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ACA "Repeal and Replace" Bill Merits Attention from Industry Stakeholders

Despite expected Senate revisions, the American Health Care Act poses potentially vast implications across the health care industry.

Key Points:

- The bill passed by the House would be expected to have the greatest impact on the individual insurance and Medicaid market segments, with varied levels of impact among geographic regions and demographic populations.
- The repeal or delay of certain taxes would bring relief to some life sciences manufacturers, large health insurance companies, and employers offering high-cost health insurance plans.

On May 4, 2017, the U.S. House of Representatives passed the American Health Care Act of 2017 (AHCA), taking the first concrete step in the process to repeal and replace the Affordable Care Act through a budget reconciliation bill. The AHCA, if passed by the Senate, would make major changes to provisions adopted through the Affordable Care Act, including:

- End the individual and employer mandates;
- Substantially reduce the subsidies that help low-income people buy health plans on the individual market;
- Replace the subsidies with flat tax credits linked primarily to age;
- Repeal cost-sharing reductions;
- Reduce federal funding for the ACA's Medicaid expansion, transitioning to a per-capita cap or block grant basis in 2020;
- Eliminate long-targeted taxes on the life sciences industry — the medical device excise tax and branded pharmaceuticals user fee;
- Further delay implementation of the "Cadillac tax" on high-cost employer-sponsored health plans;
- Allow states to obtain waivers to establish their own essential health benefits; and

- Permit health status rating for individuals who fail to maintain continuous coverage.

Many provisions of the ACA would remain in place, however, including guaranteed issue, guaranteed renewability, caps on out-of-pocket maximums for insurance plans and the prohibition on lifetime limits for most benefits.

The largest impact of the AHCA is expected in the individual, under-65 insurance segment, which accounts for less than 10% of total premium revenues commercial insurers receive across all age groups. Despite being the smallest business segment of most insurers, this segment has grown rapidly, both in terms of membership and premiums since 2014, due in large part to ACA provisions. The Medicaid segment also will likely experience a significant impact from the AHCA, with enrollees in expansion states likely to be the most affected. The employer-sponsored or group insurance segment likely will be mostly unaffected by the AHCA and the proposed replacement plan generally does not affect Medicare Advantage.

The House of Representatives' passage of the AHCA signals potentially vast shifts in health insurance coverage, requiring health care providers, suppliers and life science companies to monitor progress and potential changes to the legislation as it is considered in the Senate.

Commercial Insurance Market Changes

Refundable Tax Credits

Under the ACA, individuals with incomes up to 400% of the federal poverty line (FPL) are eligible for a refundable Premium Tax Credit (PTC) or an Advance Premium Tax Credit (APTC) to pay for premiums for insurance purchased through the Health Insurance Marketplace ("Marketplace") or state-run exchanges.[1] Individuals with incomes between 100%-250% of the FPL may also receive a cost-sharing reduction that decreases out-of-pocket expenses.[2] ACA tax credits are calculated using a formula tied to the costs of health plans in the specific geographic area where the recipient lives and are based on recipients' income levels.[3] As of March 2016, 9.4 million individuals with effectuated Health Insurance Marketplace coverage (about 85% of all individuals in the Marketplace) received an APTC.[4]

The AHCA would repeal these premium tax credits and replace them with a refundable, age-based advanced tax credit. The tax credit would range from US$2,000 for individuals under 30 years of age to US$4,000 for those 60 and over. Individuals earning less than US$75,000 per year (or joint filers earning less than US$150,000 annually) are fully eligible for the credit, and the credit would be reduced by US$100 for every US$1,000 in income over the cap. The AHCA's tax credits are estimated to average US$3,000 less than the ACA's tax credits and would not be tied to prices in local markets or designed to cover a specific percentage of health costs.

Age Band Rating Adjustment

Under the ACA, insurers are permitted to charge individuals different rates based on age at a ratio of no more 3 to 1 for adults.[5] The AHCA would replace the 3:1 ratio with a 5:1 ratio, allowing seniors to be charged up to 5 times the rate of their insurer's youngest insured. States would also be able to submit a waiver application to further increase this ratio, as described below. The additional ratios are expected to reduce premiums for the eligible younger population while raising premiums for the older population.

State Waivers

The AHCA would allow states to apply for waivers to increase the permitted age rating ratio above the AHCA's 5:1 ratio beginning in 2018, to specify their own essential health benefits beginning in 2020, and

to implement health status rating for individuals who fail to maintain continuous coverage beginning in 2019. A state may only implement health status rating if the state: (1) implements a program providing financial assistance to high-risk individuals without access to health insurance coverage; (2) implements a program that provides incentives to entities to enter arrangements with the state to help stabilize individual market premiums; or (3) participates in the Federal Invisible Risk Sharing Program (FIRSP), that the AHCA would create. The FIRSP, administered by the Centers for Medicare and Medicaid Services (CMS), would provide US$15 billion to health insurers between 2018 and 2026 to lower the premium costs of "eligible individuals." The CMS Administrator would establish the parameters of the program. The AHCA would appropriate an additional US$8 billion to states with health status rating waivers to reduce premium or other out-of-pocket costs for individuals with increased premiums as a result of the waiver.

