Impact of the American Health Care Act: How Repeal and Replace Could Affect North Carolina

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Key Findings: Impact on Medicaid

- Medicaid expansion, after March 1, 2017, would not be subject to the enhanced federal match.
- A change in federal funding for Medicaid to a per capita allotment would limit federal liability for the Medicaid program and place more risk on state budgets.
- The federal share of Medicaid expenses would increase only by enrollment and by the Consumer Price Index for Medical Costs (CPI-M), which does not keep pace with the true increases in the cost of health care.
- To control costs on Medicaid programs, states could limit enrollment in optional categories or limit optional benefits.

Key Findings: Impact on Individual Insurance

- The individual health insurance mandate would be repealed.
- States could waive the essential health benefits required for qualified health plans which would result in less comprehensive health plans with lower premiums.
- States could waive the community ratings for setting health insurance rates, allowing insurance plans to charge individuals with pre-existing conditions more while lowering costs for those without pre-existing conditions.
- Health insurance subsidies under the AHCA would, on average, be less generous than under the ACA. The change will impact older and poorer North Carolinians more than younger and more affluent North Carolinians.
- States could mitigate some of the higher costs for health insurance under the AHCA with grants from the Patient and State Stability Fund.
- The net effect of these changes will be an average lower cost for insurance. However, the cost for older Americans and those with pre-existing conditions (in states that choose to waive community rating) will increase.

Key Findings: Impact on Number Insured and the Federal Budget

- The Congressional Budget Office (CBO) estimates that the AHCA would result in 23 million fewer insured Americans by 2026 (14 million fewer covered by Medicaid, 6 million fewer in the non-group market, and 3 million fewer with employment-based coverage).
- The CBO estimates that the AHCA would reduce the cumulative federal deficit by $119 billion by 2026.

Background

On May 4th, 2017, the United States House of Representatives voted 217-213 to pass the American Health Care Act (AHCA) of 2017. The AHCA was designed to "repeal and replace" the Patient Protection and Affordable Care Act (ACA), also known as Obamacare, through the Fiscal Year (FY) 2017 budget reconciliation process.[1]

While the House passed the AHCA, to become law, the Senate must also pass the bill, and the President must sign it. The bill faces an uncertain future in the Senate, where it likely will not pass without significant changes. If the Senate passes a different version of the reconciliation bill, the two chambers of Congress must work out their differences, and consolidate the two versions into one bill that must pass in both the House and the Senate.

Changes to Medicaid

Medicaid Expansion

The AHCA makes many changes to both the ACA's Medicaid expansion and to traditional Medicaid. Under the ACA, states have the option of expanding Medicaid to those whose income is below 133% of the federal poverty limit ($16,040 for an individual, or $32,718 for a family of four). North Carolina has chosen not to expand Medicaid thus far, although legislators in the General Assembly have proposed bills to expand Medicaid in the state.[2] The AHCA discourages Medicaid expansion in non-expansion states by limiting the enhanced Medicaid match (whereby the federal government pays for a higher percentage of the cost of care than traditional Medicaid) to those states that adopted expansion as of March 1, 2017. Therefore, if North Carolina were to expand Medicaid under the AHCA, the federal government would pay a far smaller portion of the cost of expansion than they would have under the ACA. Furthermore, under the AHCA, Medicaid expansion would be phased out for all states beginning in 2020, primarily by not allowing any new enrollees in the program.

Medicaid Funding: Per Capita Allotment

Among non-expansion states, including North Carolina, the AHCA's changes to traditional Medicaid funding will have a bigger impact than changes to Medicaid expansion. Currently, one-in-five of North Carolinians receive insurance through Medicaid. Traditional Medicaid provides health insurance coverage to certain low-income groups, including children, pregnant women, parents of dependent children, people who are disabled, and seniors. Medicaid is financed through a federal-state partnership, with the federal government contributing approximately 68% of the cost of services in North Carolina.[3] States receive guaranteed Medicaid matching payments with no limits on funding for qualified Medicaid expenses.

1 Reconciliation is a congressional tool that allows for expedited consideration of certain tax, spending, and debt limit legislation, according to strict rules. In the Senate, reconciliation bills are not subject to filibuster, the scope of amendments is limited, and can pass with a simple majority of 51 votes, rather than the typical two-thirds majority.

2 For information on the Governor's proposal and proposed legislation on Medicaid expansion in North Carolina, see http://www.nciom.org/publications/?issue-brief-new-opportunities-to-expand-health-insurance-access-to-low-income-north-carolinians.

Table 1. North Carolina Medicaid spending per capita by enrollment category (2011)[e,f]

	Total		Children		Adults		Aged		Disabled	
NC	$5,450	42nd	$2,355	30th	$4,360	23rd	$10,518	50th	$15,060	39th
US	$6,502		$2,492		$4,141		$17,522		$18,518	

The AHCA would convert Medicaid financing from guaranteed matching funds to a per capita cap beginning in FY 2020. The cap would be based on each state's spending per enrollee in 2016. Per capita allotments to states would be adjusted yearly based on changes in the Consumer Price Index for Medical Care (CPI-M) and program enrollment. Enrollees would be divided into five categories: elderly (65+), blind and disabled, children, adults who gained Medicaid coverage through Medicaid expansion under the ACA, and non-expansion adults. The federal government would provide the same amount of funding for each person in a category, regardless of the person's actual health care costs. This change to per-capita spending would mark an important shift in the way Medicaid has been financed since its inception in 1965.

Impact of Per Capita Allotment on North Carolina

North Carolina's state budget relies heavily on federal Medicaid funding. Currently, North Carolina spends approximately $14 billion on Medicaid, which provides coverage to 1.97 million North Carolinians. The federal government covers 62% of the total cost ($8.7 billion) with the state covering 25% ($3.5 billion). The state's total budget is $22.3 billion.[4,a] Switching from financing through matching funds to per capita allotments could affect the state budget. Currently, cost increases in Medicaid are shared between the federal and state government. Under the AHCA's per capita cap, North Carolina would be responsible for overruns in cost.[b] Per capita allotments allow the federal government to limit the growth of federal Medicaid expenditures. Medicaid's cost to the federal government would increase only by the CPI-M and increases in enrollment. The Congressional Budget Office[5] (CBO) estimates that moving to a per capita allotment for Medicaid would cut federal Medicaid spending by 25% over ten years.[c] Additionally, the CBO estimates that Medicaid spending from 2017-2026 will grow at an average annual rate of 4.4%, exceeding the CPI-M which they estimate will be 3.7% over that time.[d]

While the federal government benefits from a per capita financing structure, states bear the risks. If Medicaid costs grow at a lower rate than the CPI-M, the state budget would see a net benefit. However, if Medicaid costs grow at a higher rate than the CPI-M, as expected, the state would have to bear the costs. Additionally, if cost cutting is needed, state lawmakers will need to choose between restricting eligibility, cutting services, or reducing provider reimbursement.

