American Health Care Act — Potential Financial Impacts

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Topics

- Brief ACA Primer
- Key ACA Developments Since Enactment
- The AHCA
- The Senate
- Trump Budget
- Fundamental Issues
The ACA

- Major focus is reducing uninsured
- CBO estimated by 2019 would reduce uninsured by 32 million, leaving 23 million uninsured
- About half of uninsured reduction anticipated due to Medicaid expansion and half due to insurance reforms
- Fully effective Jan. 1, 2014
Insurance Reform — Key Elements

- Health Insurance Exchanges
- Essential Health Benefits
- Eliminates Underwriting Based on Medical History
- Individual Mandate
- Employer “Mandate”
- Children Under 26 on Parents’ Policy
- Premium Tax Credit Based on Income
Insurance Reform — Key Elements (cont.)

- Premium Tax Credit based on income
  - Available from 100% – 400% of FPL
  - $24,300 – $97,200 for family of four
  - 2017 Amount is premium for benchmark plan above 2.04 – 9.69% of income

- Cost Sharing Reduction Payments
  - 100% to 250% of FPL
  - Limits cost sharing to $2,350 – $5,700 for an individual, or $4,700 – $11,400 for a family in 2017, depending on income
  - Silver Plan only
Insurance Reform — Key Elements (cont.)

- Limits annual cost sharing based on HSA limits
- Eliminate Lifetime and Annual Limits on EHBs
- Pricing factors limited to:
  - Geography
  - Age (1:3 maximum variation)
  - Tobacco use (1.5:1 maximum ratio)
- Risk Corridor Payments
Medicaid Reform

- States required to expand eligibility
  - Adults under age 65 under 138% of FPL
  - Children ages 6 to 19 under 138% of FPL
- Enhanced FMAP for expansion population
  - 100% 2014-2016
  - 95%  2017
  - 94%  2018
  - 93%  2019
  - 90%  2020 and after
Key Developments

- **Supreme Court:**
  - Upholds the individual mandate
  - Holds that the mandatory expansion of Medicaid is unconstitutional
- 31 states and DC expanded
- 20 states did not expand
- Studies show coverage, access, health and economic benefits in states that expanded
King v. Burwell

Supreme Court upholds premium tax credits for the 39 states under the federal exchange
House of Representatives v. Price

- DC District Court held in 2016 that payment of the cost sharing reduction (CSR) subsidies is invalid because Congress did not appropriate the funds
- DC Circuit stayed ruling pending resolution of appeal
- On May 22 parties asked for 90-day stay of proceedings to see if Congress can work something out
- $9 billion of CSR payments in 2017
Risk Corridor Litigation

- Insurers with gains to pay into pool
- Insurers with losses to get additional payments to partially offset losses
- GOP-controlled Congress, after enactment of ACA, limited payments to amount in pool
- Result is that only a fraction of payments were made; billions of dollars at issue
- Multiple cases filed; Court of Claims finds in favor of Oregon-based Moda Health ($214 million)
Impact on Premiums

- 25% average increase in premiums of benchmark plans for 39 states on federal exchange in 2017
- 13.2% average increase in California in 2017
- 2008-16, average increase in all premiums of 43%
- 2000-2008 average increase of 97%
- Premium increases largely offset by increase in premium tax credits — most of increase borne by federal government
Impact on Premiums

- HHS reports individual market average increase for states on federal exchange from 2013 – 2017 of 105%
  - Criticized for “apples to oranges” comparison
- Anticipate large premium increases in 2018 for exchange plans
Insurance Company Participation

- Multiple plans available in most locations
- However, some areas have only one or two choices
- Aetna and Humana have announce they will not participate in 2018
- Example, Kansas City BCBS announced it will exit individual market in 2018 leaving only 10 of 115 Missouri counties with more than one plan
- California continues to have multiple insurance companies participating
Impact on Number of Uninsured

