



Obamacare 2009-2016: A retrospective

In the early part of 2016, Drs. Bernardy, Berkenblit and Pyatt, as members of the ACR Managed Care Committee were charged with producing a document that would detail what led to the Affordable Care Act (ACA, “Obamacare”), what its impact on the insurance industry was and what would the new administration (at the time of the assignment the election had not yet happened) do with what was in place at the end of the Obama administration.

The following piece was written for this assignment.

While the Trump administration has tried a number of versions to “repeal and replace” “Obamacare”, as of yet no new legislation has replaced the ACA.

This piece acts as a historical perspective of what led to the ACA and how it fared.

Healthcare legislation is indeed complex and ever changing. We hope this document will enable the reader to have an overview of the ups and downs of Obamacare, keeping in mind that the project was written in 2016/early 2017 as the Obama administration was winding down, the election outcomes were uncertain and as the Trump administration just started.

Introduction-Learning objectives

The goal of this project is to assess the current (as of early 2017) state of the health insurance market in the US. We start by reviewing the reasons to create the Affordable Care Act, the provisions of the ACA, and the affects the ACA has had on the private insurance market. As the new administration promised, there will be substantial changes to the ACA, repeal, reform, or repair. The political and regulatory process will take months and years to play out, but we will discuss, even forecast, what we think may happen. Given that Healthcare is 17% of our economy, and perhaps the most regulated of our industries, we all can appreciate the immense complexity of this process.

The Promise of The Affordable Care Act (ACA) or Obamacare

Why Does the Health Insurance Industry Need ACA Reforms?

- A PBS report stated that 44 million Americans are currently Without Health Insurance. Part of this is due to the extraordinary costs of quality health insurance in the US. HealthCare reform ensures these Americans have access to health care.

- The Medicare part D prescription drug “donut hole” coverage gap was leaving seniors unable to afford their medication or paying out of pocket. The ACA closes the donut hole.
- Government funding for private Medicare Advantage plans costs the taxpayer money; it was supposed to save the taxpayer money when going on the private market. Obama’s Health Care Reform reigns in wasteful spending.
- Insurance companies could deny you for pre-existing conditions or drop you when you got sick. After 2014 you can no longer be denied coverage or treatment based on health status.
- Insurance companies could drop you for being sick or stop treating you when you reached annual or lifetime limits. Over 60% of bankruptcies were related to medical costs even though many of those bankrupted had insurance. The issue was that lifetime and annual dollar limits didn’t cover expensive treatments. The only reason you can be dropped on new ACA protected health plans is for fraud. Lifetime and annual dollar limits are on their way out.
- Insurance companies had no limits on raising your premiums. The rate review provision protects you against unjustified rate hikes. So far the program has curbed the rising cost of employer-based premiums and reduced premiums for many Americans due to the new State-based health insurance marketplaces.
- Millions of people are too poor to afford health insurance, yet make too much to qualify for Medicaid. The ACA expanded Medicaid and CHIP (Children’s Health Insurance Program) to over 15 million men, women, and children who fell through the cracks in states that chose to opt-in. Many State’s chose to opt-out of expanding Medicaid coverage.
- Before the ACA, preventative measures and wellness visits were not covered adequately. All New Plans require essential health benefits and preventive services to be covered with no out-of-pocket costs.
- Small businesses have historically had an increasingly difficult time offering health benefits due to cost. The SHOP marketplaces offer tax breaks of up to 50% of employers share of employee premium costs.
- Some of America’s largest firms do not offer health benefits. The 2015 employer mandate ensures full-time workers at large companies have access to health benefits. Small firms are exempted (1).

During the first two years of the Obama administration, legislation to fundamentally reform the US Healthcare System was proposed. It was promoted as making care more affordable and fairer.

Political sound bites from proponents of the ACA were; “if you like your insurance, you can keep it”; “if you like your doctor, you can keep him/her”; “the average family will save \$2500/year in costs”; “the individual mandate is not a tax”. These all turned out to be untrue. A more (politically) insightful comment was “I’d like a single payer system, but I can’t get there” (2).

The bill was passed despite a majority of Americans in opposition. The legislation lacked bipartisan support, no Republicans voted for it. Much of it was done through the “budget reconciliation” process. On March 23, 2010, President Obama signed the Affordable Care Act.

The key features were;

Improving Quality and Lowering Health Care Costs

- *Free preventive care*
- *Prescription discounts for seniors*
- *Protection against health care fraud*
- *Small Business Tax Credits*

New Consumer Protections

- *Pre-existing conditions*
- *Consumer Assistance*

Access to Health Care

- *Health Insurance Marketplace.*

Benefits for Women

- *Providing insurance options*
- *Covering preventive services*
- *Lowering costs*

Young Adult Coverage

- *Coverage available to children up to age 26*

Strengthening Medicare

- *Yearly Wellness Visit*
- *Many Free Preventive Services for some seniors with Medicare*

Holding Insurance Companies Accountable

- *Insurers must justify any premium increase of 10% or more before the rate takes effect (3)*

The Promise of the ACA- The implementation

The provisions were implemented over time.

2010: A new [*Patient's Bill of Rights*](#) goes into effect, protecting consumers from the worst abuses of the insurance industry. Cost-free [*preventive services*](#) begin for many Americans.

2011: People with Medicare can get key preventive services for free, and also receive a 50% discount on brand-name drugs in the Medicare “donut hole.”

2012: Accountable Care Organizations and other programs help doctors and health care providers work together to deliver better care.

2013: Open enrollment in the Health Insurance Marketplace begins on October 1st.

2014: All Americans will have access to affordable health insurance options. The Marketplace allows individuals and small businesses to compare health plans on a level playing field. Middle and low-income families will get tax credits that cover a significant portion of the cost of coverage. And the Medicaid program will be expanded to cover more low-income Americans. All together, these reforms mean that millions of people who were previously uninsured will gain coverage, thanks to the Affordable Care Act (3).

(See Appendix 1 for more detail)

The Promise of the ACA- The Challenges

There have been many challenges to the ACA, legal and otherwise.

Medicaid expansion-The law expands Medicaid. The threshold for Medicaid eligibility and ACA eligibility differ, and there is a gap, where some make too much to qualify for Medicaid, but not enough to qualify for subsidies under the ACA. In Georgia, this may be as many as 400,000 people.

Medicaid is an 80/20 program. 80% of the funding comes from the federal government, 20% from each state. The law increases the federal contribution to 90% for these “gap” patients.

The supreme court ruled against the ACA, in that expansion of Medicaid is optional for the states. To date, 31 states and the District of Columbia have expanded Medicaid. 19 states have not. These 19 states have Republican controlled state governments and are all required to maintain a balanced budget.

The individual mandate- 26 states held that the federal government could not compel individuals to purchase a commercial product (an ACA health insurance policy). The administration promoted the ACA individual mandate as a penalty, levied against those who chose not to participate. They argued publicly that this was not a tax. However, before the court, they argued the mandate was a tax, and the court upheld the law. Later, made famous by MIT professor and ACA architect Jonathan Gruber, the subterfuge by the administration was made plain (4).

Subsidies-there are ongoing challenges to subsidies that attract many to the marketplace. There are conflicting rulings in lower courts, and the Supreme Court ruled in 2105 to uphold subsidies

in states where the federal government runs the exchanges. In other states, there is still a question.

Religious organizations-Fundamentally Christian organizations, such as Hobby Lobby, sued the ACA, objecting to provisions that demanded they pay for contraception, and were upheld.

The exchanges were expensive, subsidized by the federal government for billions of dollars, and an initial catastrophic failure. Most state exchanges are now run by the federal government.

