ITUP Insure the Uninsured Project

ACA Watch

Highlighting Issues and Events Affecting Health Reform in California

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About ACA Watch

After six years of vigorous implementation of the federal Affordable Care Act (ACA), California cut the number of uninsured in the state by half and embarked on reforms and system transformations touching all aspects of the state's health care delivery system.

In the wake of the 2016 Presidential election, California's reform progress, and progress around the country, is at risk. President Trump, and Republican members of Congress now in the majority in both houses, campaigned on a platform of repealing and replacing the ACA. It is, however, far from clear what comes next.

As the federal repeal and replace debate unfolds, ITUP's ACA Watch will periodically highlight emerging federal proposals, congressional and administrative actions and potential impacts for health care and health reform in California.

Congressional Budget Office Scores the American Health Care Act

On March 13, 2017, the Congressional Budget Office (CBO), the independent, nonpartisan agency that conducts budget and economic analyses of pending legislation for federal lawmakers, released its cost estimate of the American Health Care Act (AHCA).

The AHCA is a Republican-backed two-bill package of Budget Reconciliation recommendations introduced by two House committees – Energy and Commerce, and Ways and Means. The AHCA would dismantle significant portions of the federal Affordable Care Act (ACA).

CBO found that by 2018, under the proposed AHCA, 14 million Americans would lose health coverage, growing to 24 million in 2026. ***Significantly, CBO estimates that by 2026, 52 million Americans would be uninsured, compared to 28 million in that year if the ACA remained in place.*** CBO's projection of the number of Americans who will end up uninsured exceeds the estimated 45 million Americans who were uninsured prior to the ACA.

Comparison: Number of Uninsured Americans (under 65) Affordable Care Act and the American Health Care Act (as proposed)

Year	ACA	AHCA	Increase
2017	26	31	5
2018	26	41	14*
2020	27	48	21
2026	28	52	24

Source: Congressional Budget Office, AHCA Cost Estimate
*Numbers differ due to CBO rounding.

Highlights of the AHCA

House Republicans released the AHCA on March 6, 2017, intended to deliver on the Republican pledge to "repeal and replace" the ACA. Key elements of the AHCA include:

Insurance Market

- ***Coverage Mandates***. Eliminates the ACA requirement for individuals and employers to purchase coverage (individual and employer mandates), and the penalties associated with failure to comply with the mandates, retroactive to December 31, 2015.
- ***Late Enrollment Penalty***. Starting with special enrollment in 2018, replaces the individual mandate with a late enrollment penalty (30 percent premium surcharge for up to one year) for individuals who fail to maintain "continuous coverage," meaning they have a gap in health coverage of more than 63 days in the preceding 12 months. (Special enrollment allows individuals to purchase coverage outside of the annual open enrollment period if they experience a change in life circumstances [e.g., loss of job-based coverage, divorce, a move, birth of a child, etc.])
- ***Benefits***. Maintains the requirement that health plans cover ACA essential health benefits for individual and small employer coverage, but eliminates ACA actuarial value standards. No longer requires health plans to label coverage offerings based on actuarial value (the percent of the benefits paid for by the insurer v. the consumer), often known as metal tiers, (bronze [60%], silver [70%], gold [80%] and platinum [90%]). Retains ACA limits on consumer out-of-pocket costs so that insurers could not offer products with benefits below the catastrophic coverage level in the ACA. Elimination of the metal tiers would make it more difficult for consumers to understand the level of coverage they are purchasing or to compare the relative value of different health insurance products.
- ***Changes to ACA Tax Credits***. Starting in 2018, revises eligibility for ACA premium tax credits so that the subsidies vary by age as well as income; individuals under age 30, with incomes up to 400 percent of the federal poverty level (FPL), would only have to spend up to 4.3 percent of income on health care premiums while individuals above age 59 with incomes over 300 percent FPL would have to pay up to 11.5 percent of income. Under the ACA, premium payment limits vary by income, not age, ranging from 2 percent of income for individuals under 133 percent FPL to 9.6 percent of income for individuals at 400 percent FPL. Starting in 2018, the AHCA makes tax credits available for coverage that meets specific requirements outside of exchanges. Tax credits under the ACA are only available through exchanges. Repeals the limit on amounts that low-income households (up to 400 percent FPL) must repay in the event they receive excess premium tax credits, requiring families to pay the entire amount of any excess tax credit.
- ***Premium Tax Credits (subsidies) for Individual Coverage***. Under ACA, tax credits are based on age, income, family size and geography. People who earn from 138 to 400 percent FPL are eligible for subsidies (138 percent in California because Medi-Cal eligibility extends to 138 percent FPL). In 2020, AHCA replaces ACA tax credits with new age-adjusted tax credits that do not vary by geographic region, income or premium levels. Sets maximum tax credit level at $2,000 for an individual under 30, gradually increasing up to $4,000 for individuals age 60 and over. The individual credits are additive, capped for families at $14,000 and phase out for income earners above $75,000.
- ***Cost-Sharing Reductions***. As of 2020, repeals the cost-sharing reductions that help to lower copayments and deductibles for individuals up to 250 percent FPL enrolled in silver-level coverage (70 percent actuarial value) through exchanges.
- ***Market Rules***. Maintains ACA requirements for insurers to cover all applicants regardless of health status, prohibits coverage exclusions for pre-existing conditions, and allows young adults to stay on parent policies until age 26.
- ***Age-Adjusted Rates***. Allows states to change the ratio for health care premiums between the youngest and oldest adults to 5:1 instead of the 3:1 ratio in the ACA.

