The American Health Care Act: Implications for the ACA and Medicaid

Presentation by:

Champaign County Health Care Consumers (CCHCC)

March 20, 2017

Champaign Public Library
About Health Care Consumers

- Grassroots consumer health advocacy organization that has been fighting for health care access and justice since 1977.
- Unique organization that does both direct services and community organizing.
- CCHCC is a 501(c)(3) non-profit organization.
- CCHCC is non-partisan. We advocate based on policy, not politics.
Overview of the Affordable Care Act*

* Full name is Patient Protection and Affordable Health Care Act
  * Also known as the ACA
  * Also known as “Obamacare”
About the Affordable Care Act (ACA)

- Signed into **law in 2010**.
- Designed to reform the health care system by **expanding access to affordable health insurance and improving insurance**.
- **50 million uninsured** Americans at the time it was passed.
- It is **not** “government-run health care” – health care and insurance still provided by private companies (the government has not taken over those companies).
Goals of the ACA

• Expand health insurance coverage to millions of uninsured.

• Improve coverage for those who already had/have health insurance.

• Improve access to, and quality of, care.

• Improve access to, and affordability of preventive health.

• Control rising health care costs.
What the ACA has done to expand coverage and make it affordable

• Allowed **adult children up to age 26** to get on their parents’ health insurance.

• **Expand Medicaid** to cover adults who meet income criteria (138% FPL): **650,000 adults in Illinois**.

• **Create the Marketplace (healthcare.gov)** where people can purchase affordable **private health insurance plans** and qualify for financial assistance in the form of tax credits.
How the Marketplace (healthcare.gov) makes insurance affordable

• **Tax credits that help reduce the cost of monthly premiums** are available for people earning up to $48K. 335,000 on Marketplace in Illinois and 78% get tax credits.

• **Tax credits are pegged to income level** and designed to ensure that people get enough assistance so that they do not spend more than 9% of their income on premiums.

• **Age Rating limit** – **Insurance companies can only charge older people 3x the amount that is charged for younger people.**
How the ACA has improved health insurance for everyone

- The **ACA has improved health insurance for everyone**, including those with employer-based health plans, as well as those with individual plans.

- Health insurance plans have been improved because the ACA set **new standards and protections for all health plans**.
Setting Actuarial Standards:

- Actuarial Standards refer to levels of coverage (i.e., what percent of your health costs will your health insurance plan cover).

- “Metal” Levels in the Marketplace – set a “floor” for coverage of about 60% (Bronze plans), meaning that health insurance has to be able to cover at least 60% of the health

- Also created standards for employer-based health plans through the “Employer Mandate”
Enacting New Standard Benefits:

– Allows adult children to remain on their parents’ health insurance policy until age 26

– Certain preventive services are covered at no cost including well-care visits – **this is true for ALL forms of health insurance – whether private plans, employer based plans, and Medicare.** This is very important for encouraging preventive care, which leads to early detection, prevention, and treatment of many health conditions – whether cancer, high blood pressure, diabetes, etc.

– Contraceptive coverage and STI testing/counseling with no co-pays
Enacting New Protections:

– No annual or lifetime caps or limits
– Insurance companies cannot drop coverage because of illness (rescission prohibited)
– People with pre-existing conditions cannot be denied insurance or charged more (2010 for children and 2014 for adults)
– Medical loss ratio (80% or more of your premium dollars must be used to pay for care you receive)
– Out-of-pocket maximum limits for consumers.
Essential Health Benefits Requirements: Employer-based plans (thru the Employer Mandate), private plans, Medicaid, and Marketplace plans must include 10 Essential Health Benefits at a minimum in order to be considered Qualified Health Plans (QHPs)

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment (this includes counseling and psychotherapy)
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services
Enacted the Employer Mandate:

• Employers with 50+ employees must comply
• Health insurance must be at least equivalent to “Bronze” plan (60% actuarial value)
• Premiums must be “affordable” (no more than 9% of income)
• Must be a Qualified Health Plan (QHP) that meets 10 Essential Health Benefits
The ACA and Pre-Existing Conditions

- The ACA enacted a requirement that health insurance companies sell policies to everyone, regardless of Pre-Existing Conditions.
- Health insurance companies could not discriminate by denying coverage or charging more for coverage for someone with a pre-existing condition.
- This created “guaranteed issue” health insurance; you are guaranteed to get the health plan, despite pre-existing conditions.
- Insurance companies were unsure how to set premiums for plans, which would now be “guaranteed issue” – no one could be turned down for coverage or charged different for coverage if they had a Pre-Existing condition.