What has happened in the last 8 years?

The Results of the ACA

The Good

Perhaps as many as 20 million people that previously lacked insurance are now insured. These newly insured now fall into two main groups, those through the exchanges, of which up to 87% are heavily subsidized, and those who gain coverage by Medicaid expansion. Another group, perhaps as many as 3 million, gained coverage through expanding coverage to age 26 for dependents.

Increases in healthcare spending have declined to ~3%/year from 2010-2015, 5+% for the previous 10 years. While most of this is attributed to the recession, the contribution of the ACA is unknown.

Some measurements of healthcare quality have improved. Declines in 30-day readmission rates and Hospital acquired conditions have been documented, again, the exact contribution of the ACA is unknown.

Reform of healthcare delivery systems is underway. Many ACO's have formed. Most have failed to show savings, but some have, led by Montefiore, in Bronx NY.

Payment reforms, paying physicians for value rather than volume are being formulated and implemented. Their implications for cost and quality are yet to be assessed (5, 6).

The Bad

Health Insurance premiums continue to skyrocket. Premiums are expected to go up by an average of 22%, with some states over 100%. Co pays and deductibles are going up. Choice of providers is restricted.

For example, consider an exchange enrollee in Phoenix. Before the health law took effect, the median-priced plan for a 30-year-old nonsmoker cost a little over \$1,000 a year and came with a \$5,000 deductible.

In 2017, the cheapest exchange plan available in Phoenix was slated to cost \$4,748.40 a year and comes with a \$6,800 deductible. Even worse, it's an HMO policy — so it restricts patients to a narrow network of doctors and hospitals. Any care sought outside of the network must be paid for out-of-pocket, and that money doesn't count towards the plan's deductible

This triple-whammy of higher premiums, higher deductibles, and narrow provider networks is a function of Obamacare's onerous insurance mandates. The health law prohibits insurers from turning away patients based on their health status. It also puts strict limits on how much coverage providers can raise prices for older, sicker patients.

At the same time, Obamacare demands that all exchange plans cover a host of treatments and services, from pediatric dental care to speech-language pathology. In the face of such mandates, higher premiums, higher deductibles, and restrictive provider networks are among the only options available for insurers to keep costs down (7).

Health insurers are suffering huge losses and abandoning the exchanges. United Healthcare (UHC) is abandoning most states and is, now only in three states.

Thirteen of Obamacare's 23 state-sponsored CO-OP health plans have failed. Consequently, no less than 740,000 people have had to scramble to find new coverage.

People in Alabama and Alaska had access to at least seven insurers before Obamacare. Next year, they will have just one. The same will happen for those living in many parts of Arizona, Kentucky, Mississippi, Oklahoma, Georgia, and Tennessee (8).

In surveys (NPR and Harvard) of Americans, most thought individuals were more harmed than helped by the ACA, and strongly believed the cost of healthcare was much worse (9).

Impact of the ACA on the private insurance market

One of the Affordable Care Act's (ACA) main goals was to have a greater number of people insured. This sounds like a modest and noble plan. However, 6 plus years later, we see insurance plans exiting the exchanges as they try to escape the hardship on their bottom line.

Since its passage in 2010 the ACA has brought health insurance to about 20 million people who previously lacked coverage (10). This pushed the uninsured rate in the U.S. to a record low (10).

However, there was a problem. Customers in the ACA exchanges have turned out to be costlier to insure than expected. Reasons for this include sicker people choosing to buy coverage or because people buying plans in the ACA's early years had lots of deferred medical needs to treat once they got covered. Insurers have also said some people are buying insurance, using lots of care and then dropping coverage mid-year (11). Basically, the exchange market is proving to be smaller and riskier than insurance giants like United Healthcare (UHC) had expected (11).

In March of 2016 Blue Cross Blue Shield (BCBS) released a report indicating new members who enrolled in individual plans used more medical services and accounted for health care spending 22% higher than people with employer-based insurance in 2015 (12).

Inherent to the ACA exchanges is the fact that health status information cannot be used to set the price of insurance products or to determine the kind of coverage offered to consumers. Guaranteed issue makes insurance available to everyone regardless of pre-existing conditions, however, it also drives up premiums unless the exchanges can attract younger, healthier customers (13).

Near the end of 2016, UHC officials said they expect to suffer a combined \$1B in losses for 2015 and 2016 in the exchanges. They said the losses are partly due to the higher risk associated with customers on the exchanges that has resulted in higher than expected claims (14).

A report by BCBS found that new enrollees in individual health plans in 2014 and 2015 had higher rates of hypertension, coronary artery disease, diabetes, hepatitis C, HIV and depression than those enrolled before the ACA was enacted (14).

The ACA has essentially funneled older and sicker customers to the exchanges, leaving younger, healthier patients out. One component of the ACA allows children to remain on their parent's health plans until age 26 thereby excluding a younger and, in general, healthier portion of the population from signing up for their own coverage (14).

Others have found the penalties under the ACA for not enrolling far less expensive than paying premiums and the younger, healthier customers are betting they won't need major medical treatment (14).

UHC is the biggest health care insurance provider in the country covering approximately 70 million people. In 2014 UHC lost \$425M in the ACA exchanges (15). UHC had lost \$475M in 2015 and stated they were on target to lose \$650 in 2016 (16). Aetna, Anthem and Humana were on track to lose at least \$300M each on their ACA plans in 2016 (10).

From another point of view, the ACA is a double-edged sword. On the one hand, it has contributed to a decrease in profit margins across the industry: in order to be 'affordable', insurers must now spend 80 cents for every dollar charged in premiums on patients' claims. This has prevented insurers from raising premiums to maintain profits in line with rising healthcare costs. On the other hand, the Affordable Care Act has generated significant new growth and demand in an industry that had otherwise stagnated. It has also resulted in significant industry consolidation to cut costs and capitalize on existing synergies; by the end of 2016, there are proposed mergers between Aetna and Humana and, Anthem and Cigna. With UHC these three companies would control almost 70% of the US health insurance market. (17)

Despite these massive losses that the insurance companies have taken on from their business in the ACA markets, these companies continue to reap huge profits. Analysts estimated that Aetna was on pace to post \$2.5B in profits and UHC \$7B in profits in 2016 (10). Also keep in mind that not everyone is losing money in the ACA exchanges. Centene and Molina Healthcare have been able to turn a profit on the exchanges by offering Medicaid-like health plans. These plans tend to have narrower networks at lower premiums than those available from employers (10).

However, these massive losses in the ACA markets have caused a number of companies to dropout.

While the ACA can incentivize individuals to buy insurance (tax those who do not), the law has no authority to force insurance companies to offer plans in the exchange (10).

As these companies exit the exchanges, consumers will face fewer options and even higher premiums. On average, insurers are looking to raise premiums by about 24% in 2017 according to one estimate (10).

As many as a quarter of all U.S. counties, mainly in rural areas, are at risk of having a single insurer for 2017 according to Cynthia Cox of the Kaiser Family Foundation (10).

ACA advocates had hoped that large subsidies from the government to consumers would encourage healthy people to sign up for the ACA plans. But these plans have largely been taken out by older, less healthy people that are inherently more expensive to insure. As Dan Mendelson, CEO of consulting firm Avalere Health says: “What we are left with...is a highly subsidized program for relatively low-income people.”(10).

Another problem for insurers is that under the ACA, premiums for the oldest are typically limited to three times those of the youngest. If this ratio were widened, theoretically there would be a draw to younger healthy people by lowering their premiums. This would, however, raise costs for older people (10).

The effect of the large insurers leaving the ACA markets will vary by state (11). In North Carolina, a quarter of the state’s consumers will see their choices drop to one for 2017. Many of the rest will have just two carriers to choose from (10).