Medicaid

- ***Medicaid Eligibility***. Reduces the federal Medicaid matching rate for adults newly eligible under the ACA beginning in 2020. Continues the higher rate for non-pregnant, childless adults enrolled as of the end of 2019 who do not experience a break in coverage of more than one month.
- ***Medicaid Cap***. Beginning in 2020, establishes Medicaid funding levels for states using a "per capita cap" model where states receive a fixed amount per enrollee. A specific state's funding level would be

determined based on 2016 state funding for each type of enrollee (e.g., elderly, disabled, children, adult, etc.) adjusted in subsequent years by the consumer price index medical component.

- ***Medicaid Program Changes.*** Makes a series of other changes to the Medicaid program including: (1) eliminates the requirement for state Medicaid programs to cover the same ACA essential health benefits required for individual and small employer health insurance; (2) requires Medicaid eligibility redeterminations every six months for adults eligible through the expansion, which results in individuals no longer eligible losing coverage, but can also cause a loss of coverage for eligible recipients who miss deadlines or fail to complete the necessary paperwork; and (3) increases the documentation requirements for citizens and legal immigrants to provide proof of citizenship or lawful presence before obtaining coverage.
- ***Reproductive Services.*** Expands the current limitation against the use of federal funds for abortions with a one-year moratorium on providing federal funds to nonprofit community providers that perform abortions. Prohibits the use of tax credits, or the offering of a health insurance product through exchanges, if the product covers abortions.

Taxes

- ***ACA Revenues***. Repeals ACA taxes, including tax penalties associated with the individual and employer mandates; additional Medicare payroll taxes on high-wage individuals; taxes on health insurers, pharmaceutical manufacturers and medical devices; and delays the so-called “Cadillac tax” on high-end employer-sponsored health plans until 2025.
- ***Health Savings Accounts (HSAs)***. Increases the annual limit on Health Savings Account (HSA) contributions and allows individuals to contribute to an HSA any portion of the new tax credits that they do not spend on premiums.

Federal Funds

- ***Patient and State Stability Fund.*** Establishes a $100 billion fund available to states starting in 2018 thru 2026. States must apply for the funds which will be allocated to states by formula for a variety of purposes including, among other possible uses, financial assistance to high-risk individuals, reinsurance, promoting health insurance participation and assistance to reduce out-of-pocket costs for individuals.
- ***Safety Net Providers.*** Increases federal funding for safety net providers: (1) restores ACA reductions in Medicaid Disproportionate Share Hospital (DSH) funding for expansion states in 2020 and for states that did not expand Medicaid under the ACA in 2018 and (2) increases by $422 million grant funds available for federally qualified health centers (FQHCs).

CBO found that by 2026 the Republican plan would reduce federal deficits by $337 billion, primarily because of the significant cuts to Medicaid ($880 billion) and reductions in the amount of tax credits and subsidies available to low-income individuals (decreasing from $673 billion to $361 billion).

