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JOINT INFORMATIONAL HEARING

Assembly Committee on Health and Assembly Budget Subcommittee No. 1

THE AMERICAN HEALTH CARE ACT: WHAT WILL IT COST CALIFORNIANS?

Wednesday, March 22, 2017 -- 1 p.m. to 4 p.m

Fresno City Hall Chambers

2600 Fresno Street -- Fresno, CA 93721-3623

BACKGROUND

INTRODUCTION

On March 6, 2017, House Republicans introduced, through the Budget Reconciliation process, two bills aimed at repealing and replacing the Patient Protection and Affordable Care Act (ACA). These bills, collectively known as the American Health Care Act (AHCA), were referred to the House Energy and Commerce and Ways and Means Committees. Both Committees have since passed the AHCA legislation. On March 13, 2017, the non-partisan Congressional Budget Office (CBO) and staff of the Joint Committee on Taxation (JCT) released an estimate of the budgetary effects of the AHCA proposals. Subsequently, on March 16, 2017, the House Budget Committee passed the AHCA on a 19-17 vote. A House vote is scheduled for the AHCA on March 23, 2017.

California embraced the ACA after it was enacted in 2010, and more than 5 million Californians gained coverage through the Medi-Cal expansion and Covered California. As a result, the uninsured number dropped from 6.5 million to 3.3 million. This massive reduction in the uninsured rate and the growth of the insured population radically changed healthcare in California and accounted for a reduction in health disparities, especially among those with the lowest income, young adults, part-time workers, and Latinos. California also receives more federal funding than any other state under the ACA. According to the California Legislative Analyst's Office (LAO), the state is projected to receive an estimated $24 billion in federal funds for programs and services authorized by the ACA for fiscal year (FY) 2017-18. As a result, any proposal to repeal and replace the ACA in California will undo the progress the state has made in expanding access to quality, affordable insurance and healthcare.

The purpose of this informational hearing is to examine the provisions of the AHCA and its potential impact on California. An overview of the ACA will be provided and a summary of the AHCA proposal and CBO analysis will be discussed, along with the economic impact and loss of coverage under the AHCA.

THE AFFORDABLE CARE ACT

To understand the enormity of losses that California could face if the ACA is repealed and replaced, below are some of the major provisions of the ACA that affected coverage eligibility, benefits, premium rates, market conduct, quality, and transparency. Some of the most sweeping changes affect coverage in the Medi-Cal program and the individual and small group markets.

Medicaid (Medi-Cal in California)

In California, the federal/state Medicaid program is administered by the Department of Health Care Services and is known as the California Medical Assistance Program (Medi-Cal). The federal share of Medicaid costs is known as the federal medical assistance percentage (FMAP). Prior to the ACA, Medi-Cal only covered low-income families with children, seniors and persons with disabilities, and pregnant women. Generally, California receives a 50% FMAP where the federal government pays one-half of the Medi-Cal costs for these populations. Medi-Cal covers a core set of health benefits, including doctor visits, hospital care, immunizations, pregnancy-related services, and nursing home care. Under the ACA, Medi-Cal also offers all essential health benefits (EHBs), explicitly requiring mental health, substance abuse and behavioral health services [see discussion below].

As part of the ACA, in 2014 the state expanded Medi-Cal eligibility to childless adults with incomes at or below 138% of the federal poverty level (FPL) [up to $16,394 for an individual in 2016]. The federal government paid 100% of the costs of providing health care services to the newly eligible population from 2014 to 2016. Beginning in 2017, the federal share decreased to 95%, and phases down to 90% for 2020 and thereafter. Between December 2013 and February 2016, Medi-Cal expanded enrollment from 8,605,691 to 13,526,979. The Governor's FY 2017-18 Budget estimates that over 14 million Californians will be enrolled in Medi-Cal with a combined federal and state budget of $102.6 billion ($19.1 billion in General Fund).

It should be noted that a subset of children from higher income families who do not qualify for Medi-Cal are covered under the Children's Health Insurance Program (CHIP). California's base-level FMAP for CHIP is 65%. With the ACA's FMAP enhancement beginning in October 2015, California's CHIP FMAP is currently at 88%. This enhanced CHIP rate will generate an estimated $600 million in additional federal funding for Medi-Cal in FY 2017-18. This increase is scheduled to end in federal fiscal year (FFY) 2018-19. However, funding is only appropriated through FFY 2016-17 and must be reauthorized.