Currently, North Carolina has very low per capita Medicaid spending compared to other states (see Table 1). With a per capita funding system for Medicaid, North Carolina would be "locked in" to these low capped payments.[5] Under the ACA, if the state chooses to add a new "optional" covered service for Medicaid enrollees (e.g. dental coverage for adults) or increase provider reimbursement rates, the federal government covers approximately 68% of the costs. Under the AHCA, any increases in costs other than an increase in enrollees or the CPI-M would be borne by the state.

Under the AHCA, the per capita amount per enrollee would be adjusted yearly based on enrollment by category and the CPI-M. However, historically, actual health care costs grow faster than the CPI-M.[d] The CPI-M measures only the prices of goods and services, not changes in health care consumption, creating the disparity. For example, the price of HbA1C blood testing for people with diabetes[6] may not change, but the quantity of tests being done has increased dramatically as the percentage of adults with diabetes has grown. If the state Medicaid program's costs grow above CPI-M, the state would have to bear the burden of those costs. Furthermore, the per capita amount will not adjust for other changes that could drive per enrollee costs, such as public health emergencies (e.g. H1N1 influenza outbreak, opioid addiction epidemic), changes in overall population health (e.g. the increase in obesity), and the arrival of new and potentially costly pharmaceuticals or other medical technologies. For example, treatment of hepatitis C has rapidly increased with the FDA's approval of two new curative drugs in 2014. In 2016, NC Medicaid spent over $70 million on these two drugs (Harvoni and Viekira).[g] There is little doubt that medical advances will continue to outpace the CPI-M. If the federal per capita allotment does not keep pace with Medicaid health care spending, the state would have to spend more or cut benefits.[7]

States that accept Medicaid funding must provide services to certain groups, including low-income children, income-eligible pregnant women, and individuals receiving Supplemental Security Income (SSI).[8] Most states, including North Carolina, also expand Medicaid eligibility to certain optional groups. In North Carolina, optional Medicaid-eligible groups include the aged/blind/disabled with incomes between 75-100% FPL, the medically needy, children with significant disabilities living at home, and a buy-in option for people with disabilities who are working.[h] North Carolina's Medicaid program covers mandatory benefits such as inpatient and outpatient hospital services and physician services, as well as many optional services, including prescription drug coverage, case management, personal care, physical and occupational therapy, home- and community-based services).

Under the AHCA, if the federal per capita allotment does not keep pace with Medicaid health care spending, the state would have to spend more or cut optional Medicaid covered groups or services. The CBO estimates that, "With less federal reimbursement for Medicaid, states would need to decide whether to commit more of their own resources to finance the program at current-law levels or whether to reduce spending by cutting payments to health care providers and health plans, eliminating optional services, restricting eligibility for enrollment, or (to the extent feasible) arriving at more efficient methods for delivering services."[d]

4 The remaining 13% of funding comes from other sources (e.g. fees, licenses and fines, grants, and local governments).
5 The Congressional Budget Office (CBO) is a government office that produces independent analyses of budgetary and economic reports for proposed legislation. The CBO "scores" legislative action affecting spending and revenues, as the AHCA does.
6 For patients with diabetes, an HbA1C level <9 is a widely accepted measure of whether diabetes is well-controlled.
7 Under Medicaid some services are mandatory (e.g. hospital inpatient and outpatient coverage, physician services) while others are optional (e.g. pharmacy, case management, CAP programs).
8 SSI is a program that provides supplemental income to low-income blind, disabled, and elderly (65+) individuals.

Disproportionate Share Hospital (DSH) Payments

Medicaid also provides funding to hospitals that serve a large number of Medicaid and low-income uninsured patients through disproportionate share hospital allotments (DSH). North Carolina hospitals received $320 million in DSH payments in FY 2016.[i] These payments are critical to the financial stability of many hospitals across the state from small county hospitals to large health systems. Under the ACA, based on the assumption of increases in insurance coverage and, therefore, decreases in uncompensated care, federal DSH payments will begin decreasing in FY 2018.

The AHCA repeals DSH cuts for all states for FY 2020-2025 and for non-expansion states for FY 2018-2019. Additionally, the AHCA provides $10 billion over five years (FY 2018-FY 2022) to non-expansion states for safety net funding. As of January 2017, 31 states had expanded Medicaid. That leaves 19 states to divide $2 billion per year. Funding is determined by the number of individuals in the state with incomes below 138% of FPL in 2015 relative to the total number of individuals with incomes below 138% of the FPL in all non-expansion states. The share of North Carolina's payment would be approximately 8.5% or $170 million per year for five years.[9,i,j] (Compared to between $2.6-5 billion in federal funds should North Carolina choose to expand Medicaid under the Affordable Care Act). States could use these funds to enhance payments to safety net providers. These funds could be used to increase the federal match for North Carolina Medicaid from 68% to 100% for FY 2018-2021 and 95% in FY 2022 (up to a capped amount and subject to limits).[10]

Other Medicaid Changes

In addition to changing the finance structures for Medicaid, the AHCA makes additional changes to

Medicaid, including:

- *Medicaid Eligibility for Children*: Under the ACA, children ages 6-19 in families with incomes between 100-138% of FPL were moved from the Children's Health Insurance Program (CHIP) into Medicaid. Under the AHCA, these children would be moved back to CHIP beginning January 1, 2020. CHIP funding is not an entitlement program and funding is capped, which means that eligibility does not guarantee coverage. Furthermore, CHIP is currently only funded through September 2017, and authorized through 2019.
- *Presumptive Eligibility*: Under the ACA, hospitals became qualified entities to screen for Medicaid eligibility and temporarily enroll participants until a full determination could be made. The AHCA repeals hospital presumptive eligibility.
- *Retroactive Coverage*: Currently, individuals who are determined to be eligible for Medicaid receive three months of retroactive coverage. Under the AHCA, beginning October 1, 2017, individuals determined to be eligible for Medicaid would receive coverage "in or after" the month of application.
- *Work Requirements*: The AHCA creates a state option to require work as a condition of eligibility for nondisabled, nonelderly, nonpregnant Medicaid enrollees. The work requirement exempts children and sole caretakers of young children or disabled children.[11]
- *Block Grant Option*: The AHCA gives states the option of receiving a block grant for Medicaid funding for low-income children, pregnant women and low-income parents while leaving an open-ended funding structure for other Medicaid enrollment groups.