- What provisions of the ACA make “guaranteed issue” health insurance possible?
The Individual Mandate:

• This is the “tax penalty” that people face under the ACA if they do not purchase health insurance coverage.

• The purpose of the Individual Mandate is to make sure that healthy people – not just highly-motivated sick people – purchase health insurance.

• This improves the insurance “risk pools” and helps lower costs of premiums for everyone.
Premium Tax Subsidies in the Marketplace:

- These tax subsidies help reduce the cost of health insurance premiums so that people can afford their monthly insurance premiums.

- Premium tax subsidies are based on income and geographic location (local market) and the goal is to keep health insurance costs “affordable” – 9% or less of one’s income.

- If health insurance premiums rise, the tax subsidies also rise.
Funding for “Risk Corridors”:

- A provision of the ACA that helped provide funds to health insurance companies if they lost money as a result of providing coverage in the Marketplace.
- When the ACA started requiring insurance companies to sell policies to everyone (even sick people with pre-existing conditions), those companies were caught in a tough spot. They didn’t know how much to charge in premiums to cover expenses for all those new policies.
Funding for “Risk Corridors” – cont’d:

• The ACA set up a three-year period, from 2014 to 2016, during which the government would spread the risk for insurers in the new law’s marketplaces while they adjusted premiums. This program is known as risk corridors.

• Risk Corridors are not “bailouts” – they are funding mechanisms to stabilize insurance markets. These were used under the law that created the Medicare Part D program.
Funding for “Risk Corridors” – cont’d:

• *Spending bill passed in Congress in December 2014 de-funded the “Risk Corridor”, thanks to Sen. Marco Rubio and then-Speaker of the House, John Boehner.*

• Results of de-funding the “Risk Corridor” include non-profit health insurance companies having to shut down, and several insurers leaving certain geographic markets in the Marketplace.

• This also led to increase in premiums in 2017.
De-Funding “Risk Corridors”:
De-Funding “Risk Corridors”:
Expand health insurance coverage to millions of uninsured.

• The main goal of the ACA was to expand coverage to the uninsured.

• Thanks to the ACA, our nation’s uninsured rate is at the lowest it has ever been in the history of our nation. Before ACA, 16% of Americans lacked health insurance coverage. Now that rate has been cut in half.

• Over 20 million people who previously did not have coverage, are now covered.
Improve coverage for those who already had/have health insurance and for all with pre-existing conditions.

- 27% of adults under age 65 have pre-existing conditions that in the past would have made them “uninsurable” or would have made their coverage unaffordable. This is more than 130 million people.

- All the other protections make it so that insurance companies cannot rescind your policy when you get a bad diagnosis, and they can’t place annual or lifetime caps on how much they will cover financially for the care that you need.

- Health insurance is now “guaranteed issue” - you don’t need to fill out a health history form in order to apply for coverage, and you, and your pre-existing conditions must be covered.
Improve access to, and quality of, care.

• Millions of people are now getting preventive and primary care.

• Medicare has documented significant improvements in quality of care.

Improve access to, and affordability of preventive health.

• 137 million people now benefit from preventive services without the cost of co-pays.
Control rising health care costs.

- Thanks to the ACA, we have begun to bend the cost curve on Medicare – costs are not increasing at the same rate as they had been before the ACA. And, as a result, we have extended Medicare’s solvency by 11 years.

- Rate of premium increases has decreased significantly for the first time. Recent premium increases for job-based plans have been below 5 percent on average, less than the historical trend and far lower on average than premium hikes for individual insurance.

- For consumers, we no longer see medical bills leading to bankruptcy like we used to. Medical bills used to be the #2 reason for bankruptcy in our nation, and 80% of those filing for bankruptcy because of medical bills had health insurance at the time they incurred those bills.
W/out the ACA, 2017 Premiums Would Be 30-50% Higher

Similarly, average premiums in the individual market even for less robust coverage (60 percent vs. 70
ACA “Repeal and Replace”

The House Republican health care bill:

The American Health Care Act*

*Also known as “TrumpCare” or “RyanCare” or the GOP ACA Replacement Plan
What was the “health policy” language you heard about the ACA “repeal and replace”?

• Cover more people.

• Make coverage more affordable (reduce premiums and deductibles).

• The most significant impact of the AHCA was not discussed during the campaign – 25% cutting and capping of Medicaid to pay for $860 billion tax cut.
On Monday, March 5, 2017 the House Republicans unveiled their plan to repeal and replace the ACA: the American Health Care Act (AHCA).