Health Benefit Exchanges/Covered California

Aside from the Medi-Cal optional expansion, the ACA also establishes online marketplaces, known as Health Benefit Exchanges (HBEs) to give individuals, who do not have access to

public coverage or affordable employer coverage, the ability to purchase insurance. In order to make insurance more affordable, premium tax credits and cost-sharing subsidies are available to those who qualify. Under the ACA, states are given the option to either administer their own HBEs or use the federal platform: Healthcare.gov. While the majority of states chose to use the federal platform, California created the California Health Benefit Exchange, known as Covered California. Covered California facilitates the purchase of qualified health plans (QHPs) by individuals and small employers and develops patient centered benefit designs to allow consumers to shop and compare QHP products. In order to create a competitive marketplace, Covered California negotiates premiums and QHP contract provisions that seek to lower costs, improve quality, and improve health outcomes, while ensuring a good choice of plans for consumers. Covered California has served 2.9 million residents since enrollment began in 2014 and is the largest state-run marketplace.

Advance Premium Tax Credits - Subsidized health coverage through Covered California is available to individuals between 138% and 400% of the FPL and nearly 90% of enrollees receive federal premium subsidies (approximately 1,484,537 individuals in 2016). ACA tax credits are available in advance, based on income information provided to the HBE, household size, age, and the cost of coverage in the area where individuals live. Advance Premium Tax Credits are reconciled based on actual income when a person files income taxes.

Covered California enrollees benefit from $4.2 billion in tax credits in 2016. Enrollees receive an average of $5,300 per household and more than $3,500 per individual, per year in tax credits to help them pay for the cost of coverage. Twelve percent of enrollees receive more than $10,000 per household, and 16% of individuals receive more than $6,000 per year in tax credits, playing a critical role in bringing health care coverage within reach to many who need it most (respectively more than $833 and $500 per month).

Cost Sharing Reductions - Under the ACA, in addition to premium subsidies, low-income enrollees (those with incomes below 250% of FPL) qualify for additional subsidies that reduce out-of-pocket (OOP) costs, including deductibles and copays. In California, these cost sharing reductions total over $700 million. Half of Covered California enrollees receive cost sharing reductions (approximately 829,998 individuals in 2016) that on average reduce OOP expenses by more than $1,500 per household per year or more than $1,000 for an individual.

Essential Health Benefits and Actuarial Values (AV)

Prior to the ACA, covered benefits under a health plan or insurance policy varied from policy to policy. The ACA changed this to require all health insurance plans offered in the individual and small group markets to provide a comprehensive package of items and services, known as EHBs, with no dollar limits. These benefits fit into the following 10 categories: (1) ambulatory patient services (outpatient care); (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services, including

behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and, (10) pediatric services, including dental and vision care. The ACA establishes the EHBs as the minimum standard for all HBE plans and for those in the Medicaid expansion population.

The ACA also establishes various "metal tiers" of health insurance coverage. These tiers are used for three primary purposes: (1) set the minimum amount of coverage many people must have to satisfy the requirement that they be insured or pay a federal tax penalty beginning in 2014; (2) establish standardized levels of insurance individuals and small businesses can buy in HBEs or in the outside market; and, (3) as benchmarks for premium and cost-sharing subsidies provided to lower and middle income people buying their own insurance in HBEs.

The goal of these tiers is to make it easier for consumers to compare health plans. The four metal tiers required are as follows: (1) Platinum, where the AV is 90% or more; (2) Gold, with an AV of 80% to 90%; (3) Silver, where the AV is 70% to 80%; and, (4) Bronze, with an AV of 60% to 70%. Health plans in the highest tier pay the highest percentage of an individual's expected medical costs (90%) and have higher premiums and lower copays and deductibles. Health plans in the lowest tier pay the lowest allowable percentage of medical expenses (60%) and have lower premiums and higher copays and deductibles.