In April of 2016 UHC announced that in 2017 it would exit most of the 34 states where it offers plans on the exchanges (12). Unless other carriers stepped in, UHC’s exit would leave Oklahoma and Kansas with only one insurer (16).

In 2016 analysts said UHC participated in 1,855 counties (59% of counties nationwide). In 536 counties, UHC’s withdrawal would leave enrollees with only one choice of insurer. This would impact 1.1 million marketplace participants. In another 532 counties, UHC’s exit would leave enrollees with two choices of insurers, affecting 1.8 million marketplace participants. (14).

While reduced competition might seem attractive for another insurance company to step in and offer coverage, one analyst pointed out that many insurance companies will be leery of getting into markets out of fear other insurers will exit and they’ll be the last option standing with a bunch of expensive claims on their hands. (14).

The employer insurance marketplace is changing, with more employers taking more risk, leaving less profitable claims processing to traditional insurers. However, insurers see dramatic growth in Medicare Advantage and Medicaid managed care, a new marketplace they can offer plans to compete in. With baby boomers now entering the Medicare population, significant growth in these plans is expected. They have also seen dramatic growth in profits from high deductible plans. (8).

The “surprise billing” problem is a creation of the insurance industry, creating such narrow networks, sometimes including just hospital services, with no in network physicians. Because of

the narrow networks, patients now pay significantly more out of pocket, and some of these bills come as quite a “surprise”. The countrywide push to legislate a solution to “surprise billing” or out of network billing is a push by the insurance industry to gain as much leverage as possible over contractual negotiations with physicians. Many states have enacted legislation. Many of these laws tie physician compensation to a fee schedule. Some include provisions for mediation/arbitration. Some ban balance billing entirely. Physicians in many states are advocating to close the “insurance gap”, with varied success.

What changes under President Trump?

What exactly will change under the Trump administration is uncertain. The campaign promises of repeal and replace were made and various proposals and numerous attempts at changing legislation have been made in the early stages of the new administration. However, as of yet nothing has been finalized.

According to Speaker Paul Ryan, the AHCA reforms were initially planned to come in three stages. The first stage would use the budget reconciliation process to repeal and replace as much of the ACA as possible. The second stage would utilize the regulatory process to alter other parts of the ACA, and which could include Essential Health Benefits packages. The third stage plan is to pass any remaining changes that are needed through the normal legislative channels, due to restrictions on what can be passed through budget reconciliation.

In March of 2017 the American Health Care Act (AHCA) attempted to change some components of the ACA. Some proposed changes that have been considered by the new administration include the following (the sections and the corresponding changes are noted below):

Overview:

- **Repeal ACA mandates (2016), standards for health plan actuarial values (2020), and, premium and cost sharing subsidies (2020).**
- **Modify ACA premium tax credits for 2018-2019** to increase amount for younger adults and reduce for older adults, also to apply to coverage sold outside of exchanges and to catastrophic policies. In 2020, replace ACA income-based tax credits with flat tax credits adjusted for age. Eligibility for new tax credits phases out at income levels between \$75,000 and \$115,000
- **Retain private market rules**, including the requirement to guarantee issue coverage, prohibition on discriminatory premiums and pre-existing condition exclusions and to extend dependent coverage to age 26. Modify age rating limit to permit variation of 5:1, unless states adopt different ratios.

- **Retain health insurance marketplaces, annual Open Enrollment periods (OE), and special enrollment periods (SEPs).**
- **Impose late enrollment penalty for people who do not stay continuously covered.**
- **Establish State Innovation Grants and Stability Program** with federal funding of \$100 billion over 9 years. States may use funds to provide financial help to high-risk individuals, promote access to preventive services, provide cost sharing subsidies, and for other purposes. In states that do not successfully apply for grants, funds will be used for reinsurance program
- **Repeal funding for Prevention and Public Health Fund** at the end of Fiscal Year 2018 and rescind any unobligated funds remaining at the end of FY2018. Provide supplemental funding for community health centers of \$422 million for FY 2017
- **Encourage use of Health Savings Accounts** by increasing annual tax free contribution limit and through other changes
- **Eliminate enhanced FMAP for Medicaid expansion as of January 1, 2020 except for those enrolled as of December 31, 2019 who do not have a break in eligibility of more than 1 month**
- **Convert federal Medicaid funding to a per capita allotment and limit growth beginning in 2020 using 2016 as a base year**
- **No change to Medicare benefit enhancements or provider/Medicare Advantage plan payment savings**
- **Repeal Medicare HI tax increase and other ACA revenue provision**
- **Prohibit federal Medicaid funding for Planned Parenthood clinics**

(See Appendix 2 for more detail)

Summary

The promise of the ACA was to provide affordable healthcare to all, improve quality and reduce costs. The mechanism was to fundamentally change the insurance marketplace. Main provisions were to broaden coverage by removing preexisting conditions and lifetime caps on coverage and to make insurance affordable for all by subsidizing premiums and expanding Medicaid. To improve quality and pay for dramatically expanding coverage, paying providers for value rather than volume, taxing “Cadillac” plans, and expanding the pool of insured by mandates/taxes on the young and healthy who choose not to buy insurance.

The result was dramatically increasing costs to paying patients, accelerating their transition to healthcare consumers. Many more are covered, but the cost increases to the body politic fueled a political upheaval. The private insurers are consolidating, increasingly profitable, and trying to consolidate their power and influence. Insurers see dramatic growth in the managed Medicare/Medicaid programs.

The political promise to repeal/replace/repair the ACA will be one of the pillars of the new administration. It is an immense undertaking. Paying providers for “value”, and shifting costs to consumers, will continue. Our vigilance as physicians and patient advocates will be necessary to shape the outcome of this process to improve healthcare.

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Appendix 1-year by year ACA Reforms (3)

2010

NEW CONSUMER PROTECTIONS

- **Putting Information for Consumers Online.** The law provides for where consumers can compare health insurance coverage options and pick the coverage that works for them. *Effective July 1, 2010.*
- **Prohibiting Denying Coverage of Children Based on Pre-Existing Conditions.** The health care law includes new rules to prevent insurance companies from denying coverage to children under the age of 19 due to a pre-existing condition. *Effective for health plan years beginning on or after September 23, 2010 for new plans and existing group plans.*
- **Prohibiting Insurance Companies from Rescinding Coverage.** In the past, insurance companies could search for an error, or other technical mistake, on a customer's application and use this error to deny payment for services when he or she got sick. [The health care law makes this illegal.](#) After media reports cited incidents of breast cancer patients losing coverage, insurance companies agreed to end this practice immediately. *Effective for health plan years beginning on or after September 23, 2010.*
- **Eliminating Lifetime Limits on Insurance Coverage.** Under the law, insurance companies will be [prohibited from imposing lifetime dollar limits](#) on essential benefits, like hospital stays. *Effective for health plan years beginning on or after September 23, 2010.*
- **Regulating Annual Limits on Insurance Coverage.** Under the law, [insurance companies' use of annual dollar limits](#) on the amount of insurance coverage a patient may receive will be restricted for new plans in the individual market and all group plans. In 2014, the use of annual dollar limits on essential benefits like hospital stays will be banned for new plans in the individual market and all group plans. *Effective for health plan years beginning on or after September 23, 2010.*
- **Appealing Insurance Company Decisions.** The law provides consumers with a [way to appeal coverage determinations](#) or claims to their insurance company, and establishes an external review process. *Effective for new plans beginning on or after September 23, 2010.*
- **Establishing Consumer Assistance Programs in the States.** Under the law, states that apply receive federal grants to help set up or expand independent offices to help consumers navigate the private health insurance system. These programs help consumers file complaints and appeals; enroll in health coverage; and get educated about their rights and responsibilities in group health plans or individual health insurance policies. The programs will also collect data on the types of problems consumers have, and file reports with the U.S. Department of Health and Human Services to identify trouble spots that need further oversight. *Grants Awarded October 2010.*