Changes to the Individual Insurance Market

Most individuals in North Carolina get their health insurance through either the state or federal government (e.g. Medicaid, Medicare, or Tricare[12]) or their employer. However, 18% of North Carolinians do not have health insurance through these sources.[k] These individuals can purchase health insurance through the individual, or non-group, insurance market. Currently, only 7% of North Carolinians purchase insurance through the individual market.[k]

Generally, North Carolina has lower overall health care costs and group premiums than the national average. However, North Carolina's ACA individual health insurance marketplace has the highest premiums in the continental US.[l] Since the introduction of the ACA individual marketplace in 2014, premiums in North Carolina have more than doubled. Various factors, including being a non-Medicaid-expansion state, being in the federal marketplace, having high unmet health needs among the eligible population, and allowing people to keep and renew their pre-ACA insurance policies that do not comply with ACA requirements, contribute to North Carolina's higher premiums in the ACA marketplace.[m]

Prior to the ACA, the individual insurance market had few regulations regarding the types of plans that could be offered, the prices of plans, and eligibility. Individuals with preexisting health conditions were often either deemed not eligible for insurance coverage or were offered plans that were prohibitively expensive. The ACA created health insurance marketplaces, online resources to help people shop for and enroll in health insurance plans. The ACA further established rules and regulations about the plans offered through the marketplaces (e.g. essential benefits coverage, 60% actuarial value or more, community rating pricing system). Under the ACA, in order to receive tax credits or cost-sharing subsidies, eligible individuals must purchase a qualified health plan through a health insurance marketplace.[13]

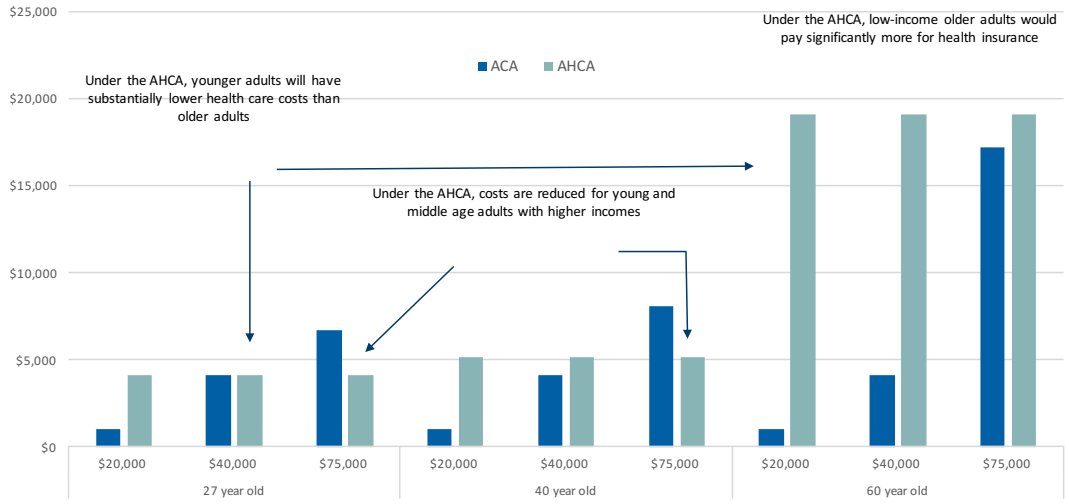
The AHCA retains some of the rules and regulations the ACA imposed on the individual insurance market, removes others, and introduces new rules and requirements. Table 1 summarizes the rules and regulations for the individual insurance market under the ACA and AHCA. In many cases, under the AHCA, states will have the option to waive requirements of the ACA. Additionally, the AHCA replaces the ACA's system of tax credits and subsidies to insurers with a different system of tax credits.

9 North Carolina's uninsured under 138% of the FPL is 379,000 out of 4,482,000 from all non-expansion states or 8.5%. 8.5% of $2 billion per year is $170 million.
10 HR 1628 Section 115
11 HB 662 in the North Carolina General Assembly proposes to add a work requirement to North Carolina's Medicaid program.
12 Tricare is the health care program for uniformed service members and their families.
13 North Carolina did not create a state health insurance marketplace, instead opting to use the federal health insurance marketplace (healthcare.gov).

Table 2: Rules and Regulation for the Individual Insurance Market under the ACA vs. AHCA

	ACA	AHCA
Individual Mandate	Requirement to have insurance that provides minimum coverage or pay penalty	Repeals individual mandate. Replaces with late enrollment penalty
Insurance Rules		
Young Adults	Dependent coverage up to age 26	Keeps dependent coverage up to age 26
Essential Health Benefits	Requires all plans sold through the marketplace to include essential benefits	Retains essential benefits requirement but gives states the option to waive requirements.
Insurance Rating (factors that can be used to set insurance premiums)	Limits factors used in insurance rating to age (3:1 ratio for adults), tobacco use, family size and geography	Keeps ACA insurance rating factors, but changes age rating ratio to 5:1, unless states adopt different ratios Option for states to waive health status rating prohibition for individuals who have not had continuous coverage
Preexisting Conditions	No denial of coverage or increased premiums for pre-existing conditions	No denial of coverage for pre-existing conditions States may allow insurers to charge more for pre-existing conditions, if they choose to use Patient and State Stability Fund grants for high risk pools or reinsurance or participate in the Federal Invisible Risk Sharing Program.
Late Enrollment Penalty	No penalty	Late enrollment penalty of 30% of otherwise applicable premium for individuals who have not maintained continuous creditable coverage (had 63 days or more uninsured in the previous 12 months) beginning with late enrollment 2018 and all plans 2019. The penalty applies to the first year of coverage only. Option for states to waive health status rating prohibition for individuals who have not maintained continuous coverage
Enrollment	Established open enrollment periods and special enrollment periods for the health insurance marketplaces	Retains health insurance marketplaces and enrollment periods
Benefit Design	Requires all plans sold through the marketplace to include coverage for ten essential benefits No annual or lifetime dollar limits for essential health benefits Cover preventive benefits with no cost sharing Requires plans apply in-network level of cost sharing for out-of-network emergencies	Retains essential benefits requirement but gives states the option to waive requirements. No annual or lifetime dollar limits for essential health benefits Cover preventive benefits with no cost sharing Requires plans apply in-network level of cost sharing for out-of-network emergencies Redefines qualified health plan to exclude any plan that includes abortion coverage
Premiums and Subsidies	Income-based tax credits Tax credits only apply to plans purchased through the Marketplaces	Flat tax credit adjusted for age starting in 2020 (smaller changes to ACA subsidies for 2018-2019) Families can claim credits for up to 5 oldest family members up to limit of $14,000/year Married couple must file jointly to claim the credit. Tax credit phases out stating at incomes above $75,000. Amount of tax credits indexed to Consumer Price Index plus one percentage point Tax credits apply to any eligible individual health insurance plan sold on or off Marketplace.
Cost Sharing Subsidies	Includes subsidies paid to insurance companies to reduce cost sharing burden for families with incomes between 100%-250% FPL	Repealed effective January 1, 2020