In the pre-ACA individual market, the most popular products had AVs that ranged from 55% to 85%, with the majority of plans having an estimated AV below 65%. Without EHBs and AV tiers, individual market products would feature higher cost sharing and leave gaps in covered benefits.

Individual Mandate

Another significant portion of the ACA requires U.S. citizens and legal residents to have qualifying health coverage. Individuals without coverage pay a tax penalty described below. Exemptions are granted for various reasons, including affordability, financial hardship, and religious objections. When consumers file their tax return, they enter information about their coverage (or their exemption). If consumers do not maintain minimum essential coverage during the year and do not qualify for an exemption, they pay a tax penalty to the Internal Revenue Service on their tax return for that year. The annual penalty is the greater of: (1) $695 for each adult and $347.50 for each child, up to $2,085 per family; or, (2) 2.5 % of the tax filer's annual household income minus the federal tax filing threshold. The purpose of the individual mandate and corresponding tax penalty is to provide incentives for healthy people to enroll and obtain coverage. Healthy people are necessary to spread the risk in an insurance marketplace when insurance companies are prohibited from excluding coverage to anyone including, exclusions due to a pre-existing condition.

Employer Mandate

The "Employer Shared Responsibility Provision" of the ACA penalizes employers who do not offer coverage which meets minimum value and affordability standards. These penalties apply to firms with 50 or more full-time equivalent employees. Affordable employer sponsored insurance is defined as requiring an employee contribution of less than 9.5% of household income for an employee-only plan that covers at least 60% of medical costs on average (minimum value). The employer mandate is intended to discourage employers from reducing or not offering coverage given the availability of subsidized coverage under the HBEs.

Other Consumer Oriented Insurance Market Reforms

Preexisting Conditions

The ACA also implements additional insurance market requirements that are consumer friendly, including prohibiting health insurers from excluding anyone from coverage. Before the ACA, health insurance sold in the individual market in most states was medically underwritten meaning insurers evaluated the health status, health history, and other risk factors of applicants to determine whether and under what terms to issue coverage. Based on this underwriting, insurers frequently denied health insurance coverage, charged more for that coverage, and limited or refused to cover benefits because of a preexisting condition.

Rating Restrictions

Rate restrictions limit how much insurance companies can vary premiums charged to individuals and businesses based on factors such as health status, age, tobacco use, and gender. Before the ACA, federal law did not place any limits on the ways that insurance companies set their premium rates. The ACA requires insurers to set prices to reflect expected costs for a single risk pool. Rating variation is permitted, but not required, for only four factors: (1) age (limited to three to one ratio – older individuals can be charged no more than three times the premiums paid by younger adults); (2) geographic rating area; (3) family composition; and, (4) tobacco use. It should be noted that in California, state law does not allow for tobacco rating.

Lifetime or Annual Limits

The ACA also prohibits health insurers from setting lifetime or annual limits on the dollar value of health insurance coverage that individuals receive under their plan for EHBs. Previously, many plans set a lifetime or annual dollar limit on what the insurer would pay. Once the limit was reached, the enrollee was then required to pay the entire cost above those limits. This left many enrollees, especially those with conditions that required high cost treatments, vulnerable to costs that could be unaffordable.

Dependent Coverage

One of the most popular provisions of the ACA, insurers are required to extend dependent coverage on a family plan until the dependent reaches the age of 26. Prior to the ACA, most employer-based health insurance plans ended dependent coverage at either 19 or upon college graduation. The ACA requirement is unconditional and does not depend on whether the young adult lives at home, is a full-time student, married, tax dependent, or eligible to buy insurance on the HBE. The goal of this new policy is to cover as many young adults under the age of 26 as possible, with the least burden.

THE AMERICAN HEALTH CARE ACT

On January 12, 2017, the United States Senate voted 51 to 48 to approve a budget resolution instructing House and Senate Committees to begin work on legislation to repeal major provisions of the ACA. On January 13, 2017, the House passed its own budget resolution on a 227-198 vote. The budget resolutions allow both houses to repeal the tax and spending provisions of the ACA on a majority vote. In the House, 216 votes are needed for passage. In the Senate, 51 votes are needed.