- Nationally, rate of uninsured declined from 16% – 9% from 2013 – 2015
- In California, rate declined from 17.2% in 2013 to 7.4% in 2016
  - About 3.8 million newly eligible Medi-Cal enrollees
  - About 1.57 million have coverage through Covered California
Reasons For Premium Increases and Insurer Exits

- CSR payment uncertainty
- Repeal and replace uncertainty
- Uncertainty concerning enforcement of individual mandate
- Pool becoming more costly
- Failure of ACA programs to mitigate risk
- Failure to support enrollment on federal exchange through advertising
Approval of Affordable Care Act Tops Previous High of 48%

Do you generally approve or disapprove of the 2010 Affordable Care Act, signed into law by President Obama that restructured the U.S. healthcare system?

% Approve  % Disapprove

Democrats Split on Making Changes to ACA; Republicans Favor Repeal

Would you rather keep the ACA in place largely as it is, keep the ACA in place but make significant changes to it, or repeal the ACA and replace it with a new healthcare plan?

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GALLUP

Phase 1: Repeal and Replace the ACA through Budget Reconciliation; this is what the AHCA would do

Phase 2: Administrative Changes through the Department of Health and Human Services (HHS) on Insurance Reforms and Market Stabilization

Phase 3: Follow-up Health Care Legislation to Support Replacement Plan
AHCA Insurance Provisions

- Removes penalties for individual and employer mandates effective Jan. 1, 2016
  - Replaces with 30% premium penalty if lapse in coverage
- Tax penalty for large employers not providing health benefits reduced to zero retroactive to Jan. 1, 2016
- Removes requirement that insurers in nongroup market must offer plans that cover at least 60% of cost of covered benefits
AHCA Tax Credits

- Effective 2020 replaces ACA premium tax credits with age-based credits:
  - $2000 per individual up to age 29
  - $2500 per individual age 30-39
  - $3000 per individual age 40-49
  - $3500 per individual age 40-59
  - $4000 per individual age 60 and older
- Family can claim 5 oldest members; $14,000 annual limit per family
- Increase by CPI plus 1%
- Tax credits phased out based on income
- Can be used to purchase any Exchange policy
AHCA Features

- CSR payments repealed Jan. 1, 2020
- Permitted pricing ratio based on age increased from 1:3 to 1:5
- Maintain guarantee issue requirement
- Prohibits pre-existing exclusion periods
- But, can take health status into account if state obtains waiver
- Dependent coverage up to age 26 retained
AHCA Insurance Waivers

- States may obtain waiver to allow health status to be taken into account in pricing if:
  - State uses Patient and State Stability Fund grant for high risk pools or reinsurance, or
  - Participate in Invisible Risk Sharing Program (federal reinsurance for high risk individuals; funded at $15 billion for 2018-2026)
Benefits

- Retains essential health benefit requirement for credible coverage
- Starting 2020, states may seek waivers to redefine required benefits
- Retains annual and lifetime limit prohibitions as to essential health benefits
- Abortion coverage may not be required
  - Tax credits cannot be applied to plan offering abortion coverage
High Risk Funding

- **Patient and State Stability Fund**
  - $115 B over 9 years available to all states
  - $8 B over 5 years for states electing community rating waivers
  - Provide financial help to high risk individuals (state high risk pools), promote access to preventive services, cost sharing subsidies

- **Federal Invisible Risk Sharing Program**
  - $15 B in 2018-26 for reinsurance
AHCA Medicaid Provisions

- Per Capita Caps
- Block Grants
- Expansion Population
Per Capita Caps

- Beginning 2020, federal payments limited to a fixed amount per beneficiary
- Separately computed for 5 enrollee categories
- 2016 base year payments adjusted to 2019 based on medical component of CPI
- Annual inflation adjustment
- Non-DSH supplement payments (like HQAF) are factored in
- No adjustment for technology changes or other factors
Block Grant Option

- States may elect block grants rather than per capita caps
- 10 fiscal years beginning 2020
- Limited to (a) children and nonexpansion adults, or (b) nonexpansion adults only
- States can set conditions on eligibility
- Must provide hospital care, surgical care, obstetrical and prenatal care, prescribed drugs, medications and prosthetic devices, and certain other services
Block Grant (cont.)