IMPROVING QUALITY AND LOWERING COSTS

- **Providing Small Business Health Insurance Tax Credits.** Up to 4 million small businesses are eligible for tax credits to help them provide insurance benefits to their workers. The first phase of this provision provides a credit worth up to 35% of the employer's contribution to the employees' health insurance. Small non-profit organizations may receive up to a 25% credit. *Effective now.*
- **Offering Relief for 4 Million Seniors Who Hit the Medicare Prescription Drug "Donut Hole."** An estimated four million seniors will reach the gap in Medicare prescription drug coverage known as the "donut hole" this year. Each eligible senior will receive a one-time, tax free \$250 rebate check. *First checks mailed in June, 2010, and will continue monthly throughout 2010 as seniors hit the coverage gap.* Learn more about the "donut hole" and Medicare.
- **Providing Free Preventive Care.** All new plans must cover certain preventive services such as mammograms and colonoscopies without charging a deductible, co-pay or coinsurance. *Effective for health plan years*

beginning on or after September 23, 2010. [Learn more about preventive care benefits.](#) [See the full list of covered preventive services.](#)

- **Preventing Disease and Illness.** A new \$15 billion Prevention and Public Health Fund will invest in proven prevention and public health programs that can help keep Americans healthy – from smoking cessation to combating obesity. *Funding begins in 2010.*
- **Cracking Down on Health Care Fraud.** Current efforts to fight fraud have returned more than \$2.5 billion to the Medicare Trust Fund in fiscal year 2009 alone. The new law invests new resources and requires new screening procedures for health care providers to boost these efforts and [reduce fraud and waste in Medicare, Medicaid, and CHIP.](#) *Many provisions effective now.*

INCREASING ACCESS TO AFFORDABLE CARE

- **Providing Access to Insurance for Uninsured Americans with Pre-Existing Conditions.** The [Pre-Existing Condition Insurance Plan](#) provides new coverage options to individuals who have been uninsured for at least six months because of a pre-existing condition. States have the option of running this program in their state. If a state chooses not to do so, a plan will be established by the Department of Health and Human Services in that state. *National program effective July 1, 2010.*
- **Extending Coverage for Young Adults.** Under the law, [young adults will be allowed to stay on their parents' plan until they turn 26 years old](#) (in the case of existing group health plans, this right does not apply if the young adult is offered insurance at work). Check with your insurance company or employer to see if you qualify. *Effective for health plan years beginning on or after September 23.*
- **Expanding Coverage for Early Retirees.** Too often, Americans who retire without employer-sponsored insurance and before they are eligible for Medicare see their life savings disappear because of high rates in the individual market. To [preserve employer coverage for early retirees](#) until more affordable coverage is available through the new Exchanges by 2014, the new law creates a \$5 billion program to provide needed financial help for employment-based plans to continue to provide valuable coverage to people who retire between the ages of 55 and 65, as well as their spouses and dependents. *Applications for employers to participate in the program available June 1, 2010.* For more information on the Early Retiree Reinsurance Program, visit www.ERRP.gov.
- **Rebuilding the Primary Care Workforce.** To strengthen the availability of primary care, there are new incentives in the law [to expand the number of primary care doctors, nurses and physician assistants.](#) These include funding for scholarships and loan repayments for primary care doctors and nurses working in underserved areas. Doctors and nurses receiving payments made under any state loan repayment or loan forgiveness program intended to increase the availability of health care services in underserved or health professional shortage areas will not have to pay taxes on those payments. *Effective 2010.*
- **Holding Insurance Companies Accountable for Unreasonable Rate Hikes.** The law allows states that have, or plan to implement, measures that require insurance companies to justify their premium increases will be eligible for \$250 million in new grants. Insurance companies with excessive or unjustified premium exchanges may not be able to participate in the new health insurance Exchanges in 2014. *Grants awarded beginning in 2010.*
- **Allowing States to Cover More People on Medicaid.** States will be able to receive federal matching funds for covering some additional low-income individuals and families under Medicaid for whom federal funds were not previously available. This will make it easier for states that choose to do so to cover more of their residents. *Effective April 1, 2010.*
- **Increasing Payments for Rural Health Care Providers.** Today, 68% of medically underserved communities across the nation are in rural areas. These communities often have trouble attracting and retaining medical professionals. The law provides increased payment to rural health care providers to help them continue to serve their communities. *Effective 2010.*

- **Strengthening Community Health Centers.** The law includes new funding to support the construction of and expand services at community health centers, allowing these centers to serve some 20 million new patients across the country. *Effective 2010.*

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2011

IMPROVING QUALITY AND LOWERING COSTS

- **Offering Prescription Drug Discounts.** Seniors who reach the coverage gap will receive a 50% discount when buying Medicare Part D covered brand-name prescription drugs. Over the next ten years, seniors will receive additional savings on brand-name and generic drugs until the coverage gap is closed in 2020. *Effective January 1, 2011.* [Download a brochure to learn more - PDF](#)
- **Providing Free Preventive Care for Seniors.** The law provides certain free preventive services, such as annual wellness visits and personalized prevention plans for seniors on Medicare. *Effective January 1, 2011.* Learn more about preventive services under Medicare.
- **Improving Health Care Quality and Efficiency.** The law establishes a new [Center for Medicare & Medicaid Innovation](#) that will begin testing new ways of delivering care to patients. These methods are expected to improve the quality of care, and reduce the rate of growth in health care costs for Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). Additionally, by January 1, 2011, HHS will submit a national strategy for quality improvement in health care, including by these programs. *Effective no later than January 1, 2011.* [Learn more about the Center for Medicare & Medicaid Innovation.](#)
- **Improving Care for Seniors After They Leave the Hospital.** The [Community Care Transitions Program](#) will help high risk Medicare beneficiaries who are hospitalized avoid unnecessary readmissions by coordinating care and connecting patients to services in their communities. *Effective January 1, 2011.*
- **Introducing New Innovations to Bring Down Costs.** The Independent Payment Advisory Board will begin operations to develop and submit proposals to Congress and the President aimed at extending the life of the Medicare Trust Fund. The Board is expected to focus on ways to target waste in the system, and recommend ways to reduce costs, improve health outcomes for patients, and expand access to high-quality care. *Administrative funding becomes available October 1, 2011.* Learn more about strengthening Medicare.