In introducing the AHCA, Speaker Paul Ryan outlined the three steps that Congress and the Trump Administration will take to replace the ACA: (1) pass the AHCA through budget reconciliation; (2) make additional changes through the regulatory process; and, (3) pass legislation to address insurance elements of the ACA.

MEDICAID PROVISIONS

Elimination of the Medicaid Expansion by December 31, 2019

As indicated above, the ACA expands Medicaid eligibility to all non-elderly adults with incomes at or below 138% FPL. To finance the eligibility expansion, the federal government finances 100% of the expansion population for 2014 through 2016; 95% in 2017; 94% in 2018; then stepping down and leveling out at a 90% federal share for the year 2020 and subsequent years.

Under the AHCA, after January 1, 2020, this enhanced financing would only apply to expansion-eligible individuals already enrolled in Medicaid as of December 31, 2019, and who do not have a break in eligibility for more than one month after that date. After January 1, 2020, the state could only enroll newly eligible individuals at the state's traditional FMAP. The AHCA also repeals the increase in Medicaid eligibility to 138% FPL for children ages six to 19 as of December 31, 2019. The federal income eligibility limit for these children will revert to 100% FPL which means fewer children will qualify.

Elimination of EHBs in certain Medicaid plans

The AHCA also repeals EHB requirements for Medicaid expansion enrollees by December 31, 2019. This means that Medicaid programs, including Medi-Cal, are no longer required to cover all EHBs, which added mental health, substance abuse, and behavioral health services.

Restricted Eligibility Requirements

The AHCA would require expansion states, like California, to redetermine expansion enrollee eligibility every six months. The additional paperwork generated may result in many people losing their coverage and create an increased workload for county workers. The AHCA also ends presumptive eligibility (PE) which allows individuals to quickly enroll in Medi-Cal based on income information and then later submit a completed application. The AHCA only allows PE for children, pregnant women, and for breast and cervical cancer patients and ends this practice for hospitals and adults whose PE was expanded through the ACA. The AHCA also eliminates the ability of Medi-Cal applicants to access health care services for a limited time while waiting for citizenship or immigration status verification.

MEDICAID PER CAPITA ALLOTMENT

The AHCA converts the Medicaid program that guarantees coverage with no pre-set limits on federal government matches to a per capita allotment. Currently, the federal government matches state Medicaid spending at a rate determined by a formula set in statute. Federal spending increases as the total cost of providing care to enrollees increases, with no limit on total federal contributions.

Under a per capita allotment program, states would receive an allotment of federal funds per Medicaid enrollee, regardless of the actual amount of Medicaid spending. According to a Kaiser Family Foundation (KFF) issue brief, a per capita cap model would not account for changes in the costs per enrollee beyond a set growth limit. KFF points out that implementing a per capita cap could be administratively difficult and could maintain current inequities in per enrollee costs across states. Pre-set growth rates cannot easily account for changes in costs of medical services, patient acuity, or epidemics. If costs are above per enrollee amounts, costs could be shifted to states, providers, and beneficiaries. States may have incentives to reduce Medicaid payment rates and restrict benefits; with changes in federal law, states could also restrict eligibility for high-cost enrollees and shift costs to beneficiaries through premiums or cost sharing.[1]

Under the AHCA, implementation of the per capita cap will start in FY 2020. A state's spending in FY 2016 will be used as the base-year targeted spending for each enrollee category (elderly, blind, and disabled, children, non-expansion adults, and expansion adults) in FY 2019

[1] http://kff.org/medicaid/issue-brief/overview-of-medicaid-per-capita-cap-proposals/

and subsequent years. Each state's targeted spending amount would increase by the percentage in the medical care component of the consumer price index (CPI) for all urban consumers from September 2019 to September of the following fiscal year. Starting in FY 2020, if a state's spending is higher than its targeted aggregate amount, it would experience reductions to Medicaid funding for the following fiscal year.

INSURANCE MARKET/CONSUMER REFORMS

Elimination of Individual and Employer Mandates

The AHCA repeals the individual and employer mandates retroactively to January 1, 2016, and zeros out the penalty for the individual and employer mandates.

Penalty for Break in Coverage

Under the AHCA, if an individual has a break in coverage for more than 63 days within a 12-month lookback period, a 30% late-enrollment surcharge will be applied to a base premium for 12 months.