Figure 1: The Impact of the AHCA on the Cost of Health Insurance Premiums after Tax Credits in the Individual Market, based on Income, Age, in North Carolina in 2020



Notes: Data presented are for Mecklenberg county, data for all Noth Carolina counties is available online
The AHCA would allow states to waive certain consumer protections, including essential health benefits, community rating and age rating. If a state takes up such a waiver, the premium amounts for that state would no longer be applicable. For example, enrollee costs could depend on their health status, with healthy people paying less and sicker people or those with pre-existing conditions paying more. The data also does not include cost-sharing assistance under the ACA that lowers deductibles and copayments for low-income marketplace enrollees.

Source: The Henry J. Kaiser Family Foundation. Premiums and Tax Credits Under the Affordable Care Act vs. the American Health Care Act: Interactive Maps. Accessed online at http://kff.org/interactive/tax-credits-under-the-affordable-care-act-vs-replacement-proposal-interactive-map/.

Late Enrollment Penalty

Under the AHCA, beginning in 2018, individuals who do not maintain continuous health care coverage (those who were uninsured for 63 or more days in the previous 12 months) can be charged a late enrollment penalty of 30% of their otherwise applicable premium. The penalty applies for only the first year of coverage under the new plan. This is meant to incentivize individuals to enroll in and maintain coverage in the absence of the individual mandate.

Many changes to the individual insurance market in the short-term (2018-2019) are different from changes after 2020, when the AHCA goes into full effect.

Short-Term Impact of Changes in the Individual Insurance Market in North Carolina (2018-2019)

Changes to the individual market under the AHCA will impact the almost 550,000 North Carolinians who purchase individual health insurance through the federal health insurance marketplace.[n] Of these, more than 90% receive tax credits to reduce the amount they pay for insurance and more than 70% also receive cost sharing reductions.[n]

In the short-term under the AHCA, the CBO estimates that most currently enrolled individuals eligible for ACA tax credits, which stay in place until 2020, will continue to get health insurance through the marketplace.[c] Some healthy individuals are expected to drop insurance because the AHCA eliminates the individual mandate to have insurance or pay a tax penalty. Under the AHCA, the Secretary of Health and Human Services can change the age rating[14] from 3-1 to 5-1 in 2018, thereby reducing the cost of insurance for younger adults and increasing costs for older adults. In the short-term, the ACA subsidies will likely shield older adults from increases in the cost of their insurance.

The CBO estimates that the marketplace's stability will depend upon insurers in the short-term.[c] Blue Cross Blue Shield North Carolina (BCBSNC), one of only two insurers currently offering ACA plans in North Carolina, indicated they will continue to offer plans on the ACA marketplace in 2018 and have requested a 24.3% increase in premiums for 2018.[o] BCBSNC reports a number of reasons for this steep increase, including increasing medical costs. However, BCBSNC cites the uncertainty around whether the federal government will eliminate "cost sharing reductions," which are paid directly to insurers to underwrite the cost of providing significantly reduced prices for ACA plans, as the main reason for such large premium increases for 2018.[o]

Long-Term Impact of Changes in the Individual Insurance Market in North Carolina (2020 on)

Beginning in 2020, the AHCA would dramatically alter the individual insurance market. However, the size and nature of the impact of the AHCA on the individual insurance market will vary depending on the course of action states choose. Under the AHCA, states have a wide range of options, most notably states can request waive requirements for essential health benefits[15] and/or community rating.[16]

Without the need to include essential health benefits, health insurance providers could offer health insurance plans with fewer benefits than currently required. The CBO estimates that states would be most likely to drop maternity care, mental health and substance abuse benefits, and rehabilitative and habilitative services.[d,17] Waiving the community rating requirement[18] would allow health insurance providers to use health status (i.e. pre-existing conditions) to determine the cost of plans.[19]

14 Age rating is the practice of varying health insurance premiums based on age. Under the ACA, an age rating of 3-1, meaning older adults could not be charged more than 3 times what younger adults were charged, was mandated. Prior to the ACA, many states had age ratings of 5-1.

15 The ACA defines a set of 10 categories of services that health insurance plans must cover under the ACA. These "essential health benefits" under the ACA include ambulatory patient services, emergency services, hospitalization, pregnancy, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services, and pediatric services including oral and vision care.

16 Community rating rules under the ACA requires insurance providers to offer health insurance policies to individuals within a given community at the same price, allowing variation only on smoking status, family size, and age (3-to-1 variance maximum).

17 The ban on annual and lifetime limits only applies to services covered under essential health benefits, so those protections will not apply to any dropped services.

18 Under the ACA, community rating is a rule that requires health insurance providers to offer policies to all people within a given community at the same price, without medical underwriting, regardless of their health status."