To be eligible for a waiver, states must demonstrate that the waiver will assist in reducing premiums, increasing enrollment, stabilizing the state's market for health insurance, stabilizing premiums for individuals with preexisting conditions or increasing the choice of health plans in the state. All waivers will be approved within 60 days, unless the Secretary of Health and Human Services provides a basis for denial.

Effective Repeal of the Individual Mandate

Under the ACA, most individuals who do not receive minimum essential coverage from the government or through their employer are required to purchase health insurance or face a tax penalty, a requirement commonly known as the "individual mandate."[6] The AHCA would effectively repeal the individual mandate by reducing the penalty to zero, effective from December 31, 2015, to provide retroactive relief. The AHCA replaces the individual mandate with a policy that allows insurers to charge a 30% surcharge to individuals who allow their insurance to lapse and then attempt to purchase a new policy.

Other Market Changes

Under the ACA, certain employers are required to provide minimum essential coverage to their full-time employees or face penalties, a requirement commonly referred to as the "employer mandate."[7] AHCA would effectively repeal the employer mandate by reducing the penalty to zero. Like the repeal of the individual mandate, the repeal of the employer mandate would be retroactive, effective after December 31, 2015. Starting in 2018, the AHCA would also increase the permitted level of contributions to Health Savings Accounts (HSAs) and Flexible Spending Accounts (FSAs) and reduce the tax on distributions from an HSA or Archer Medical Savings Account.

In connection with coverage for those with pre-existing conditions or others seen as "high risk" enrollees, the AHCA would create a Patient and State Stability Fund. The AHCA would appropriate US$15 billion annually from 2018-2019 and US$10 billion from 2020-2026 (totaling US$100 billion) for states to use to in a variety of ways. Eligible uses would include providing financial assistance to high-risk individuals; reducing the cost of coverage to individuals with high utilization rates or with high costs of coverage due to low density population; promoting participation in the individual and small-group markets; promoting access to preventive, dental and vision services; covering maternity and newborn care; and addressing prevention, treatment or recovery services for individuals with mental or substance use disorders. The AHCA would also appropriate a one-time additional appropriation of US$15 billion in 2020 specifically for maternity coverage, newborn care and services for individuals with mental or substance abuse disorders.

Changes to the Medicaid Program

Generally, the ACA expanded Medicaid coverage for adults in participating states who earn up to 138% of the FPL.[8] In 2016, Federal funds matched 100% of Medicaid expenditures for the "expansion population" who became qualified for Medicaid through the ACA's Medicaid expansion.[9] This match will reduce to 90% in 2020 and beyond under the ACA.[10]

The AHCA would repeal the ACA's mandatory expansion of Medicaid for certain childless, non-disabled, non-elderly and non-pregnant adults who earn up to 138% of the FPL. Under the AHCA, States that participated in the Medicaid expansion would continue to receive federal funding for the expansion until January 2020 and could continue to enroll individuals who earn up to 138% of the poverty line until that date. Beginning January 1, 2020, the federal government would no longer provide Medicaid funding for individuals who become newly eligible for the expansion after that date or who are part of the expansion population and become ineligible for Medicaid one or more months after that date. States will receive the enhanced matching rate under current law for individuals enrolled in Medicaid expansion prior to December 31, 2019, provided the individuals continuously remain in the program. The AHCA would also allow states to institute work requirements for non-disabled, non-elderly, non-pregnant adults as a condition of enrollment in the Medicaid program.

Beginning in 2020, the AHCA would institute an enrollee per capita cap on federal funding to states for their Medicaid programs. The caps would apply to enrollee categories (elderly, blind and disabled, children, non-expansion adults and expansion adults) and be based on each state's spending in 2016. Caps would increase annually by the percentage increase in the medical care component of the consumer price index for all consumers. States with spending higher than their targeted aggregate amount would receive reductions to their Medicaid funding for the following fiscal year. The AHCA would also allow states the option to receive a block grant, rather than the per capita allotment, for adults and children enrolled in Medicaid. Block grants would not be available for elderly and disabled enrollees, who would continue to be funded through the per capita funding arrangement.

States that did not participate in the Medicaid expansion would be eligible under the AHCA for up to US$10 billion in aggregate additional safety net funding, from Fiscal Year 2018-2022. A state's annual allotment would be calculated based on the state's relative share of individuals who earn under 138% of the FPL, not to exceed costs for providing healthcare to Medicaid enrollees and the uninsured.

Repeal/Delay of Taxes and Fees

The AHCA would also repeal a variety of taxes and fees established by the ACA. The ACA created a new excise tax of 2.3% on the sale of certain medical devices, though later legislation enacted a two-year moratorium on collecting the tax through 2017.[11] The AHCA would repeal the tax, effective from the date on which the moratorium will end. The ACA also imposed a 40% tax on high-cost employer-sponsored health coverage, referred to colloquially as a tax on "Cadillac plans."[12] The Consolidated Appropriations Act of 2016 delayed implementation of the tax until 2020.[13] Under the AHCA, the tax would be delayed from 2020 until 2026.