The House Republicans plan to vote on this bill on Thursday, March 23, 2017.
The GOP’s American Health Care Act:

- Medicaid Expansion “freezes” in 2020
- Removal of Essential Health Benefit requirements for Medicaid plans.
- Medicaid Funding changes from Entitlement to a Per Capita Cap
- *Permanently cuts $880 billion – or 25% - from the Medicaid program, and then caps it to pay for tax cuts.*
The GOP’s American Health Care Act:

• Ends Cost-Sharing Reductions and cuts ACA Tax Credits

• Older people can be charged 5 times as much as younger people

• Change in Actuarial Value requirement and removal of metal levels (e.g., “Silver” Plan).
Key Features of the AHCA – cont’d.

The GOP’s American Health Care Act:

• No Individual Mandate – instead a continuous coverage requirement
• No Employer Mandate
• Cuts Federal Funding to Planned Parenthood
• Tax Cuts to Wealthy, Insurers, Pharmaceutical Companies, Medical Device, Tanning Salons
• *Tax cuts to these total $860 billion.*

(This appears to be a tax bill masquerading as a health care bill.)
The GOP’s American Health Care Act:

• Slashes the billion dollar prevention fund, Prevention and Public Health Fund, which comprises about 12% of CDC budget.
AHCA and Tax Credits

Ends the ACA’s tax credits, which were based on income, starting in 2020 and replaces them with tax credits that only go up with age.

- The ACA pegs tax credits to income levels and, when premiums rise, those tax credits rise along with them, protecting consumers against increases in medical costs.

- The AHCA provides a flat-rate tax credit based on age, and the tax credit ranges from $2,000/yr. for people under 30 to $4,000/yr. for people over 60.

- Tax credits are not adjusted for local cost of living.

- Insurance will become unaffordable for lower-income.
AHCA and Tax Credits

Obamacare imposed a Medicare Hospital Insurance (HI) surtax based on income at a rate equal to 0.9 percent of an employee’s wages or a self-employed individual’s self-employment income. This section repeals the additional 0.9 percent Medicare tax beginning in 2018.

SECTION_15: REFUNDABLE TAX CREDIT FOR HEALTH INSURANCE

This section creates an advanceable, refundable tax credit for the purchase of state-approved, major medical health insurance and unsubsidized COBRA coverage. To be eligible, generally, an individual must not have access to government health insurance programs or an offer from any employer; and be a citizen, national or qualified alien of the United States, and not incarcerated. The credits are adjusted by age:

- Under age 30: $2,000
- Between 30 and 39: $2,500
- Between 40 and 49: $3,000
- Between 50 and 59: $3,500
- Over age 60: $4,000

The credits are additive for a family and capped at $14,000. The credits grow over time by CPI+1. The credits are available in full to those making $75,000 per year ($150,000 joint filers). The credit phases out by $100 for every $1,000 in income higher than those thresholds.

The Secretary of the Treasury is empowered to create a system— building upon already developed systems— to deliver the credit. Eligibility determinations will continue to be conducted by the federal government, while insurers and licensed agents and brokers will be able to do more of the consumer-facing actions currently performed in 39 states by healthcare.gov.

The program also calls for simplified reporting of an offer of coverage on the W-2 by employers. Reconciliation rules limit the ability of Congress to repeal the current reporting, but, when the current
Examples of changes in tax credits under GOP plan:

• In Champaign County, a 27-year old with an income of $20,000 would get an ACA tax credit of $3,660. Under the GOP plan, their tax credit would be $2,000.

• In Champaign County, a 60-year old with an income of $20,000 would get an ACA tax credit of $11,010. Under GOP plan, their tax credit would be $4,000.

• In Champaign County, a 60-year old with an income of $40,000 would get an ACA tax credit of $7,890. Under the GOP plan, their tax credit would $4,000.
AHCA and Tax Credits – cont’d.
AHCA and Older Americans

The AHCA imposes an “age tax” by allowing health insurance companies to charge much more for older people (ages 50 – 64).

• The ACA allows insurance companies to charge older people up to 3 times the amount they charge for younger people.

• The AHCA allows insurance companies to charge older people up to 5 times the amount they charge for younger people.

• And the AHCA only offers 2:1 tax credit rate for older people compared to younger people ($4,000 vs. $2,000)
AHCA and Older Americans

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1 orting after "3 to 1 for adults (consistent with section
2 2707(e))" the following: "or, for plan years beginning on
3 or after January 1, 2018, as the Secretary may implement
4 through interim final regulation, 5 to 1 for adults (con-
5 sistent with section 2707(e)) or such other ratio for adults
6 (consistent with section 2707(e)) as the State involved
7 may provide".
AHCA – Individual & Employer Mandates

The AHCA immediately eliminates the ACA’s Individual Mandate and the Employer Mandate (more than 50 employees).