19 The definition of "pre-existing conditions" is set by health insurance providers. Health insurance providers use a practice called medical underwriting to help determine which medical conditions an applicant has. An individuals' pre-existing or emergent health conditions are used

Approximately 27% of adults in North Carolina under the age of 65 are estimated to have health conditions that would likely make them uninsurable without the community rating.[p] Many more have medical conditions that would be grounds for higher premiums, exclusions, or limitations on coverage.[p]

Both of these options would reduce costs for younger, healthier adults while steeply increasing costs for individuals with pre-existing conditions and more health needs.[d] The impact in North Carolina would vary based on what the state legislature chose to do:

- *No additional changes to insurance regulation*: The CBO estimates that if North Carolina chose to implement the AHCA as written with no waivers, average premiums in 2026 would be about 4% lower than under the ACA. Furthermore, the CBO estimates that the AHCA tax credit system and other changes will lower average premiums enough to keep enough healthy people in the markets to keep them stable.[c] Health insurance premiums would rise significantly for older adults and decrease significantly for younger adults.

- *Waive Essential Health Benefits or Waive Community Rating*: If North Carolina opted to waive essential health benefits or waive community rating, the CBO estimates that average premiums in the individual insurance market would be 10-30% lower because insurance policies would provide fewer benefits. Reductions would be much larger for younger adults and much smaller for older adults.

  While prices would decline for healthy adults, those who need services no longer included in essential health benefits or who have pre-existing or newly acquired conditions would have drastically higher premiums (e.g. more than $1,000/month for maternity coverage), and/or out-of-pocket costs, and may be unable to purchase coverage at all. As a result of higher premiums for some consumers and repeal of the insurance mandate, the Congressional Budget Office estimates 6-10 million who received health insurance under the ACA will be uninsured under the AHCA.[c]

- *Waive both Essential Health Benefits and Community Rating*: If North Carolina were to waive requirements for both essential health benefits and community rating, average premiums would be lower for healthy adults while individuals with health conditions would face drastically increased premiums if they could find coverage at all.

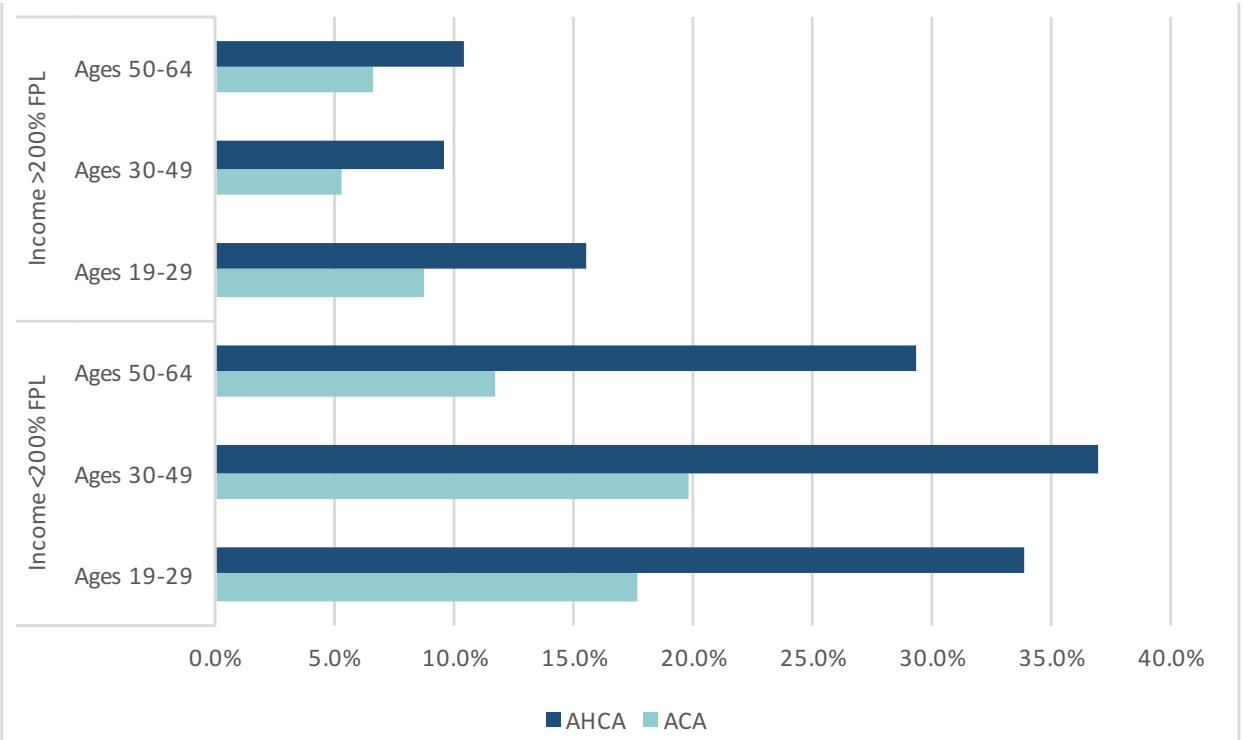
Premiums and Subsidies

The AHCA tax credits for individuals purchasing insurance through the individual marketplace, which would replace the ACA tax credit and cost-sharing subsidies in 2020, would generally be less generous for those receiving subsidies under the ACA (See Figure 1).[c] Under the ACA, for individuals and families with incomes below 400% of the FPL and eligible for tax credits, the maximum that any individual/family can be charged for health insurance premiums is 9.5% of family income. Under the AHCA, subsidies are determined by age (although they do begin to phase out at incomes above $75,000). As you can see in Figure 1, individuals making $20,000 per year face much higher premiums under the AHCA, rising from 20% of a 27-year old's yearly income to 95% of a 60 year old's yearly income. In contrast, under the AHCA, young and middle age individuals making $75,000 per year will pay a smaller percentage of their incomes towards health insurance premiums.

Under the AHCA, the uninsured rate is expected to increase substantially across all age and income categories (See Figure 2 below).

to determine if a policy should be issued and the cost of the individual's premium.

Figure 2: Share of Nonelderly Adults Without Health Insurance Coverage Under Current Law and AHCA, by Age and Income Category, 2026



Source: Data from Congressional Budget Office. H.R. 1628, American Health Care Act of 2017. Congressional Budget Office website. https://www.cbo.gov/publication/52752. Published May 24, 2017. Accessed May 31, 2017.

High Risk Pools

The AHCA sets aside up to $138 billion to support high risk pools and coverage for those with pre-existing conditions from 2018-2026.[q] States could choose whether to create high risk pools. High risk pool plans would provide coverage for individuals who are locked out or priced out of the individual insurance market because of pre-existing conditions. Insurance offered through high risk pools is subsidized by state governments. North Carolina ran a high-risk pool, Inclusive Health, from 2009-2013. Inclusive Health covered 11,000 residents in 2013, but had to close for new enrollees due to a lack of funding.[r] In 2014, with the implementation of the ACA's community rating and other requirements, individuals enrolled in Inclusive Health were moved to plans offered through the individual insurance marketplace.