- States determine cost sharing and delivery system
- Federal free choice of provider, statewideness, amount, duration and scope of services requirements do not apply
- Amount is based on the per capita calculation for state for FY 2019 adjusted based on urban CPI
- Unused amounts may be rolled over
- Independent audits of each state
- States must submit plans to Secretary of HHS, deemed approved unless Secretary determines plan is incomplete or actuarially unsound within 30 days
Expansion Population

- States that have not expanded may not expand effective 12/31/17
- Enhanced FMAP limited to states that expanded as of 3/1/17
- Enhance FMAP sunsets 1/1/2020, except for “grandfathered enrollees”
- Grandfathered enrollees are individuals enrolled through Medicaid expansion as of 12/31/19 who do not have a break in eligibility of more than one month
Other Changes

- Eligibility redetermination required every 6 months for expansion enrollees
- Eliminates hospital presumptive eligibility provisions and presumptive eligibility for expansion adults effective 1/1/2020
- Creates state option to require work as a condition of eligibility for nondisabled, nonelderly, nonpregnant Medicaid enrollees as of 10/1/17
- Repeals increase in minimum Medicaid eligibility from 100% to 138% of FPL for children ages 6-19 effective 12/31/19
Other Changes (cont.)

- Eliminates 3-month retroactive coverage requirement — eligibility would begin in month of application
- Prohibits Medicaid funding for Planned Parenthood for one year
- Eliminates Medicaid DSH cuts for FYs 2020-2025
Revenue Changes

- Eliminates most ACA revenue provisions
  - Individual mandate penalty
  - Large employer penalty
  - Surcharge on high income taxpayers’ net investment income
  - Annual fee on health insurance providers
  - Increase in Medicare tax for high-income taxpayers
  - Delays “Cadillac tax” on high end health insurance plans
CBO Cost Estimate

- Reduce deficit by $119 B over 2017-2026
- Increase uninsured by 23 million over prior law by 2026
CBO — Budget Impacts (2017-26)

- Reductions in expenditures
  - Medicaid
    - $834 billion
  - Tax credits and coverage provisions
    - $276 billion
  - Total
    - $1,111 billion
Decreases in revenue/increases in expenditures
  - Spending to reduce premiums
    - $117 billion
  - Reduced collections of penalties
    - $210 billion
  - Repeal or delay of taxes in high-income people, manufacturer fees, excise taxes, and modification of tax preferences for medical care
    - $664 billion
  - Total — $992 billion
Projects uninsured will increase by 14 million in 2018 rising to 23 million in 2026 as compared to current law

2026 — 51 million uninsured compared to 28 million under current law

Projects coverage decreases to affect all income levels and age groups, with most significant impacts on older people with lower income
Projects 14 million reduction in Medicaid enrollees by 2026 (17%) relative to current law

Projects 8 million in 2018, 10 million in 2020, and 6 million in 2026 fewer people would have insurance through nongroup market than under current law
CBO — Impact on Premiums (non-group market)

- Gross premiums decline for younger and increase for older individuals
- Net premiums increase substantially for older low-income individuals
- Net premiums decline for younger higher income individuals

See Table 5 of CBO Report (handout)
Impact on Medi-Cal per DHCS

- Reduction in federal payments of $6 billion in 2020 growing to $24.3 billion in 2027
- Per capita limit impact of $680 million in 2020 increasing to $5.3 billion in 2027
- Reduced FMAP for non-grandfathered expansion population — impact of $4.8 billion in 2020 growing to $18.6 billion in 2027
The Senate

- Will not pass the AHCA
- Likely (?) will advance a bill that includes some of the AHCA elements, but with substantial changes
- Will only include items affecting budget (the Byrd rule) to require only 50 votes
- Likely to be more moderate than AHCA
- But, will then need to get 216 House votes (AHCA passed 217-213)
Lindsay Graham: “Any bill that has been posted less than 24 hours, going to be debated 3 or 4 hours, not scored? Needs to be viewed with suspicion.”