Higher Premiums for Seniors

The AHCA changes the age rating bands to five to one, which means that insurers can charge seniors five times more in premiums than younger consumers. (Under the ACA, the age rating band for seniors is three to one. As such, a 64-year-old currently can generally be charged premiums up to only three times as much as those offered to a 21-year-old.) Under the AHCA, premiums would be reduced for younger people (who need health insurance less) and increased for older people (who need health insurance more).

Repeal of the AV Levels

The AHCA repeals the AV levels that correspond to "metal tiers" of coverage under the ACA, as described above.

Premium Subsidies and Tax Credits

The AHCA repeals current ACA premium subsidies beginning in 2020. In the meantime, it also revises calculation of individual or family income contribution to premiums so it considers both household income as well as age. The AHCA allows current subsidies to be applied to catastrophic plans and certain plans not sold through the HBEs. Starting in 2020, the AHCA creates an advanceable, refundable tax credit for the purchase of state-approved, major medical health insurance to those making $75,000 per year ($150,000 for joint filers). Credits are age-adjusted and are as follows:

(1) Under age 30: $2,000;
(2) Between 30 and 39: $2,500;

(3) Between 40 and 49: $3,000;
(4) Between 50 and 59: $3,500; and,
(5) Over age 60: $4,000.

The tax credits phase down by $100 for every $1,000 in income higher than the above income thresholds. The AHCA credits are capped at $14,000 for families and are indexed at CPI plus 1%. Additionally, eligibility is based on not having access to government or employer coverage and being a citizen, national, or qualified alien.

Repeal of Cost-Sharing Reductions in 2020

The AHCA repeals the cost sharing reductions that are available through the HBEs described above.

Repeal of Various Taxes

To finance the ACA, various healthcare related taxes were enacted, including a surcharge on High Income individuals and their investments, a fee on health insurers, and taxes on pharmaceutical and medical device manufacturers.

Under the AHCA, after December 31, 2017, the following taxes will be eliminated:

Provision	2017-2026 Cost
Repeal 3.8% investment income tax	$158 billion
Repeal health insurer tax	$145 billion
Repeal 0.9% HI surtax	$117 billion
Delay Cadillac tax from 2020 to 2025	$49 billion
Repeal increase in medical expense deduction floor	$35 billion
Repeal prescription drug tax	$25 billion
Repeal 2.3% medical device tax	$20 billion
Repeal limit on flexible spending accounts	$19 billion
Repeal other taxes	$8 billion
Subtotal, Repeal/Delay ACA Taxes	**$575 billion**
Expand Health Savings Accounts	$19 billion
Total	**$594 billion**

Source: (http://www.crfb.org/blogs/jct-aca-repeal-will-cut-taxes-least-600-billion)
Committee for a Responsible Federal Budget

Lower Health Savings Account Distribution

The AHCA also lowers Health Savings Account (HSA) distribution tax to pre-ACA levels as of December 31, 2017. The AHCA also repeals limits on contributing to Flexible Savings Account (FSAs) as of December 31, 2017. Beginning in 2018, AHCA sets basic limit

of $6,550 for individuals and $13,100 for families. These higher limits would especially benefit those with higher and more disposable income.

OTHER FUNDING PROVISIONS

Patient and State Stability Fund

The AHCA establishes the Patient and State Stability Fund (Fund) to provide $15 billion in 2018 and 2019 and $10 billion annually for 2020 through 2026, which can be used for specified purposes, including providing financial assistance to high-risk individuals who do not have access to health insurance coverage in the individual market, help incentivize stable premiums, and reduce cost sharing and premiums. Funding is allocated for the first two years based mainly on healthcare spending in the individual market and to a lesser extent on other factors such as the state uninsured rate below 100% FPL (favoring non-expansion states) and the number of plans participating in state exchanges. After the first two years, funding is based on "cost, risk, low income uninsured population, and issuer competition." In 2020, the bill would phase in a state matching formula, presumably to help assist states that use money to build their own program. California's prior experience with high risk pool, which the AHCA supports, is that these pools provide coverage for a very limited population.