• Ending the individual mandate, combined with keeping coverage for pre-existing conditions and lowering tax credits will lead to higher premiums and more people dropping out.

• Employers will no longer be required to offer plans that meet criteria under the ACA’s Employer Mandate.
AHCA – Continuous Coverage & High Risk

Hikes health care costs for people with pre-existing conditions.

- Insurance companies must charge anyone who has not been insured for 63 days a 30% surcharge on their premiums.
- Sets up a “Patient and state stability fund,” which can fund state high-risk pools, for people who need costly medical care. The 35-year history of states attempting high-risk pools resulted in high-premiums, high-deductibles and long-waiting lists.
The AHCA ends the current financing structure of Medicaid.

The CBO estimates that several major provisions affecting Medicaid would decrease direct spending by $880 billion over 2017-2026 and result in 14 million individuals losing Medicaid.
1. AHCA Implements a Per Capita Cap

Since 1965, Medicaid has operated as a federal-state partnership where states receive on average 63% of the costs of Medicaid from the federal government. The federal share is based on actual costs of providing services. AHCA limits the federal contribution, based on a state’s 2016 expenditures inflated at a rate that is projected to be less than the yearly growth of Medicaid health care costs. So starting January 1, 2020, funding for state Medicaid programs will shrink over time, resulting in states cutting coverage and services for all beneficiaries.
2. Repeals Medicaid Expansion.

AHCA effectively repeals the Medicaid expansion on January 1, 2020 by eliminating the enhanced federal funding for states to enroll non-pregnant childless adults. It also requires those in the Medicaid expansion population to submit eligibility renewal paperwork every six months just to stay on Medicaid, beginning October 1, 2017. Thus, states can continue to cover this group, but only at regular matching rates and, this, coupled with the stringent re-determination requirements for this group, will effectively repeal the coverage (CBO estimates only 5 percent will be left in this group by 2024).
3. Repeals Mandatory Medicaid Coverage for Children ages 6-18 over 100% FPL.

The ACA requires states to provide Medicaid coverage to all children ages from birth to age 19 under 138% of the Federal Poverty Level (FPL). Prior to the ACA, states had to cover children ages 0-5 years old up to 133% FPL but states only had to cover children ages 6-19 (or up to 21 at state option) up to 100% FPL. AHCA lowers the eligibility level for children ages 6-19 from 133% FPL back to 100% FPL. This means that (in some states) children may lose their Medicaid and can only be enrolled in CHIP or be uninsured. These children may get fewer benefits than on Medicaid and may not receive all services they need to correct or ameliorate their medical or mental health conditions.
4. Repeals Presumptive Eligibility for the Medicaid Expansion Population and Repeals Hospital Presumptive Eligibility for Everyone.

In addition to repealing the Medicaid expansion, AHCA prevents states from using “presumptive eligibility” for non-pregnant childless adults after January 1, 2020 even if a state chose to continue covering non-pregnant childless adults under its regular Medicaid funding. Further, AHCA repeals the ability of states to use Hospital Presumptive eligibility to enroll any individual in Medicaid.
5. Eliminates Retroactive Eligibility.

Medicaid currently provides coverage up to three months before the month an individual applies for coverage. This “retroactive coverage” protects individuals from medical expenses they incurred before they apply for Medicaid. An individual may not be able to apply for Medicaid immediately due to hospitalization, a disability, or other circumstances and retroactive coverage provides that critical coverage and ensures providers can get reimbursed for their costs and low-income individuals do not end up facing severe medical debt or bankruptcy due to these medical expenses. **AHCA repeals this coverage for all Medicaid beneficiaries starting October 1, 2017.**
6. Imposes Stricter Citizenship Verification Requirements.

Currently Medicaid applicants must provide documentation of their citizenship or nationality to enroll in Medicaid, but can access health care services while waiting for verification. Beginning 6 months after this bill is enacted, AHCA would prevent states from obtaining reimbursement for any services received while an individual is obtaining the necessary documentation (called a “reasonable opportunity period”) even if the individual meets all other Medicaid eligibility requirements and attests to his or her citizenship status. It is likely that states will also elect to delay eligibility until after documentation is verified so they do not have to pay 100% of the costs during the reasonable opportunity period.