INCREASING ACCESS TO AFFORDABLE CARE

- **Increasing Access to Services at Home and in the Community.** The Community First Choice Option allows states to offer home and community based services to disabled individuals through Medicaid rather than institutional care in nursing homes. *Effective beginning October 1, 2011.*

HOLDING INSURANCE COMPANIES ACCOUNTABLE

- **Bringing Down Health Care Premiums.** To ensure premium dollars are spent primarily on health care, the law generally requires that at least 85% of all premium dollars collected by insurance companies for large employer plans are spent on health care services and health care quality improvement. For plans sold to individuals and small employers, at least 80% of the premium must be spent on benefits and quality improvement. If insurance companies do not meet these goals, because their administrative costs or profits are too high, they must provide rebates to consumers. *Effective January 1, 2011.*
- **Addressing Overpayments to Big Insurance Companies and Strengthening Medicare Advantage.** Today, Medicare pays Medicare Advantage insurance companies over \$1,000 more per person on average than is spent per person in Traditional Medicare. This results in increased premiums for all Medicare beneficiaries, including the 77% of beneficiaries who are not currently enrolled in a Medicare Advantage plan. The law

levels the playing field by gradually eliminating this discrepancy. People enrolled in a Medicare Advantage plan will still receive all guaranteed Medicare benefits, and the law provides bonus payments to Medicare Advantage plans that provide high quality care. *Effective January 1, 2011.* [Learn more about Medicare and the Affordable Care Act.](#)

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2012

IMPROVING QUALITY AND LOWERING COSTS

- **Linking Payment to Quality Outcomes.** The law establishes a hospital Value-Based Purchasing program (VBP) in Traditional Medicare. This program offers financial incentives to hospitals to improve the quality of care. Hospital performance is required to be publicly reported, beginning with measures relating to heart attacks, heart failure, pneumonia, surgical care, health-care associated infections, and patients' perception of care. *Effective for payments for discharges occurring on or after October 1, 2012.*
- **Encouraging Integrated Health Systems.** The new law provides incentives for physicians to join together to form "Accountable Care Organizations." These groups allow doctors to better coordinate patient care and improve the quality, help prevent disease and illness and reduce unnecessary hospital admissions. If Accountable Care Organizations provide high quality care and reduce costs to the health care system, they can keep some of the money that they have helped save. *Effective January 1, 2012.*
- **Reducing Paperwork and Administrative Costs.** Health care remains one of the few industries that relies on paper records. The new law will institute a series of changes to standardize billing and requires health plans to begin adopting and implementing rules for the secure, confidential, electronic exchange of health information. Using electronic health records will reduce paperwork and administrative burdens, cut costs, reduce medical errors and most importantly, improve the quality of care. *First regulation effective October 1, 2012.*
- **Understanding and Fighting Health Disparities.** To help understand and reduce persistent health disparities, the law requires any ongoing or new federal health program to collect and report racial, ethnic and language data. The Secretary of Health and Human Services will use this data to help identify and reduce disparities. *Effective March 2012.*

INCREASING ACCESS TO AFFORDABLE CARE

- **Providing New, Voluntary Options for Long-Term Care Insurance.** The law creates a voluntary long-term care insurance program – called CLASS -- to provide cash benefits to adults who become disabled. **Note: On October 14, 2011, Secretary Sebelius transmitted a report and letter to Congress stating that the Department does not see a viable path forward for CLASS implementation at this time. View a copy of [the CLASS report.](#)**

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2013

IMPROVING QUALITY AND LOWERING COSTS

- **Improving Preventive Health Coverage.** To expand the number of Americans receiving preventive care, the law provides new funding to state Medicaid programs that choose to cover preventive services for patients at little or no cost. *Effective January 1, 2013.* [Learn more about the law and preventive care.](#)
- **Expanding Authority to Bundle Payments.** The law establishes a national pilot program to encourage hospitals, doctors, and other providers to work together to improve the coordination and quality of patient

care. Under payment “bundling,” hospitals, doctors, and providers are paid a flat rate for an episode of care rather than the current fragmented system where each service or test or bundles of items or services are billed separately to Medicare. For example, instead of a surgical procedure generating multiple claims from multiple providers, the entire team is compensated with a “bundled” payment that provides incentives to deliver health care services more efficiently while maintaining or improving quality of care. It aligns the incentives of those delivering care, and savings are shared between providers and the Medicare program. *Effective no later than January 1, 2013.*

INCREASING ACCESS TO AFFORDABLE CARE

- **Increasing Medicaid Payments for Primary Care Doctors.** As Medicaid programs and providers prepare to cover more patients in 2014, the Act requires states to pay primary care physicians no less than 100% of Medicare payment rates in 2013 and 2014 for primary care services. The increase is fully funded by the federal government. *Effective January 1, 2013.* [Learn how the law supports and strengthens primary care providers.](#)
- **Open Enrollment in the Health Insurance Marketplace Begins.** Individuals and small businesses can buy affordable and qualified health benefit plans in this new transparent and [competitive insurance marketplace](#). *Effective October 1, 2013.*

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2014

NEW CONSUMER PROTECTIONS

- **Prohibiting Discrimination Due to Pre-Existing Conditions or Gender.** The law implements strong reforms that prohibit insurance companies from refusing to sell coverage or renew policies because of an individual’s pre-existing conditions. Also, in the individual and small group market, the law eliminates the ability of insurance companies to charge higher rates due to gender or health status. *Effective January 1, 2014.* Learn more about protecting Americans with pre-existing conditions.
- **Eliminating Annual Limits on Insurance Coverage.** The law prohibits new plans and existing group plans from imposing annual dollar limits on the amount of coverage an individual may receive. *Effective January 1, 2014.* [Learn how the law will phase out annual limits by 2014.](#)
- **Ensuring Coverage for Individuals Participating in Clinical Trials.** Insurers will be prohibited from dropping or limiting coverage because an individual chooses to participate in a clinical trial. Applies to all clinical trials that treat cancer or other life-threatening diseases. *Effective January 1, 2014.*

IMPROVING QUALITY AND LOWERING COSTS

- **Making Care More Affordable.** Tax credits to make it easier for the middle class to afford insurance will become available for people with income between 100% and 400% of the poverty line who are not eligible for other affordable coverage. (In 2010, 400% of the poverty line comes out to about \$43,000 for an individual or \$88,000 for a family of four.) The tax credit is advanceable, so it can lower your premium payments each month, rather than making you wait for tax time. It’s also refundable, so even moderate-income families can receive the full benefit of the credit. These individuals may also qualify for reduced cost-sharing (copayments, co-insurance, and deductibles). *Effective January 1, 2014.*
- **Establishing the Health Insurance Marketplace.** Starting in 2014 if your employer doesn’t offer insurance, you will be able to buy it directly in the Health Insurance Marketplace. Individuals and small businesses can buy affordable and qualified health benefit plans in this new transparent and competitive insurance marketplace. The Marketplace will offer you a choice of health plans that meet certain benefits and cost

standards. Starting in 2014, Members of Congress will be getting their health care insurance through the Marketplace, and you will be able buy your insurance through Marketplace too. [Learn more about the Health Insurance Marketplace.](#)

- **Increasing the Small Business Tax Credit.** The law implements the second phase of the small business tax credit for qualified small businesses and small non-profit organizations. In this phase, the credit is up to 50% of the employer's contribution to provide health insurance for employees. There is also up to a 35% credit for small non-profit organizations. *Effective January 1, 2014.* [Learn more about the small business tax credit.](#)

INCREASING ACCESS TO AFFORDABLE CARE

- **Increasing Access to Medicaid.** Americans who earn less than 133% of the poverty level (approximately \$14,000 for an individual and \$29,000 for a family of four) will be eligible to enroll in Medicaid. States will receive 100% federal funding for the first three years to support this expanded coverage, phasing to 90% federal funding in subsequent years. *Effective January 1, 2014.*
- **Promoting Individual Responsibility.** Under the law, most individuals who can afford it will be required to obtain basic health insurance coverage or pay a fee to help offset the costs of caring for uninsured Americans. If affordable coverage is not available to an individual, he or she will be eligible for an exemption. *Effective January 1, 2014.*

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2015

IMPROVING QUALITY AND LOWERING COSTS

- **Paying Physicians Based on Value Not Volume.** A new provision will tie physician payments to the quality of care they provide. Physicians will see their payments modified so that those who provide higher value care will receive higher payments than those who provide lower quality care. *Effective January 1, 2015*

Appendix 2- details of the American Health Care Act (AHCA)

What changes are Proposed by the GOP and President Trump?