Additional Funding for Community Health Centers

The AHCA would increase the funds available to the Community Health Center Program (Program) by $422 million in fiscal year 2017. The Program provides grant funds to health centers that offer primary and preventive care to patients regardless of their ability to pay. Under current law, the Program will receive about $4 billion in fiscal year 2017.

Repeal of the Prevention and Public Health Fund

The ACA established the Prevention and Public Health Fund (PPHF) to provide expanded and sustained national investments in prevention and public health, to improve health outcomes, and to enhance health care quality. To date, the PPHF has invested in a broad range of evidence-based activities including community and clinical prevention initiatives; research, surveillance and tracking; public health infrastructure; immunizations and screenings; tobacco prevention; and, public health workforce and training. According to the LAO, for 2017-18, California agencies are projected to receive $60 million from the PPHF.

The AHCA repeals the PPHF appropriations for FY 2019 and beyond and rescinds unobligated FY 2018 funds.

ABORTION COVERAGE

The AHCA includes various provisions relating to abortion. For example, there would be a one year freeze on mandatory federal funding going to prohibited entities (describing Planned

Parenthood) or through managed care organizations under contract with the state. Additionally tax credits cannot be used for premiums to pay for abortion coverage. Lastly, the AHCA provides that a health issuer may offer separate coverage for abortions, so long as premiums for such coverage or plan are not paid for with any allowable tax credit.

CBO ESTIMATE OF THE AHCA (SEE LAO HANDOUT)

ADDITIONAL AMENDMENTS

On March 20, 2017, House Republicans released policy and technical amendments to the AHCA. The key changes proposed in the amendments include: (1) preventing non-expansion states from expanding Medicaid at the enhanced federal matching rate; (2) allowing states the option of imposing work requirements for Medicaid; (3) allowing a block grant option for Medicaid; and, (4) accelerating repeal of the ACA's taxes. Also included in the amendments is a placeholder provision to help make care more affordable for seniors who do not yet qualify for Medicare (a key concern of many moderate Republicans). Instead of offering enhanced tax credits, the amendments would enact a different, placeholder provision to increase a medical tax deduction (a policy that would reportedly cost around $85 billion over 10 years). Tax deductions especially benefit high income taxpayers. House Republicans have indicated that they expect the Senate will change the policy to increase tax credits for people between the ages of 50 and 64.

CONCLUSION

Under the ACA, 3.7 million Californians enrolled in the Medi-Cal expansion, and another 1.4 million Californians received federal subsidies that make purchasing insurance through Covered California more affordable. These two ACA provisions are the largest drivers of the historic reduction in the state's uninsured rate from 17.2% in 2013 to 7.1% in 2017. These coverage gains are at risk if the ACA is repealed. Most Californians who rely on these programs are in working families. Eight out of 10 Medi-Cal enrollees are in families with at least one worker, according to the KFF. The majority of those enrolled in Covered California with subsidies are also part of working families. Repealing the ACA threatens not only to leave millions without health insurance, but also to undo the progress California has made in reducing inequality of health insurance access.

The AHCA, in contrast, will decrease the number of people eligible for Medi-Cal, reduce subsidies for people to buy insurance, and eliminate the ACA's OOP subsidies completely. As important to Republican lawmakers as reducing health benefits for millions of Americans are, those AHCA provisions that will lower income taxes for high income earners, eliminate an investment tax on high income taxpayers, and eliminate taxes on health insurers, pharmaceutical companies, and medical device manufacturers.

According to the CBO, under the AHCA, 21 million more people will be uninsured in the United States in 2020 (compared with the ACA) and 24 million more will be uninsured by 2024. Extrapolating to California's population, there will be 2.5 million more uninsured in California in 2020 and 3 million more in 2024. By next year, CBO estimates that the cost of insurance will increase by 15-20% more than under the ACA. Although average premiums are expected to be lower after 2020, this is only because benefits will be substantially reduced under the AHCA. Furthermore, premiums on older Americans, who can be charged five times the premiums paid by the young, are expected to rise substantially.

At the end of the day, the AHCA could do great damage to Californians. Millions will lose health insurance coverage and millions more will be paying more and getting less. For all these reasons, the AHCA is a giant step back in time.