States may seek waivers from the federal government allowing the state to stop having to follow certain federal Medicaid requirements so the state can test experimental, pilot, or demonstration projects that promote the objectives of the Medicaid program. Normally, states would have to ensure this would be “budget neutral” to the federal government over the course of the waiver period (typically five years), thus, can spend more federal funds up front to build new infrastructure or provide more intensive services. **AHCA takes away states’ flexibility to spend these waiver funds up front by imposing yearly budget caps.**
8. Repeals Essential Health Benefits (EHBs) for Medicaid Expansion Beneficiaries.

Under the ACA, states that expanded coverage to non-pregnant childless adults had to provide coverage in at least the 10 “essential health benefit” categories. AHCA repeals this requirement, which will no longer apply after December 31, 2019, resulting in beneficiaries losing services such as mental health and substance use disorder services, and losing access to some free preventive health services.
9. **Repeals Enhanced Funding for States for Community First Choice (CFC) Attendant Supports.**

Established under the ACA, the "Community First Choice Option" allows States to provide home and community-based attendant services and supports to eligible Medicaid enrollees under their State Medicaid Plan. CFC funds assist individuals with Activities of Daily Living (ADLs), habilitative services and emergency back-up systems like electronic indicators. CFC also gives states the option to cover many of the costs of transitioning individuals from institutional care to supported community living, including rent deposits, moving expenses and some nonmedical transportation. Some of these services compliment the transition services. AHCA repeals the 6% increase in funds established to cover these services starting January 1, 2020.
10. Limits Home Equity Exclusions.

Currently, individuals needing nursing home or other long-term care services must have home equity below a certain limit to qualify for those Medicaid services. States can exclude up to $750,000 of these individuals’ home equity. AHCA prohibits states from exceeding $500,000 of home equity, starting 6 months after the bill is enacted into law, potentially limiting the availability of nursing home and other long term care services to individuals who may live in high-cost areas and have substantial home equity but limited income and other assets.
Five Consequences of Changing Medicaid’s Financing Structure

1. Funding will not keep up with need, burdening state budgets. Of course, IL is in peculiar position of having no budget :(

2. Medicaid will no longer respond automatically to economic downturns.

3. States will be under pressure to cut benefits and reimbursements.

4. States may cut eligibility, pitting vulnerable populations against each other.

5. The safety net will be inconsistent across states.
The “State Medicaid Flexibility” Argument

• Proponents of the House GOP plans for Medicaid argue that Block Grants or Per Capita Caps are needed to give states more “flexibility.”

• States already have flexibility in the Medicaid program. States can choose to have Medicaid cover adult dental care, prescription drugs, etc. Also, states can apply for waivers to do innovative programming such as addressing the opioid crisis, etc.
The “State Medicaid Flexibility” Argument – cont’d.

- As Governor John Bel Edwards of Louisiana explained, “Under such a scenario, flexibility would really mean flexibility to cut critical services for our most vulnerable populations, including poor children, people with disabilities, and seniors in need of nursing home and home-based care.”

- The kind of flexibility the GOP is talking about is giving states flexibility to, for example, put work requirements on Medicaid beneficiaries, or cut certain groups or forms of care out of coverage.

- “State flexibility” is just a Trojan Horse for passing the buck and we have to resist it.
Impact on Medicare:

- AHCA would cut several years from the life of the Medicare Trust Fund (ACA extended it by 11 years). Life of Medicare reduced by 30%.
- Over time, would increase costs of the Medicare program as more people would “arrive” into Medicare sicker and needing more costly care because of previous years spent being unable to afford health insurance.
- When that happens, GOP will push to turn Medicare into a “voucher” program in order to save money for the federal government.
Pushes people into high deductible health plans, through several provisions.

• Allows insurance companies to sell catastrophic plans, ending the requirement that plans cover a set percentage of medical costs – the ACA’s platinum, gold, silver and bronze plans.

• Ends the ACA’s cost-sharing subsidies that limit out of pocket costs for people with moderate incomes.

• Increases tax benefits of health savings accounts, which are usually high deductible plans that only work if you are rich enough to save money out of your paycheck.
Will hurt women.

• Defunds Planned Parenthood – no Medicaid payments to Planned Parenthood or other similar women’s health clinics.

• Will not allow tax credits for individual plans that provide coverage for abortion services. Therefore, most health insurance plans will cut this coverage.

• Starting in 2020, will not require plans to meet the 10 Essential Health Benefits requirements, which include maternity/prenatal care, preventive services, and prescription drug coverage.
Huge tax breaks for the wealthy and for drug, insurance, medical device corporations, and tanning salons.