On March 8, 2017, the details of the American Health Care Act (AHCA) were released to the public. The AHCA has many details that are related to repeal of many provisions in the ACA. However, there are also various components of the ACA that are unchanged under the AHCA.

According to Speaker Paul Ryan, the AHCA reforms will come in three stages. The first stage uses the budget reconciliation process to repeal and replace as much of the ACA as possible. This process has already started and has passed the House Budget Committee in a close vote. The second stage will utilize the regulatory process to alter other parts of the ACA, and which could include Essential Health Benefits packages. The third stage plan is to pass any remaining changes that are needed through the normal legislative channels, due to restrictions on what can be passed through budget reconciliation.

The sections and the corresponding changes are noted below:

Overview:

- **Repeal ACA mandates (2016), standards for health plan actuarial values (2020), and, premium and cost sharing subsidies (2020).**
- **Modify ACA premium tax credits for 2018-2019** to increase amount for younger adults and reduce for older adults, also to apply to coverage sold outside of exchanges and to catastrophic policies. In 2020, replace ACA income-based tax credits with flat tax credits adjusted for age. Eligibility for new tax credits phases out at income levels between \$75,000 and \$115,000
- **Retain private market rules**, including requirement to guarantee issue coverage, prohibition on discriminatory premiums and pre-existing condition exclusions, requirement to extend dependent coverage to age 26. Modify age rating limit to permit variation of 5:1, unless states adopt different ratios.
- **Retain health insurance marketplaces, annual Open Enrollment periods (OE), and special enrollment periods (SEPs).**
- **Impose late enrollment penalty for people who don't stay continuously covered.**

- **Establish State Innovation Grants and Stability Program** with federal funding of \$100 billion over 9 years. States may use funds to provide financial help to high-risk individuals, promote access to preventive services, provide cost sharing subsidies, and for other purposes. In states that don't successfully apply for grants, funds will be used for reinsurance program
- **Repeal funding for Prevention and Public Health Fund** at the end of Fiscal Year 2018 and rescind any unobligated funds remaining at the end of FY2018. Provide supplemental funding for community health centers of \$422 million for FY 2017
- **Encourage use of Health Savings Accounts** by increasing annual tax free contribution limit and through other changes
- **Eliminate enhanced FMAP for Medicaid expansion as of January 1, 2020 except for those enrolled as of December 31, 2019 who do not have a break in eligibility of more than 1 month**
- **Convert federal Medicaid funding to a per capita allotment and limit growth beginning in 2020 using 2016 as a base year**
- **No change to Medicare benefit enhancements or provider/Medicare Advantage plan payment savings**
- **Repeal Medicare HI tax increase and other ACA revenue provision**
- **Prohibit federal Medicaid funding for Planned Parenthood clinics**

Individual Mandate:

- Tax penalty for not having minimum essential coverage is eliminated effective January 1, 2016
- Late enrollment penalty (30% of otherwise applicable premium) applies for individuals buying non-group coverage who have not maintained continuous coverage. Continuous coverage is assessed during a 12-month look back period prior to the date of enrollment in new coverage. If individual had a lapse in coverage of 63 consecutive days or longer during the look back period, late enrollment penalty applies during the plan year in which the individual enrolls in new non-

group coverage. (For SEP, penalty applies for the remainder of the plan year). Late enrollment penalty is effective for special enrollments during the 2018 plan year, for all other enrollments beginning with the 2019 plan year. Private health plans continue to be required by law to provide certificates of creditable coverage; however, no requirement for governmental programs (e.g., Medicaid, CHIP, state high-risk pools) to provide such certificates.

Premium Subsidies to Individuals:

- For 2018-2019, modify premium tax credits as follows:
 - Increase credit amounts for young adults with income above 150% FPL and decrease amounts for adults 50 and older above that income level.
 - For end of year reconciliation of advance credits, the cap on repayment of excess advance payments does not apply.
 - Tax credits cannot be used for plans that cover abortion.
 - Premium tax credits can be used to purchase catastrophic plans.
 - Premium tax credits can be used to purchase qualified health plans (i.e., covering essential health benefits) sold outside of the exchange, but are not advance-payable for such plans. Premium tax credits cannot be used to purchase grandfathered or grand-mothered individual health insurance policies sold outside of the exchange.
- Starting in 2020, replace ACA income-based tax credits with flat tax credit adjusted for age. Credits are payable monthly; annual credit amounts are:
 - \$2,000 per individual up to age 29
 - \$2,500 per individual age 30-39
 - \$3,000 per individual age 40-49
 - \$3,500 per individual age 50-59
 - \$4,000 per individual age 60 and older
- Families can claim credits for up to 5 oldest members, up to limit of \$14,000 per year.
- Amounts are indexed annually to CPI plus 1 percentage point.
- U.S. citizens and legal immigrants who are not incarcerated and who are not eligible for coverage through an employer plan, Medicare, Medicaid or CHIP, or TRICARE, are eligible for tax credit. Married couples must file jointly to claim the credit. In addition, eligibility for the tax credit phases out starting at income above \$75,000 (credit is reduced, but not below zero, by 10 cents for every dollar of income above this threshold; tax credit reduced to zero at income of \$95,000 for single individuals up to age 29, \$115,000 for individuals age 60 and older. For joint filers, credits begin to phase out at income of \$150,000; tax credit reduced to zero at income of \$190,000 for couples up to age 29; tax credit reduced to zero at income \$230,000 for couples age 60 or older; tax credit reduced to zero at income of \$290,000 for couples claiming the maximum family credit amount.)
- Taxpayers who are also enrolled in qualified small employer health reimbursement arrangements (HRA) that apply to non-group coverage will have tax credit reduced, but not below zero, by the amount of the HRA benefit.

- Premium tax credit can be applied to any eligible individual health insurance policy (but not grandfathered or grand-mothered policies) sold on or off the exchange. In addition, credit can be applied to unsubsidized COBRA premiums. Eligible policies do not include those for which substantially all coverage is for excepted benefits; policies that cover abortion (with Hyde exceptions) are not eligible policies. States shall certify plans eligible for the credit; employer group health plan sponsors shall certify COBRA coverage eligible for the credit. The federal government must establish a program for making advance payment of tax credits no later than January 1, 2020; to the greatest extent practicable the program will use methods and procedures used for the ACA advance payable premium tax credit.
- Excess credit amounts (above the actual cost of individual coverage or COBRA policy) are payable to health savings accounts.

Cost Sharing subsidies to individuals:

ACA cost sharing subsidies are repealed effective January 1, 2020.

Individual Health Insurance Market Rules:

- Require guaranteed issue of all non-group health plans during annual open enrollment. Insurers also must offer 60-day special enrollment periods (SEP) for individuals after qualifying events. Short-term non-renewable policies can continue to be sold using medical underwriting.
- For health plans first sold on or after January 1, 2014, ACA rating rules continue, except age rating of 5:1 is permitted unless states adopt a different ratio. Short-term non-renewable policies can continue to set premiums based on health status.
- Prohibition on pre-existing condition exclusion periods is not changed. Short term non-renewable policies can continue to exclude pre-existing conditions.

Benefit Design:

- ACA requirement to cover 10 essential health benefit categories is not changed. ACA requirement for maximum out of pocket limit on cost sharing is not changed. ACA requirement for plans to be offered at specified actuarial values/metal levels sunsets on 12/31/2019.
- Prohibition on lifetime and annual dollar limits is not changed

- Requirement for individual and group plans to cover preventive benefits with no cost sharing is not changed.
- Requirement for all plans to apply in-network level of cost sharing for out-of-network emergency services is not changed
- Prohibit abortion coverage from being required. Federal premium tax credits cannot be applied to plans that cover abortion services, beyond those for saving the life of the woman or in cases of rape or incest (Hyde amendment). Nothing prevents an insurer from offering or an individual from buying separate policies to cover abortion as long as no premium tax credits are applied.