Funding for state high risk pools under the AHCA would be administered through a variety of mechanisms, including grants to states and payments to insurance companies. CMS will be responsible for determining the allocation of funds and rules around pre-existing conditions. States will be required to match the core funds of these programs ($100 million) with a 7% match in 2020, and increasing to a 50% match in 2026. Depending on the way high-risk persons are defined, one analysis predicts that between 2.5 and 7.6 million people will qualify for this service costing a total of $496 to $827 billion from 2020 to 2029.[s]

Health Care Savings

The AHCA would encourage contributions to Health Savings Accounts in several ways. The tax free yearly contribution limits would increase (from $3,400 to $6,550 per person, and from $6,750 to $13,100 per family). The AHCA also adds a catch-up contribution for people over 55 ($1000 per year), and decreases the tax penalty from 20% to 10% if funds are used for non-qualified expenses.[q]

Reproductive Health

The AHCA may impact reproductive health in several important ways:[q]

- In states electing to receive Medicaid as a block grant, family planning would no longer be a mandatory service.
- The AHCA maintains that qualified health plans must pay for recommended preventive services, such as cervical cancer screening and contraceptive counselling, with no cost sharing.
- Under the ACA, maternity coverage is considered an essential health benefit. However, states that apply to waive essential health benefits may waive the requirement that insurance covers maternity care.
- The ACHA continues to prohibit excluding people from insurance for pre-existing conditions. However, states that waive community rating would allow insurers to use medical underwriting, meaning pre-existing conditions, such as pregnancy and previous cesarean section, which would impact insurance rates.
- Under the AHCA, qualified health plans (the only plans eligible for a subsidy) cannot include abortion coverage beyond cases of incest, rape, or to save a women's life. Women could buy a separate plan to cover abortion services. Medicaid funds could not be paid to Planned Parenthood for one year.

Other Components of the AHCA

The AHCA includes a number of other components around financing which mainly focus on repealing ACA taxes. More information on these changes is available online at http://files.kff.org/attachment/Proposals-to-Replace-the-Affordable-Care-Act-Summary-of-the-American-Health-Care-Act

Conclusions

The AHCA has a long path to becoming law. The CBO score of the AHCA, which was not available when the House passed the bill, makes a few things clear:

- The primary impact of AHCA would be to reduce the federal government's deficit over the next decade, primarily through reductions in federal Medicaid spending and reductions in subsidies for individuals purchasing health insurance.
- The AHCA would lead to a significant decrease in the number of people with health insurance.
- Stability of the individual health insurance markets after full AHCA implementation will depend on whether states remove existing requirements to cover pre-existing conditions and essential health benefits.
- Premiums will rise in the short-term (2018-2019).
- After full AHCA implementation in 2020, premiums for young, healthy individuals will be significantly lower, while premiums and out-of-pocket costs for older adults and individuals with pre-existing or other health conditions will be significantly more expensive.

If the AHCA is implemented, Medicaid expansion will gradually be eliminated and federal Medicaid liabilities will be limited over time. States will either face higher costs or be forced to decrease benefits, reimbursement rates, or number of enrollees. The CBO estimates that younger, healthier individuals will have lower premiums because they will be able to purchase less comprehensive coverage, while older, poorer, and less healthy individuals will face steep increases in premiums and out-of-pocket costs. The changes to both Medicaid and the private group and non-group market will result in approximately 23 million fewer insured Americans by 2026. The impact would be less dramatic in states, such as North Carolina, that chose not to expand Medicaid.

The AHCA appears unlikely to pass the Senate in its current form. Many senators have expressed concerns about the CBO's scoring of the AHCA. The Senate is currently working on drafting a health care bill—how closely it will match the AHCA is unknown. If the Senate votes on and passes a bill, any differences between the House and Senate and versions of the will be bill negotiated in conference, and then the final bill will require passage in the House and Senate and the President's signature before it becomes law.

At this point, the AHCA has set the stage for discussion of health care reform at the federal level. The Senate bill, whether an amended version of the AHCA or a newly drafted bill, will almost certainly be crafted with the AHCA and the CBO score in mind. Federal lawmakers will be considering how to accommodate competing priorities of choice, price, coverage, and deficit reduction. As the discussions of health reform at the federal level continue, North Carolina's congressional delegation should consider the impact of any changes on the health and well-being of residents.

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Appendix: Difference in Tax Credits in 2020 for single coverage under the Affordable Care Act vs. the American Health Care Act, by county