- Ends the ACA’s taxes on unearned income for people with high incomes.
- The top 0.1% of households — those with income of at least $3.7 million a year — would receive a tax cut of about $197,000 in 2017, on average.
- Ends the ACA’s taxes on insurance, drug and medical device corporations.
- Even ends an ACA provision that limited insurance companies from writing off high executive salaries.
AHCA – What it means for IL’s 13th District

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<th>Representative Name</th>
<th>Total Coverage Loss (Nonelderly)</th>
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<th>Medicaid (Elderly)</th>
<th>Employer-Sponsored Insurance</th>
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Net Loss in Health Insurance Coverage for 2026, by Congressional District and Coverage Type.
AHCA – What it means for IL’s 13th District

From Table of CBO Coverage Loss by Congressional District:

- **Total Coverage Loss (non-elderly):** 51,200
- **Medicaid (non-elderly) total:** 32,700
- **Medicaid Adults:** 6,200
- **Medicaid Children:** 13,200
- **Medicaid Disabled:** 1,700
- **Medicaid Expansion:** 11,600
- **Medicaid Elderly:** 2,500
- **Employer-Sponsored Insurance:** 15,800
- **Exchanges and Other Coverage:** 2,700
Opposition to AHCA

• AARP
• AMA
• America’s Essential Hospitals
• Federation Of American Hospitals
• American College Of Physicians
• American Cancer Society
• American Lung Association
• Consumers Union
• J. Mario Molina, CEO Of Molina Healthcare
In Summary: ACA vs. AHCA
The Congressional Budget Office (CBO) Report on the AHCA

CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE
March 13, 2017

American Health Care Act

Budget Reconciliation Recommendations of the House Committees on Ways and Means
and Energy and Commerce, March 9, 2017

SUMMARY

The Concurrent Resolution on the Budget for Fiscal Year 2017 directed the House Committees on Ways and Means and Energy and Commerce to develop legislation to reduce the deficit. The Congressional Budget Office and the staff of the Joint Committee on Taxation (JCT) have produced an estimate of the budgetary effects of the American Health Care Act, which combines the pieces of legislation approved by the two committees pursuant to that resolution. In consultation with the budget committees, CBO used its March 2016 baseline with adjustments for subsequently enacted legislation, which underlies the resolution, as the benchmark to measure the cost of the legislation.
The non-partisan Congressional Budget Office and the staff of the Joint Committee on Taxation (JCT) have produced an estimate of the budgetary effects of the American Health Care Act.

Report was issued on Monday, March 13, 2017.

Summary of the report: The AHCA would *increase* costs for consumers while providing *less* coverage. The AHCA would benefit the healthy and wealthy.
• In 10 years, a total of **24 million more people will be uninsured** under the AHCA than is projected under current law. The uninsured rate under the House Republicans' bill will be higher than before the ACA was passed.

• **$880 billion dollars will be cut from the Medicaid program through elimination of the Medicaid expansion and a fundamental restructure of the Medicaid program.** This massive, unprecedented cost shift to states means **14 million people will lose Medicaid coverage** and millions of seniors, disabled individuals, and other vulnerable populations who rely on the program will be at risk.
Premiums and out-of-pocket costs will increase, particularly for older adults and those with lower incomes. At the same time, plans available on the marketplace will be less comprehensive than they are today—meaning **individuals will be paying more for less.**
Uninsured: Under the AHCA bill, the number of uninsured people will skyrocket and dramatically increase over time:

- **By 2026, 24 million more people will be uninsured** than under current law. This means that in 2026, 52 million people would be uninsured.

- In 2018 alone, 14 million more people will be uninsured than would be under current law.

- By 2020, roughly 17 percent of non-elderly adults (or 48 million people) will be uninsured. That is 21 million more people than we’d see under the Affordable Care Act.
Out-of-Pocket Costs:

Plans will cover a lower share of health care costs, so consumers will face higher deductibles and cost-sharing.

Low-income consumers will be particularly affected by these higher out-of-pocket costs.
Premiums:

Premiums will significantly increase for older and low-income consumers, leaving many with no option for affordable coverage.

- A stark example included in the analysis shows that a 64-year old making 175 percent of the federal poverty level (or $26,500 a year) will see his or her yearly premium increase nearly $13,000.
Tax Breaks:

This bill is a giveaway to wealthy individuals and corporations: The legislation would provide nearly $600 billion in tax breaks to high-income earners and health insurers.
Types of Coverage: This bill will negatively impact people with all different types of health coverage. In 2020, compared to current law:

- 9 million fewer people will have coverage through the individual market
- 9 million fewer people will be covered through Medicaid
- 2 million fewer people will have coverage through their employer
Cost Shift to States: This bill would cut $880 billion in federal Medicaid spending over 10 years, passing those costs on to states.

