate for newly eligible adults is 90 percent of medical costs. Under the AHCA, the federal matching rate for newly eligible adults enrolled beginning in 2020 will be reduced to the rate for other enrollees in the state, which ranges from 50 to 75 percent (see Republicans present health reform that is neither repeal nor replacement, March 7, 2017). Because the CBO predicts that the new legislation would cause existing nonexpansion states not to expand, five million fewer people will enroll in Medicaid annually. In addition, some existing expansion states would reduce coverage, reducing the share of the newly eligible population to 30 percent in those states by 2026. The 90 percent federal matching rate would likely apply to fewer than 5 percent of newly eligible enrollees by the end of 2024.

Per-capita caps. The AHCA would limit state reimbursement by imposing limits calculated by establishing the average per-enrollee cost of medical services for enrollees who receive full benefits in 2016, "inflating" the costs for each state by the consumer price index for medical care services (CPI-M) growth, and determining the average cost per enrollee in five specific groups: the elderly, the disabled, children, newly eligible adults, and all other adults. Medicaid per-enrollee spending is expected to grow at a faster rate (4.4 percent) than the CPI-M (3.7 percent) between 2017 and 2026. To account for this discrepancy, states will be forced to either commit additional state resources to the program, or reduce spending by cutting payments to providers and plans, eliminating optional services, restricting eligibility for enrollment, developing more efficient methods for delivering services, or a combination thereof.

Individual mandate. Eliminating the individual mandate would result in decreased coverage for Americans —many of whom are young and healthy—who are no longer concerned with facing penalties. However, the elimination would have the effect of increasing premiums, as fewer older and less healthy people would withdraw from coverage.

Although the individual mandate would be eliminated, the legislation would require insurers to impose penalties on enrollees in the nongroup or small-group markets who were uninsured for more than 63 days in the last year. The penalty would take the form of a surcharge equal to 30 percent of a person’s monthly premium for up to 12 months. The penalty would begin for those enrolling in a special enrollment period in 2018 and for all others in 2019. The CBO predicts that roughly one million people will enroll in 2018 in order to avoid the surcharge in the future, while roughly 2 million fewer people—mostly young and healthy—will enroll annually beginning in 2019 due to the need to pay the surcharge or the need to provide paperwork demonstrating prior enrollment.

Employer will also be less likely to offer coverage, since employees would not be concerned about complying with the individual mandate and may be eligible for tax credits.
Actuarial value. The ACA permits plans to carry actuarial values, which are the percentage of total costs for covered benefits that plans must pay, of 60, 70, 80, and 90 percent. The ACHA would repeal those requirements. The requirement to cover essential benefits would make it difficult for insurers to develop plans with actuarial values below 60 percent, but would likely lower the average actuarial value of plans to align with the amount of premium tax credits, thereby attracting younger, healthier adults with low out-of-pocket costs and attracting fewer older, less healthy adults. The CBO and JCT expect nongroup cost-sharing payments to increase overall as a result; repealing cost-sharing subsidies will also increase out-of-pocket costs for lower-income enrollees.

Premiums, tax credits, and subsidies. Average nongroup premiums would increase initially, but would become lower than expected under the ACA by 2026, with a single nongroup policyholder paying 10 percent less. However, age-rating rules that would allow insurers to charge older enrollees premiums five times higher than premiums for younger enrollees would result in substantially lower premiums for young adults and substantially higher premiums for older adults.

The AHCA would do away with income-based premium tax credits and subsidies and instead award refundable tax credits based on age—$4,000 for those aged 60 and above and $2,000 for those aged 30 up to 60—if their single income is below $75,000 or their joint income is below $150,000. This structure provides incentives for enrollees to choose lower-priced health plans and puts people living in high-cost areas at a price disadvantage. Tax credits for lower-income people are likely to decrease compared to current credits, while tax credits for higher-income people are likely to increase. Older people will be affected; although they may pay premiums up to five times higher than those imposed on younger people, their tax credits are only two times higher than those of younger people. Generally, subsidies would also be smaller, with the CBO predicting that subsidies in 2026 will be 50 percent of the average subsidy under current law.

Market stability. Overall, the CBO and JCT anticipate market stability, since health young adults would take advantage of government subsidies and purchase health insurance, the Patient and State Stability Fund would help stabilize premiums and reduce potential losses to insurers, and the risk adjustment program would protect insurers from high-risk loss.

Macroeconomic effects. The CBO noted that, although House rules require it to include the budgetary impact of macroeconomic effects for "major legislation" such as the AHCA, it was not practicable to do so due to "the very short time available to prepare this cost estimate."

Reaction. HHS Secretary Tom Price issued a statement opining that the CBO’s "coverage numbers defy logic." Sen. Patty Murray (D-Wash) however, said the report confirms that the legislation is "reckless" and "mean-spirited" and vowed that Democrats will not let Republicans hide from the facts.