	Dollar difference ACA tax credit vs. AHCA tax credit								
	Single coverage for a 27-year-old			Single coverage for a 40-year-old			Single coverage for a 60-year-old		
	$20,000 Income	$40,000 Income	$75,000 Income	$20,000 Income	$40,000 Income	$75,000 Income	$20,000 Income	$40,000 Income	$75,000 Income
County									
Alamance	-$2,990	$140	$2,000	-$3,290	-$170	$3,000	-$10,440	-$7,310	$4,000
Alexander	-$2,810	$310	$2,000	-$3,080	$50	$3,000	-$9,980	-$6,860	$4,000
Alleghany	-$3,740	-$620	$2,000	-$4,210	-$1,090	$3,000	-$12,380	-$9,260	$4,000
Anson	-$3,670	-$550	$2,000	-$4,130	-$1,000	$3,000	-$12,210	-$9,090	$4,000
Ashe	-$3,740	-$620	$2,000	-$4,210	-$1,090	$3,000	-$12,380	-$9,260	$4,000
Avery	-$3,470	-$350	$2,000	-$3,880	-$760	$3,000	-$11,680	-$8,560	$4,000
Beaufort	-$3,670	-$550	$2,000	-$4,130	-$1,000	$3,000	-$12,210	-$9,090	$4,000
Bertie	-$3,600	-$480	$2,000	-$4,040	-$920	$3,000	-$12,030	-$8,910	$4,000
Bladen	-$4,140	-$1,020	$2,000	-$4,700	-$1,580	$3,000	-$13,440	-$10,310	$4,000
Brunswick	-$3,060	$70	$2,000	-$3,370	-$250	$3,000	-$10,610	-$7,490	$4,000
Buncombe	-$3,470	-$350	$2,000	-$3,880	-$760	$3,000	-$11,680	-$8,560	$4,000
Burke	-$2,810	$310	$2,000	-$3,080	$50	$3,000	-$9,980	-$6,860	$4,000
Cabarrus	-$3,670	-$550	$2,000	-$4,130	-$1,000	$3,000	-$12,210	-$9,090	$4,000
Caldwell	-$2,810	$310	$2,000	-$3,080	$50	$3,000	-$9,980	-$6,860	$4,000
Camden	-$3,600	-$480	$2,000	-$4,040	-$920	$3,000	-$12,030	-$8,910	$4,000
Carteret	-$3,670	-$550	$2,000	-$4,130	-$1,000	$3,000	-$12,210	-$9,090	$4,000
Caswell	-$2,900	$220	$2,000	-$3,180	-$60	$3,000	-$10,210	-$7,090	$4,000
Catawba	-$2,810	$310	$2,000	-$3,080	$50	$3,000	-$9,980	-$6,860	$4,000
Chatham	-$2,830	$290	$2,000	-$3,100	$20	$3,000	-$10,030	-$6,910	$4,000
Cherokee	-$3,470	-$350	$2,000	-$3,880	-$760	$3,000	-$11,680	-$8,560	$4,000
Chowan	-$3,600	-$480	$2,000	-$4,040	-$920	$3,000	-$12,030	-$8,910	$4,000
Clay	-$3,470	-$350	$2,000	-$3,880	-$760	$3,000	-$11,680	-$8,560	$4,000
Cleveland	-$3,650	-$530	$2,000	-$4,100	-$980	$3,000	-$12,160	-$9,030	$4,000
Columbus	-$3,060	$70	$2,000	-$3,370	-$250	$3,000	-$10,610	-$7,490	$4,000
Craven	-$3,670	-$550	$2,000	-$4,130	-$1,000	$3,000	-$12,210	-$9,090	$4,000
Cumberland	-$4,140	-$1,020	$2,000	-$4,700	-$1,580	$3,000	-$13,440	-$10,310	$4,000
Currituck	-$3,600	-$480	$2,000	-$4,040	-$920	$3,000	-$12,030	-$8,910	$4,000
Dare	-$3,670	-$550	$2,000	-$4,130	-$1,000	$3,000	-$12,210	-$9,090	$4,000
Davidson	-$3,050	$80	$2,000	-$3,360	-$240	$3,000	-$10,590	-$7,470	$4,000
Davie	-$3,050	$80	$2,000	-$3,360	-$240	$3,000	-$10,590	-$7,470	$4,000
Duplin	-$3,060	$70	$2,000	-$3,370	-$250	$3,000	-$10,610	-$7,490	$4,000
Durham	-$2,900	$220	$2,000	-$3,180	-$60	$3,000	-$10,210	-$7,090	$4,000
Edgecombe	-$3,870	-$750	$2,000	-$4,370	-$1,250	$3,000	-$12,730	-$9,610	$4,000
Forsyth	-$3,050	$80	$2,000	-$3,360	-$240	$3,000	-$10,590	-$7,470	$4,000
Franklin	-$2,870	$250	$2,000	-$3,150	-$30	$3,000	-$10,130	-$7,010	$4,000
Gaston	-$3,650	-$530	$2,000	-$4,100	-$980	$3,000	-$12,160	-$9,030	$4,000
Gates	-$3,600	-$480	$2,000	-$4,040	-$920	$3,000	-$12,030	-$8,910	$4,000
Graham	-$3,470	-$350	$2,000	-$3,880	-$760	$3,000	-$11,680	-$8,560	$4,000
Granville	-$3,940	-$820	$2,000	-$4,460	-$1,330	$3,000	-$12,910	-$9,790	$4,000
Greene	-$3,870	-$750	$2,000	-$4,370	-$1,250	$3,000	-$12,730	-$9,610	$4,000
Guilford	-$3,270	-$140	$2,000	-$3,630	-$510	$3,000	-$11,160	-$8,040	$4,000
Halifax	-$3,600	-$480	$2,000	-$4,040	-$920	$3,000	-$12,030	-$8,910	$4,000
Harnett	-$4,140	-$1,020	$2,000	-$4,700	-$1,580	$3,000	-$13,440	-$10,310	$4,000
Haywood	-$3,470	-$350	$2,000	-$3,880	-$760	$3,000	-$11,680	-$8,560	$4,000
Henderson	-$3,470	-$350	$2,000	-$3,880	-$760	$3,000	-$11,680	-$8,560	$4,000
Hertford	-$3,600	-$480	$2,000	-$4,040	-$920	$3,000	-$12,030	-$8,910	$4,000
Hoke	-$4,140	-$1,020	$2,000	-$4,700	-$1,580	$3,000	-$13,440	-$10,310	$4,000
Hyde	-$3,670	-$550	$2,000	-$4,130	-$1,000	$3,000	-$12,210	-$9,090	$4,000
Iredell	-$2,810	$310	$2,000	-$3,080	$50	$3,000	-$9,980	-$6,860	$4,000
Jackson	-$3,470	-$350	$2,000	-$3,880	-$760	$3,000	-$11,680	-$8,560	$4,000
Johnston	-$2,720	$410	$2,000	-$2,960	$160	$3,000	-$9,740	-$6,610	$4,000
Jones	-$3,670	-$550	$2,000	-$4,130	-$1,000	$3,000	-$12,210	-$9,090	$4,000
Lee	-$2,990	$140	$2,000	-$3,290	-$170	$3,000	-$10,440	-$7,310	$4,000
Lenoir	-$3,670	-$550	$2,000	-$4,130	-$1,000	$3,000	-$12,210	-$9,090	$4,000
Lincoln	-$3,650	-$530	$2,000	-$4,100	-$980	$3,000	-$12,160	-$9,030	$4,000
McDowell	-$3,470	-$350	$2,000	-$3,880	-$760	$3,000	-$11,680	-$8,560	$4,000
Macon	-$3,470	-$350	$2,000	-$3,880	-$760	$3,000	-$11,680	-$8,560	$4,000
Madison	-$3,470	-$350	$2,000	-$3,880	-$760	$3,000	-$11,680	-$8,560	$4,000
Martin	-$3,600	-$480	$2,000	-$4,040	-$920	$3,000	-$12,030	-$8,910	$4,000
Mecklenburg	-$3,670	-$550	$2,000	-$4,130	-$1,000	$3,000	-$12,210	-$9,090	$4,000
Mitchell	-$3,470	-$350	$2,000	-$3,880	-$760	$3,000	-$11,680	-$8,560	$4,000
Montgomery	-$3,870	-$750	$2,000	-$4,370	-$1,250	$3,000	-$12,730	-$9,610	$4,000
Moore	-$3,870	-$750	$2,000	-$4,370	-$1,250	$3,000	-$12,730	-$9,610	$4,000