• Capping and cutting Medicaid will affect every state, whether it expanded coverage or not.
• By 2026, federal Medicaid spending will be cut by 25 percent. With cuts of that magnitude, every state will be affected.
• CBO even acknowledges that states will be left making hard decisions.
State Economies: Federal funds make up more than half of state Medicaid budgets. Taking $880 billion out of state economies will have a significant ripple effect and every state will be hit at some level.

• The economic impact of an $880 billion federal funding cut to states would be felt in employment losses, reduced business activity, and state and local tax losses.
What you might be hearing: Sorting fact from fiction
**Fiction:** The AHCA will bring down premiums

- Premiums would actually rise for older Americans
- Pricing for older Americans would go from 3:1 compared to younger people, to 5:1
- And subsidies would be capped at $4,000, which is a 2:1 ratio to that of younger people
• In 2018 and 2019, according to CBO and JCT’s estimates, **average premiums for single policyholders in the non-group market would be 15 percent to 20 percent higher than under current law**, mainly because the individual mandate penalties would be eliminated, inducing fewer comparatively healthy people to sign up.

• Starting in 2020, premiums **may** drop as a result of changes to individual mandate and employer mandate – **cheaper plans with less coverage will be offered** (elimination of actuarial minimum requirement)
Fiction: The market is “collapsing” or is in a “death spiral”

- The CBO report dispels Ryan’s assertion that the law is **collapsing upfront on page 2**: “In CBO and JCT’s assessment, however, the non-group market would probably be stable in most areas under either current law or the legislation.”
- With this finding, the CBO joins experts across the health care industry in dismissing a favorite GOP talking point that the law is in a “death spiral”.
- Analysts at S&P, CMS Office of Actuary agree with CBO.
- 4 Million new people bought coverage in 2017.
Trump says Obamacare 'is collapsing.' Here's what he's getting wrong

President Trump, as he has repeatedly in the past, said Tuesday that the Affordable Care Act is a disaster.
**Fiction**: The market is “collapsing” – *cont’d.*

The AHCA by contrast, would create a stable market only by making it nearly impossible for older adults and the sick to find affordable coverage, leaving only the healthy or wealthy in the market.

In essence, under the AHCA, the people that need health insurance the most would be cut out of the market entirely.
**Fiction**: Health Insurance Premiums are rising and becoming unaffordable

- Health insurance premiums on marketplaces created by the law did increase markedly this year in many parts of the country as insurers dealt with higher-than-expected medical claims from patients.
- But most consumers are still able to get health plans for less than $100 a month on the marketplaces, thanks to insurance subsidies made available by the ACA.
- 84% in Marketplaces had 0% cost increases.
Fiction: Health Insurance Premiums are rising and becoming unaffordable – cont’d.

• Healthcare costs in the employer market and in Medicare have been rising at historically low levels since the enactment of the 2010 health law.
**Fiction:** Health Insurance Premiums are rising and becoming unaffordable – *cont’d.*

- In 2016, for example, annual family premiums for employer-sponsored health insurance rose an average of just 3%, according to an annual survey by the nonprofit Kaiser Family Foundation and the Health Research & Educational Trust.

- And since 2011, premiums have risen 20%, far lower than in the previous five years, when premiums jumped 31%, and even lower than in the five years between 2001 and 2006, when they shot up 63%.
Sorting Fact from Fiction

**Family Premiums:**

**Average Annual Increase**

**Obamacare & America’s Comeback**

- Decade Before Obamacare: 7.9%
- 6 Years With Obamacare: 4.7%

Source: Kaiser Family Foundation, 2016 Employer Health Benefits Survey
Fiction: Health Insurance Premiums are rising and becoming unaffordable – cont’d.

Medicare has seen a similar slowdown, as the cost per enrollee has grown by an average of just 1.4% annually since 2011, according to the last report by the program’s trustees. That was the lowest growth rate in Medicare’s history, dating to 1965.
**Fiction:** The ACA is destroying jobs

- The U.S. has added more private sector jobs every month since the ACA was signed into law by President Obama in March 2010, a stark reversal from the months before the law was enacted when the economy was hemorrhaging jobs amid the recession.