Women's Health:

- ACA essential health benefit requirement for individual and small group health insurance policies is not changed, including requirement to cover maternity care as an essential health benefit.
- Requirement for individual and group plans to cover preventive benefits, such as contraception and cancer screenings, with no cost sharing is not changed.
- Prohibition on gender rating is not changed
- Prohibition on pre-existing conditions exclusions, including for pregnancy, prior C-section, and history of domestic violence, is not changed.
- Prohibits federal Medicaid funding for Planned Parenthood clinics for one year, effective upon date of enactment. Specifies that federal funds to states including those used by managed care organizations under state contract are prohibited from going to such entity.
- Redefine qualified health plan to exclude any plan that covers abortion services, beyond those for saving the life of the woman or in cases of rape or incest (Hyde amendment), effective in 2018
- Prohibit federal premium tax credits from being applied to plans that cover abortion services, beyond Hyde limitations. Disqualify small employers from receiving tax credits if their plans include abortion coverage beyond Hyde limitations, effective in 2018. Does

not prevent an insurer from offering or an individual from buying separate policies to cover abortion as long as no tax credits are applied.

Health Savings Accounts(HSAs):

- Modify certain rules for HSAs, changes take effect January 1, 2018:
 - Increase annual tax free contribution limit to equal the limit on out-of-pocket cost sharing under qualified high deductible health plans (\$6,550 for self only coverage, \$13,100 for family coverage in 2017, indexed for inflation). Excess premium tax credit amounts contributed to an HSA do not count against the contribution limit.
 - Additional catch up contribution of up to \$1,000 may be made by persons over age 55. Both spouses can make catch up contributions to the same HSA.
 - Amounts withdrawn for qualified medical expenses are not subject to income tax. Qualified medical expense definition expanded to include over-the-counter medications and expenses incurred up to 60 days prior to date HSA was established
 - Tax penalty for HSA withdrawals used for non-qualified expenses is reduced from 20% to 10%.

High Risk Pools:

States may use Innovation and Stability Program grants to fund high-risk pools, and for other purposes.

Selling Insurance Across State Lines:

No provision.

Exchanges/Insurances through associations:

- State exchanges continue, though premium tax credits can be used for eligible non-group policies regardless of whether they are sold through an exchange. Through 2019, tax credits are only advance payable for policies purchased through an exchange.
- Single risk pool rating requirement for plans first sold on or after January 1, 2014 is not changed.

Dependent Coverage to age 26:

Requirement to provide dependent coverage for children up to age 26 for all individual and group policies is not changed.

Other Private Insurance Standards:

- Minimum medical loss ratio standards for all health plans are not changed.
- Requirement for all health plans to offer independent external review is not changed.
- Requirements for all plans to report transparency data, and to provide standard, easy-to-read summary of benefits and coverage are not changed.

Employer Requirements and Provisions:

- Tax penalty for large employers that do not provide health benefits is reduced to zero, retroactive to January 1, 2016
- Wellness incentives permitted under the ACA are not changed
- Repeal tax credits for low-wage small employers, effective January 1, 2020. Requires that small business tax credits cannot be used to purchase plans that cover abortions, beyond Hyde limitations, effective in 2018

Medicaid:

Expansion/Financing

- Codify that the Medicaid expansion is a state option upon enactment; eliminate option to extend coverage to adults above 133% FPL effective January 1, 2020; eliminate the enhanced match for the Medicaid expansion as of January 1, 2020 (except for individuals who were enrolled through the Medicaid expansion as of December 31, 2019 and who do not have a break in eligibility of more than one month).
 - Limits the “expansion state” enhanced match rate transition percentage to CY 2017 levels of 80% (instead of phasing up the match to equal the ACA enhanced match rate by 2020).
- Convert federal Medicaid financing to a per capita cap beginning in FY 2020.
 - Per enrollee caps for five enrollment groups—elderly, blind and disabled, children, expansion adults, and other adults—are based on 2016 expenditures (excluding administrative costs, DSH, Medicare cost-sharing, and safety net provider payment adjustments in non-expansion states, and certain categories of individuals, including CHIP, those receiving services through Indian Health Services, those eligible for Breast and Cervical Cancer services, and partial-benefit enrollees) divided by full-year equivalent enrollees in each category and trended forward to 2019 by medical CPI.

- For states opting to adopt the Medicaid expansion after 2016, the per enrollee amount for this group would be the same as the other adult group under the per capita cap.
- Per enrollee amounts are adjusted to exclude non-DSH supplemental payments
- The target expenditures in 2020 are calculated based on the 2019 per enrollee amounts for each enrollment group adjusted for non-DSH supplemental payments and increased by medical CPI multiplied by the number of enrollees in each group. In 2021 and beyond, per enrollee amounts are based on the prior year amounts increased by medical CPI.
- States with medical assistance expenditures exceeding the target amount for a fiscal year will have payments in the following fiscal year reduced by the amount of the excess payments.
- Provide 100% FMAP for MMIS and eligibility systems for FY 2018 and FY 2019 and increase other administrative matching to 60% for expenses related to implementing new data requirements.
- Repeal Medicaid DSH cuts for FY2020 - FY2025; exempt non-expansion states from DSH cuts for FY2018 - FY 2019
- Provide \$10 billion over 5 years (CY2018 – CY 2022) to non-expansion states for safety-net funding (applies to states not adopting the expansion by July 1 of the previous year). Allotments based on the number of individuals in the State with income below 138% of FPL in 2015 relative to the total number of individuals with income below 138% of FPL for all the non-expansion States in 2015. Payments 100% funded by the federal government in CY 2018-2021 and 95% in CY 2022. Payments to providers may not exceed providers' costs in providing health care services to Medicaid and uninsured patients. States receiving these funds in a year in which they also adopt expansion shall no longer be eligible to receive these funds in any subsequent year.

Other Changes

- Repeal the essential health benefits requirement for those receiving alternative benefit packages, including the expansion group, as of December 31, 2019.
- Repeal increase in Medicaid eligibility to 138% FPL for children ages 6-19 as of December 31, 2019. The minimum federal income eligibility limit for these children will revert to 100% FPL.
- Repeal hospital presumptive eligibility provisions and presumptive eligibility for expansion adults, effective January 1, 2020
- Repeal enhanced FMAP for the Community First Choice Option to provide attendant care services effective January 1, 2020
- Prohibit federal Medicaid funding for Planned Parenthood for one year, effective upon date of enactment
- Require states to consider lottery winnings (and other lump sum payments including gambling winnings and liquid assets from an estate) as income over a period of months in determining Medicaid ineligibility for individual and spouse beginning, January 1, 2020. Secretary can establish hardship criteria and state can intercept lottery winnings for Medicaid recoupment.

- Eliminate 3-month retroactive coverage requirement (start eligibility “in or after” the month of application) beginning October 1, 2017.
- Eliminate reasonable opportunity period for citizenship/immigrant status verification and require documentation before enrolling in coverage and prohibit payments during reasonable opportunity periods with exceptions for people receiving Medicare, SSDI, SSI, foster care, born to a Medicaid eligible woman or other basis established by the Secretary for states that choose to offer reasonable opportunity periods, effective six months after enactment.
- Require states to limit home equity to federal minimum (removes the option to expand the limit from \$500,000 to \$750,000 (adjusted for CPI), effective six months after the bill is enacted or longer if states must pass legislation to change.
- Require eligibility redeterminations every 6 months for expansion enrollees beginning October 1, 2017. Expands civil monetary penalties up to \$20,000 per individual for intentionally claiming Medicaid matching funds for an individual not eligible for expansion. Provide a temporary (10/1/17 through 12/31/19) five percentage point FMAP increase for expenditures directly related to complying with this provision.