	Dollar difference ACA tax credit vs. AHCA tax credit								
	Single coverage for a 27-year-old			Single coverage for a 40-year-old			Single coverage for a 60-year-old		
	$20,000 Income	$40,000 Income	$75,000 Income	$20,000 Income	$40,000 Income	$75,000 Income	$20,000 Income	$40,000 Income	$75,000 Income
Nash	-$2,870	$250	$2,000	-$3,150	-$30	$3,000	-$10,140	-$7,020	$4,000
New Hanover	-$3,060	$70	$2,000	-$3,370	-$250	$3,000	-$10,610	-$7,490	$4,000
Northampton	-$3,600	-$480	$2,000	-$4,040	-$920	$3,000	-$12,030	-$8,910	$4,000
Onslow	-$3,060	$70	$2,000	-$3,370	-$250	$3,000	-$10,610	-$7,490	$4,000
Orange	-$2,830	$290	$2,000	-$3,100	$20	$3,000	-$10,030	-$6,910	$4,000
Pamlico	-$3,670	-$550	$2,000	-$4,130	-$1,000	$3,000	-$12,210	-$9,090	$4,000
Pasquotank	-$3,600	-$480	$2,000	-$4,040	-$920	$3,000	-$12,030	-$8,910	$4,000
Pender	-$3,060	$70	$2,000	-$3,370	-$250	$3,000	-$10,610	-$7,490	$4,000
Perquimans	-$3,600	-$480	$2,000	-$4,040	-$920	$3,000	-$12,030	-$8,910	$4,000
Person	-$2,900	$220	$2,000	-$3,180	-$60	$3,000	-$10,210	-$7,090	$4,000
Pitt	-$3,870	-$750	$2,000	-$4,370	-$1,250	$3,000	-$12,730	-$9,610	$4,000
Polk	-$3,470	-$350	$2,000	-$3,880	-$760	$3,000	-$11,680	-$8,560	$4,000
Randolph	-$3,270	-$140	$2,000	-$3,630	-$510	$3,000	-$11,160	-$8,040	$4,000
Richmond	-$4,140	-$1,020	$2,000	-$4,700	-$1,580	$3,000	-$13,440	-$10,310	$4,000
Robeson	-$4,140	-$1,020	$2,000	-$4,700	-$1,580	$3,000	-$13,440	-$10,310	$4,000
Rockingham	-$3,270	-$140	$2,000	-$3,630	-$510	$3,000	-$11,160	-$8,040	$4,000
Rowan	-$3,670	-$550	$2,000	-$4,130	-$1,000	$3,000	-$12,210	-$9,090	$4,000
Rutherford	-$3,470	-$350	$2,000	-$3,880	-$760	$3,000	-$11,680	-$8,560	$4,000
Sampson	-$4,140	-$1,020	$2,000	-$4,700	-$1,580	$3,000	-$13,440	-$10,310	$4,000
Scotland	-$4,140	-$1,020	$2,000	-$4,700	-$1,580	$3,000	-$13,440	-$10,310	$4,000
Stanly	-$3,670	-$550	$2,000	-$4,130	-$1,000	$3,000	-$12,210	-$9,090	$4,000
Stokes	-$3,050	$80	$2,000	-$3,360	-$240	$3,000	-$10,590	-$7,470	$4,000
Surry	-$3,050	$80	$2,000	-$3,360	-$240	$3,000	-$10,590	-$7,470	$4,000
Swain	-$3,470	-$350	$2,000	-$3,880	-$760	$3,000	-$11,680	-$8,560	$4,000
Transylvania	-$3,470	-$350	$2,000	-$3,880	-$760	$3,000	-$11,680	-$8,560	$4,000
Tyrrell	-$3,670	-$550	$2,000	-$4,130	-$1,000	$3,000	-$12,210	-$9,090	$4,000
Union	-$3,670	-$550	$2,000	-$4,130	-$1,000	$3,000	-$12,210	-$9,090	$4,000
Vance	-$3,940	-$820	$2,000	-$4,460	-$1,330	$3,000	-$12,910	-$9,790	$4,000
Wake	-$2,720	$410	$2,000	-$2,960	$160	$3,000	-$9,740	-$6,610	$4,000
Warren	-$3,940	-$820	$2,000	-$4,460	-$1,330	$3,000	-$12,910	-$9,790	$4,000
Washington	-$3,670	-$550	$2,000	-$4,130	-$1,000	$3,000	-$12,210	-$9,090	$4,000
Watauga	-$3,740	-$620	$2,000	-$4,210	-$1,090	$3,000	-$12,380	-$9,260	$4,000
Wayne	-$3,870	-$750	$2,000	-$4,370	-$1,250	$3,000	-$12,730	-$9,610	$4,000
Wilkes	-$3,740	-$620	$2,000	-$4,210	-$1,090	$3,000	-$12,380	-$9,260	$4,000
Wilson	-$3,870	-$750	$2,000	-$4,370	-$1,250	$3,000	-$12,730	-$9,610	$4,000
Yadkin	-$3,050	$80	$2,000	-$3,360	-$240	$3,000	-$10,590	-$7,470	$4,000
Yancey	-$3,470	-$350	$2,000	-$3,880	-$760	$3,000	-$11,680	-$8,560	$4,000

Note: Under the ACA, individuals' tax credit amount depends on their income, age, and geography (individuals with incomes up to 400% of the federal poverty limit ($60,240) are eligible for tax credits under the ACA). Under the AHCA, tax credits are based on age: 27-year-olds receive a $2,000 credit; 40-year-olds receive a $3,000 credit, and 60-year-olds receive a $4,000 credit.

Source: Data downloaded from The Henry J. Kaiser Family Foundation. Tax Credits for 2020 for Single Coverage. Accessed online at http://kff.org/interactive/tax-credits-under-the-affordable-care-act-vs-replacement-proposal-interactive-map/.