**Fiction:** ACA has caused shift to part-time jobs

- There are no studies that show this.
Sorting Fact from Fiction

Private Sector Job Creation

Obamacare & America's Comeback

Decade Before Obamacare 6 Years & 10 Mos. with Obamacare

- 3.5 Million Jobs

+ 15.9 Million Jobs

Employment growth in the recovery
Change since June 2009, seasonally adjusted
Fiction: Men shouldn’t have to pay for women’s prenatal care coverage

- Statement by Rep. John Shimkus of IL’s 15th Congressional District shows a fundamental lack of understanding about how health insurance works. He would like to have “a la carte” health insurance, where you pick the specific coverage provisions you think you will need for yourself.
- Ignores the realities of how risk pools work.
"Unified risk pools are the team work that makes the dream work, baby."
fusion.net/story/391238/g... via @fusion

This GOP lawmaker wants to know why men should pay for maternity care!
fusion.net
Fiction: Men shouldn’t have to pay for women’s prenatal care coverage – cont’d.

- Women’s premiums help subsidize coverage for men’s health conditions, including prostate or testicular cancers, heart attacks and heart disease, etc.
- Also, we discovered many years ago that prenatal care is more cost-efficient than not providing such care. It helps produce healthier pregnancies and deliveries, and healthier babies, children, and moms.
**Fiction**: The AHCA will provide “patient-centered care” and get the government out of the way.

- There is absolutely nothing in the AHCA that addresses or provides for “patient-centered care”. It in no way reshapes how care is delivered.
- The ACA is not “government-run” health care.
**Fiction:** The CBO got the ACA analysis wrong, so they are wrong again.

- Non-partisan CBO correctly projected record coverage and that ACA would be fully paid for.
- CBO did not project Supreme Court case, which reduced Medicaid coverage or Congress defunding the rate stabilization fund ("Risk Corridor").
In Summary: ACA vs. AHCA
What consumers can do
What consumers can do

• Remember that democracy does not begin and end in the voting booth. Stay engaged throughout the legislative process!

• Make phone calls to your Representatives and Senators.

• Social media is great, but nothing compares to flooding your Representative with phone calls.

• Don’t just call once – call throughout the entire process. Let your Rep. know you are paying attention!
What consumers can do – cont’d.

• Teach others how to make phone calls!
• You can also contact your legislator with letters and in-office visits.
• Write Letters to the Editor.
Making that call

• **Sample message:**
  “Hi. My name is __________________. I live in ______________, Illinois. I am calling to demand that Representative ____ vote against repealing the ACA and cutting Medicaid funding. The American Health Care Act is not an adequate replacement that protects my care!”

• **You can add a short personal story of how the Affordable Care Act has helped you or someone you know. Or how you won’t be able to afford your health insurance premiums under the GOP’s health care law’s tax credits.**
Making that call – Phone Numbers

• Rep. Rodney Davis (IL 13th Congressional District) - Please call Rep. Davis’s district office at (217) 403-4690.

• Rep. John Shimkus (IL 15th Congressional District) – Please call his district office at (217) 446-0664.
• Not sure who your Representative is, or you don’t have their phone number?

• You can call the SEIU Health Care Protection Line at 866-426-2631 to contact your member of Congress. You will be prompted to type in your zip code in order to connect you to your Representative.

• You can also call the Capitol Switchboard at 202-224-3121 and an operator will connect you with the offices your request.
If you have never called your representative – some tips

• If you have never called your representative before, we want to let you know that it is very easy, and highly effective!

• When you call your Representative, you will not actually speak to him or her, but will most likely be leaving a message with the person whose job it is to answer the phone for the Representative.
If you have never called your representative – some tips

#1: Know what you want to say – you can have a short script, if that helps.

#2: Call the Representative’s District Office in your community, or their Washington, DC office, or both!

#3: Tell the person who answers the phone that you want to leave a message for the Representative

#4: Be prepared to give them your name and address. You can give them your phone number if you would like a call back.

#5: Tell them what it is you want your Representative to know.
There is hope!

#1: Millions of Americans just like you are getting involved in the efforts to #ProtectOurCare!

#2: The GOP has already changed its message from “repeal” to “repeal and replace”, and now to “repeal and repair” – they know that Americans don’t want to lose their coverage.

#3: Lots of public interest organizations are actively advocating and championing the effort – but they can’t do it, without “we, the people”.

#4: People with Medicare and employer-based health insurance are beginning to understand that they, too, will be affected, and they are joining these efforts.
Resources

CCHCC: http://healthcareconsumers.org
Healthy Illinois: http://healthyillinoiscampaign.org/
EverThrive IL: http://www.everthriveil.org/
Sargent Shriver National Center on Poverty Law: http://www.povertylaw.org/
Kaiser Family Foundation: http://healthreform.kff.org/
Families USA: http://www.familiesusa.org/
Community Catalyst: http://www.communitycatalyst.org/
Illinois Health Matters: http://illinoishealthmatters.org/

Champaign County Health Care Consumers
(217) 352-6533  |  cchcc@healthcareconsumers.org