The AHCA would also repeal the ACA's branded prescription drug fee, effective after December, 31 2017. Under the ACA, the Internal Revenue Service (IRS) is authorized to collect a sum from certain manufacturers of branded pharmaceuticals.[14] The ACA specifies a formula for IRS collection for a given year, which the IRS collects based on market share from manufacturers of branded prescription drugs with more than US$5 million in sales to certain government programs.[15] In 2017, the total fee is US$4 billion.[16] The AHCA would repeal the fee retroactively from the beginning of 2017.

Lastly, the ACA created a tax on net health insurance premiums for those engaged in the provision of health insurance (*e.g.*, insurers or health management organizations) with an excess of US$50 million in annual premiums.[17] The Consolidated Appropriations Act of 2016 placed a moratorium on the tax for the 2017 calendar year.[18] The AHCA would repeal this tax effective retroactively, beginning in 2017.

Industry Responses

Stakeholders in the health care industry and patient groups have published varied responses to the AHCA, with some provider and patient groups criticizing the estimated reduction in insured individuals and others supporting the bill's provisions to repeal the individual and employer mandates and eliminate taxes on life sciences companies. For instance, the American Hospital Association (AHA) and American Medical Association (AMA) have raised concerns that the AHCA would result in reduced insurance coverage and Medicaid funding, particularly with respect to states' ability to obtain waivers from certain insurance requirements.[19] The AARP generally opposes the bill based on concerns that it could increase health care costs for Americans aged 50-64, weaken Medicare's fiscal sustainability, and reduce Medicaid coverage.[20] The Association of Mature American Citizens (AMAC) has taken a different position, supporting the AHCA's expansion of Health Savings Accounts, repeal of the individual and employer mandates and the legislation's restraint in not dissolving current healthcare exchanges.[21] Other groups have remained relatively neutral. For example, America's Health Insurance Plans (AHIP), led by Marilyn Tavenner, a former CMS Administrator, reflected that the bill "includes a number of positive steps to help stabilize the market and create a bridge to a reformed market during the 2018 and 2019 transition period."

Conclusion: Market Shifts Ahead

Although the fate of the AHCA in the Senate is uncertain, its framework presents a consensus from House Republicans that would strongly shift current market trends in the individual and Medicaid insurance markets. If all or some aspects of the AHCA become law, providers, suppliers and manufacturers must continue to adjust reimbursement and commercial sales strategies to account for anticipated short-term and long-term impacts of the AHCA's staggered implementation, weighted impacts on certain demographics and the resulting market dynamics.

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Endnotes

1 26 U.S.C. § 36B.

2 42 U.S.C. § 18071.

3 26 U.S.C. §36B(b)(2).

4 Centers for Medicare and Medicaid Services, March 31, 2016 Effectuated Enrollment Snapshot, available at https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-06-30.html (last visited May 5, 2017).

5 42 U.S.C. § 300gg(a)(1)(A)(iii).

6 26 U.S.C. § 5000A.

7 26 U.S.C. § 4980H.

8 The method of calculation results in a standard of 138% of the FPL. 42 U.S.C. §§ 1396a(e)(14), 1396a(k).

9 42 U.S.C. § 1396d(y)(1)(A).

10 Id. § 1396d(y)(1)(E).

11 26 U.S.C. § 4191(a)-(c).

12 26 U.S.C. § 4980I(a).

13 Consolidated Appropriations Act of 2016, Pub. L. No. 114-113, § 101, 129 Stat. 3037 (2015).

14 Patient Protection and Affordable Care Act, Pub. L. 111-148, § 9008, 124 Stat. 859 (2010); 26 C.F.R. Part 51.

15 Id. § 9008(e).

16 Internal Revenue Service, Annual Fee on Branded Prescription Drug Manufacturers and Importers, https://www.irs.gov/businesses/corporations/annual-fee-on-branded-prescription-drug-manufacturers-and-importers.

17 This tax is imposed by § 9010 of the ACA. See also 26 C.F.R. Part 57.

18 Consolidated Appropriations Act of 2016, supra note 15, § 201.

19 See AHA, Statement on the American Health Care Act, available at http://www.aha.org/presscenter/pressrel/2017/042717-pr-ahca.shtml (last visited May 4, 2017); see AMA, Letter to Speaker Ryan and Leader Pelosi (April 27, 2017), available at https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2017-4-27%2520AMA-Letter-to-Hill-re-MacArthur-Amendment-et-al.pdf (stating that the AMA "remains opposed to passage of this legislation" after reviewing the MacArthur amendment).

20 See AARP, Letter to the House Committee on Energy and Commerce and House Committee on Ways and Means (Mar. 7, 2017), available at http://www.aarp.org/content/dam/aarp/politics/advocacy/2017/03/aarp-letter-to-congress-on-american-healthcare-act-march-07-2017.pdf (last visited Mar. 9, 2017).

21 See AMAC, Letter to House Committee on Energy and Commerce and House Committee on Ways and Means (Mar. 7, 2017), available at https://waysandmeans.house.gov/wp-content/uploads/2017/03/AMAC-Support.pdf (last visited Mar. 9, 2017).