How AHCA Would Increase the Number of Uninsured

By 2026, CBO estimates that the number of Americans losing coverage under AHCA would grow to 24 million (includes 14 million fewer Medicaid enrollees), in large part because of the elimination of the ACA enhanced federal match for new populations in Medicaid, the Medicaid per capita cap, and reductions in the amount of tax credits and subsidies that will be available to purchase individual coverage.

CBO estimates that once the individual mandate ends, many people would decide not to purchase coverage, especially comparatively healthy people. Others would drop or choose not to purchase coverage because of increased premium costs. CBO estimates that the AHCA would increase premiums for individual coverage prior to 2020, averaging 15-20 percent increases in 2018 and 2019.

CBO determined that the increase in average premiums from repealing the mandate would eventually be offset by other features of the AHCA, including: state grants under the Patient and State Stability Fund (assuming states use the funds to offset impacts of enrollees with very high costs), declines in the value of coverage products from repeal of the ACA actuarial value standards and a younger mix of enrollees. According to CBO, by 2026, average health insurance premiums would be roughly 10 percent lower than under current law. Average premiums would go down but the average value of health insurance products (portion of benefit costs covered by the policy) would also decline.

CBO found increases in the uninsured between 2018 and 2026 from changes in subsidies available and the major changes proposed for the Medicaid program. CBO anticipates that some states would lower Medicaid eligibility levels

given the proposed cap on Medicaid funding and the amount states could spend per enrollee would also be subject to the per capita cap. CBO estimates that every year after 2026, the number of people enrolled in Medicaid would drop by 5 million per year.

Importantly, CBO notes that while average premiums would increase prior to 2020 and decrease starting in 2020, the impact would vary for people of different ages. If states allow insurers to charge five times more for older enrollees than younger ones, instead of the ACA ratio of 3-1, the AHCA would have the effect of substantially reducing premiums for young adults and substantially raising premiums for older people.

What AHCA Means for California's Uninsured Rate

Among states, California has the most to lose from rollbacks of the ACA because the state fully embraced reform and had the largest reduction in the uninsured of any state.

California's uninsured rate steadily dropped following the state's implementation of the ACA in 2014. In 2013, California's uninsured rate was 17 percent. In 2016, California's uninsured rate reached a historic low of 7.1 percent, based on estimates from the National Health Interview Survey. There are currently less than 3 million uninsured Californians.

California's progress in covering the uninsured included more than 3.9 million adults who gained coverage under the ACA Medicaid expansion and more than 1.4 million Californians who enrolled in Covered California. In addition, the number of Californians enrolled in the state's Medicaid program, Medi-Cal, overall grew to more than 14 million in response to the state's robust ACA enrollment and outreach efforts and simplifications in the Medi-Cal application process.

The eventual impact on California's uninsured rate will depend on the final provisions of the AHCA, or any measure to modify or repeal the ACA. Changes most likely to affect the number of uninsured are the insurance market rules, tax credits for low-income families and changes in Medicaid eligibility and funding. The impact on the uninsured will also depend on the flexibility states have and the policy choices California makes if it has to respond to a seismic shift in the federal landscape.

By 2026, CBO estimates 52 million uninsured Americans under the AHCA, almost twice as many uninsured when compared to 28 million if the ACA remained in place. As a result of the AHCA, the CBO analysis suggests that California can expect to once again be faced with as many as 5-7 million uninsured residents. This would be a devastating blow to individuals and families in the state, potentially erasing the gains in coverage of the past four years.

ITUP will continue to monitor federal developments closely. Stay tuned for future issues of ACA Watch which will highlight specific issues and challenges arising from federal efforts to repeal and / or replace the Affordable Care Act.

Insure the Uninsured Project (ITUP) is a nonprofit, 501(c)(3) organization, founded in 1996, based in Sacramento, California. ITUP's mission is to advance creative and workable policy solutions that expand health care access and improve the health of Californians. ITUP conducts policy-focused research and convenes broad-based stakeholders on health policy topics, acting as an honest broker among diverse health care leaders in the state. To assist with implementation of health reform in California, ITUP hosts an annual statewide conference in Sacramento and facilitates regional and statewide workgroups on topics affecting health and health care in the state.

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