Medicare:

Revenues

- Repeals the HI payroll tax on high earners, beginning after December 31, 2017
- Repeals the annual fee paid by branded prescription drug manufacturers, beginning after December 31, 2017
- Reinstates the tax deduction for employers who receive Part D retiree drug subsidy (RDS) payments to provide creditable prescription drug coverage to Medicare beneficiaries, beginning after December 31, 2017.

Coverage enhancements

- ACA benefit enhancements (no-cost preventive benefits; phased-in coverage in the Part D coverage gap) are not changed

Reductions to provider and plan payments

- ACA reductions to Medicare provider payments and Medicare Advantage payments are not changed

Other ACA provisions related to Medicare are not changed, including:

- Increase Medicare premiums (Parts B and D) for higher income beneficiaries (those with incomes above \$85,000/individual and \$170,000/couple).
- Authorize an Independent Payment Advisory Board to recommend ways to reduce Medicare spending if the rate of growth in Medicare spending exceeds a target growth rate.
- Establish various quality, payment and delivery system changes, including a new Center for Medicare and Medicaid Innovation to test, evaluate, and expand methods to control costs and promote quality of care; Medicare Shared Savings Accountable Care Organizations; and penalty programs for hospital readmissions and hospital-acquired conditions.

State Role:

- States may determine age rating ratio; otherwise federal standard of 5:1 applies.
- Establish new Patient and State Stability Fund. Funds can be used by states for financial help for high-risk individuals, to stabilize private insurance premiums, promote access to preventive services, provide cost sharing subsidies, and for other purposes. \$100 billion over 9 years appropriated (\$15 billion per year for 2018-2019, \$10 billion per year for 2020-2026). In states that do not successfully apply for grants, innovation funds will be used for a default reinsurance program, administered by CMS, that will pay 75% of claims between \$50,000 and 350,000 (starting in 2020, CMS Administrator can establish different reinsurance rate and claims thresholds.) State matching funding of 7% required in 2020, phasing up to 50% in 2026. A different state matching schedule applies for the CMS-administered default reinsurance program (10% in 2020, phasing up to 50% in 2024.) Grants cannot be made to a state unless it agrees to make matching funds available. Any remaining funds at year end will be re-allocated the following year to states for which allocations were made.
- State option to establish a state based health insurance exchange is not changed.

- State consumer assistance/ombudsman program is not changed, and is not funded.
- State option to establish a Basic Health Program is not changed. State option to obtain a five-year waiver of certain new health insurance requirements (Section 1332 waiver) is not changed.
- States continue to administer the Medicaid program with Federal matching funds available up to the federal cap.

Financing:

- ACA taxes repealed, effective January 1, 2018, except where otherwise noted:
 - Tax penalties associated with individual and large employer mandate, reduced to zero effective on January 1, 2016
 - Cadillac tax on high-cost employer-sponsored group health plans is suspended for tax years 2020 through 2024, no revenues shall be collected during this period
 - Increase in Medicare payroll tax (HI) rate on wages for high-wage individuals; also 3.8% tax on unearned income for high-income taxpayers
 - Tax on tanning beds
 - Tax on health insurers
 - Tax on pharmaceutical manufacturers
 - Excise tax on sale of medical devices
 - Provision excluding costs for over-the-counter drugs from being reimbursed through a tax preferred health savings account (HSA)
 - Provision increasing the tax (from 10% to 20%) on HSA distributions that are not used for qualified medical expenses.
 - Chronic care tax
 - Codification of economic substance doctrine and penalties
- Annual limit on contributions to Flexible Spending Accounts (FSAs) repealed
- Annual limit on deduction for salary in excess of \$1 million paid to employees of publicly held corporations repealed
- Federal Medicaid funding capped, effective FY 2020; enhanced match for Medicaid expansion population eliminated beginning January 1, 2020; and Medicaid DSH cuts repealed, effective FY 2020

The Congressional Budget Office (CBO) has released their evaluation of the AHCA, on Monday, March 13th. They evaluated the impact on costs and coverages, using 2016 data as their baseline. Here are some excerpts from their 37-page report:

Financial Impact: “CBO and JCT estimate that enacting the legislation would reduce federal deficits by \$337 billion over the 2017-2026 10-year period. Outlays would be reduced by \$1.2 trillion over the period and revenues would be reduced by \$0.883 trillion. The largest reductions

would come from the elimination of the Affordable Care Act's (ACA's) subsidies for nongroup health insurance. The largest costs would come from repealing many of the changes the ACA made to the Internal Revenue Code (total \$559 billion) including an increase in the Hospital insurance payroll tax rate for high income taxpayers, a surtax on those taxpayers' net investment income, and annual fees imposed on health insurers, and from the establishment of a new tax credit for health insurance..."

Coverage: "CBO and JCT estimate that in 2018, 14 million more people would be uninsured under the legislation than under the current law. Most of that increase would stem from repealing the penalties associated with the individual mandate. Some of those people would chose not to have insurance because they chose to be covered by insurance under the current law only to avoid paying penalties, and some people would forgo insurance in response to higher premiums. Later, following additional changes to subsidies for insurance purchased in the nongroup market and to the Medicaid program, the increase in the number of uninsured people relative to the number under current law would rise to 21 million in 2020 and then to 24 million in 2026. The reductions in insurance coverage between 2018 and 2026 would stem in large part from changes in Medicaid enrollment (loss of 5 million enrollees) because some states would discontinue their expansion of eligibility, some state that would have expanded eligibility in the future would chose not to do so, and per-enrollee spending in the program would be capped. In 2026, an estimated 52 million people would be uninsured, compared with 28 million who would lack insurance that year under the current law."

Insurance Market Stability: "The market for insurance purchased individually (that is, nongroup coverage) would be unstable, for example, if the people who wanted to buy coverage at any offered price would have average health care expenditures so high that offering the insurance would be unprofitable. In CBO and JCT's assessment, however, the nongroup market would probably be stable in most areas under either current law or the legislation. Under the legislation, in the agencies' view, key factors bringing about market stability include subsidies to purchase insurance, which would maintain sufficient demand for insurance by people with low health care expenditures, and grants to states from the Patient and State Stability Fund, which would reduce the costs to insurers of people with high health care expenditures. Even though the new tax credits would be structured differently from the current subsidies and would generally be less generous for those receiving subsidies under the current law, the other changes would, in the agencies' view, lower average premiums enough to attract a sufficient number of relatively healthy people to stabilize the market."

Premiums: “In 2018 and 2019, according to CBO and JCT’s estimates, average premiums for single policyholders in the nongroup market would be 15-20% higher than under the current law, mainly because the individual mandate penalties would be eliminated, inducing fewer comparatively healthy people to sign up. Starting in 2020, the increase in average premiums from repealing the individual mandate penalties would be more than offset by the combination of several factors that would decrease those premiums: grants to states from the Patient and State Stability Fund (which CBO and JCT expect to largely be used by states to limit the costs to insurers of enrollees with very high claims); the elimination of the requirement for insurers to offer plans covering certain percentages of the cost of covered benefits; and a younger mix of enrollees. By 2026, average premiums for single policyholders in the nongroup market under the legislation would be roughly 10% lower than under the current law. Under the legislation, insurers would be allowed to generally charge five times more for older enrollees than younger ones rather than three times more as under current law, substantially reducing the premiums for young adults, and substantially raising the premiums for older people.”