Lamar Alexandar: “We’re writing a Senate bill and not passing the House bill. We’ll take whatever good ideas we find there that meet our goals.”
The Senate (cont.)

- Anticipate this will take a while.
- Lamar Alexandar: “There will be no artificial deadlines in the Senate. We’ll move with a sense of urgency but we won’t stop until we think we have it right.”
- John Cronyn: “When we have 51 senators, we’ll vote,” he said. “Not until then.”
The Senate (cont.)

- 12-member working group of GOP senators has been formed including moderates and conservatives
- Can only lose 2 Republican votes, and there are 3 very conservative members (Rand Paul, Mike Lee and Ted Cruz), as well as a number of moderates
- How open will the process be?
  - Committee hearings?
  - Wait for CBO score to vote?
Some likely issues:

- Relaxation of pre-existing condition ban
- Perhaps additional funding for high risk states that seek waivers above AHCA levels
- Pace and extent of Medicaid expansion phase-out (GOP governors in expansion states)
- Defunding Planned Parenthood (at least two GOP senators oppose)
- Aligning tax credits more with income
Trump 2018 Budget

- OMB estimates would balance budget in 10 years
- Rosy scenario — assumes 3% annual growth rate in economy
- Fuzzy math — may count 3% twice
Trump Budget (cont.)

- $1.7 trillion cut to mandatory spending
- $1.8 trillion cut to discretionary spending
- Largest mandatory spending reduction is to Medicaid — $616 billion
- Combined with additional Medicaid reduction under the AHCA could exceed $1.2 trillion
- Provides CHIP funding for 2018 and 2019
  - Would eliminate enhanced CHIP match
  - Cap eligibility at 250% of FPL
  - Reduce CHIP spending by $5.8 billion
$250 billion in net deficit savings over 10 years from repealing and replacing the ACA
- $1.25 trillion in reduction to Medicaid, and ACA payments (premium tax credits, CSR subsidies, reinsurance and risk adjustment payments, small business health insurance tax credits)
- Offsetting $1 trillion revenue loss
- Note CBO scores AHCA deficit reduction at $119 billion
Trump Budget (cont.)

- Most discretionary health spending cut
  - E.g., CDC, NIH, SAMHSA, HRSA
- Office of Medicare Hearing and Appeals budget increased
- Defense increased by 10.8%, VA and Homeland Security also increased
- Most other departments cut
- 17% overall cut in funding for research
- No cuts to Medicare or Social Security
Fundamental Issues

- Should healthier, younger individuals subsidize health care for others?
- If yes, how? Through a mandate to buy insurance?
- If not, what do you do about unaffordable premiums?
- Do you take high risk people out of pool to reduce premiums?
- If so, are we willing to adequately subsidize premiums through the federal government?
Fundamental Issues (cont.)

- Is universal coverage an important objective?
- Should the federal government mandate a minimum benefit package?
- Should people be allowed to buy crummy coverage if it can be sold at low cost?
- Are high risk pools a reasonable alternative to a ban on medical underwriting?
Fundamental Issues (cont.)

- Should the feds continue to pay for expanded Medicaid?
- What is the alternative for people who will lose Medicaid due to enhanced FMAP phase-out?
- Was the ACA shift of wealth from well off to low-income individuals a good idea?
- Is the AHCA’s shift of wealth for low-income individuals to the well off a good idea?
Fundamental Issues (cont.)

- Could our health care financing system be more complicated?
- Should we just start over?
Questions?
Thank you

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