SUMMARY: AMERICAN HEALTH CARE ACT

On March 6, 2017, Congressional Republicans introduced the American Health Care Act (AHCA) in the House of Representatives as a step toward their "repeal and replace" of the Affordable Care Act (ACA). The AHCA was officially pulled from Congressional consideration on March 24, 2017, and was put back into consideration with the MacArthur Amendment on April 25, 2017. We have not yet updated this summary to reflect the amendment; however, this summary may however be helpful in analyzing future proposals.

The legislation is summarized below in four main categories of proposed changes: Medicaid, private market, miscellaneous, and no change, and we offer our perspective on the components. This summary doesn't intend to answer every question, and incorporates the information we had available at the time despite any amendments incorporated into the AHCA.

COLOR KEY	
(red)	Change would likely be detrimental to vulnerable Coloradans
(yellow)	Change may or may not affect vulnerable Coloradans, or enough detail has not yet been provided for adequate analysis
(gray)	No change to policies, which would continue to protect vulnerable Coloradans

MEDICAID CHANGES

AMERICAN HEALTH CARE ACT	OUR PERSPECTIVE
Beginning in 2020, Medicaid would be converted into a per-capita based on five enrollment groups (elderly, blind and disabled, children, expansion adults, and other adults). The per capita rates would be set based on 2016 expenditures and adjusted forward based on the medical care component of the consumer price index. .	**The AHCA proposal erodes the core of Medicaid funding.** Colorado has made incredible progress in insuring our more vulnerable populations, and we want to continue to build upon this to cover even more of our uninsured. We are able to achieve this with the support of federal dollars, and research has shown that long-term investments in coverage contributes to improved health and lower costs over the long term. This is a cut in the federal investment in Medicaid. Colorado cannot afford to spend more on Medicaid and would therefore have to make tough decisions about reducing spending by doing one or a combination of the following: 1. Covering fewer people, 2. Cutting benefits, 3. Reducing reimbursement to Medicaid providers. Some say these proposals would give states more flexibility, which is inaccurate. States already have flexibility in how they administer their program. Per capita caps actually restrain states' ability to respond to economic downturns, natural disasters (Medicaid was essential in Hurricanes Katrina and Sandy where many were displaced and lost jobs), public health challenges, such as the opiod crisis, and other situations where there were unexpected

	influxes in cost. Medicaid is also a primary source for long-term care services, as many private insurance sources and Medicare do not provide this benefit. Through the expansion population, Medicaid provides healthcare coverage for adults who work in the service industry, are going to school, or are in between jobs.
Enhanced federal match for expansion population would be reduced to funding levels used for non-expansion Medicaid enrollees.	At these lower levels, Colorado would not be able to sustain the current levels of enrollment and would have to make cuts, which would negatively affect access to care and the percentage of insured in Colorado.
Medicaid would no longer be required to provide the same essential benefit package.	This greater "flexibility" allows states to cut fundamental services like preventive services added through the ACA.
Medicaid DSH cuts would be repealed for FY 2020-FY 2025.	These payments are a critical portion of funding that makes it possible for Colorado's hospitals to care for vulnerable Coloradans, as well as to support our Medicaid expansion. Removing these payments would be detrimental to Coloradans' ability to access care as well as to our ability to cover vulnerable populations on Medicaid.

PRIVATE MARKET CHANGES

AMERICAN HEALTH CARE ACT	OUR PERSPECTIVE
The age-rating ratio for adjusting premiums would be increased to a 5-to-1 ratio. However, states could set different age-rating premiums for their own states.	The 5-to-1 ratio would decrease costs for younger adults, and would increase costs for older adults who may be on a fixed income and/or have higher health needs as they age. Even if states elect to continue the current 3-to-1 ratio, inconsistencies across the country could pose challenges to that state's cost of private insurance.
The AHCA would allocate $15 billion for 2018-19 and $10 billion for 2020-2026 to the "Patient and State Stability Fund." This fund could be used by states to help high risk individuals gain health insurance coverage, stabilize premiums, reduce cost of providing coverage in the individual and small group market, promote participation in the individual and small group market, promote access to preventative care, provide payments directly to healthcare providers, provide assistance to reduce out of pocket costs. Grants would require state matching funds. Note: Cost sharing assistance would be included in this pool of funds as ACA cost sharing subsidies are repealed as of 2020.	This fund has requirements that far exceed the allocated amount of money, which does not set up states for success in addressing gaps in coverage and maintaining patient protections.
There would be no provisions related to the parameters of high risk pools. States would have some flexibility to create their own.	High risk pools are only necessary if the protections for people with pre-existing conditions are weakened and plans are able to adjust premiums or other cost-sharing based on risk. In the current system, individuals who have high risk can purchase insurance and pay the same as people with less severe health care needs. Before the ACA, the majority of states had high risk pools. In these pools, premiums were usually more expensive, there was often a lifetime cap on spending, and often there were pre-existing conditions exclusions so you often couldn't get care for the thing you

	needed most for six months to a year after enrolling.
Individual mandate would be repealed retroactive to January 1, 2016.	Removing the individual mandate may result in a number of people choosing not to be covered. These tend to be people who are healthier. By removing the healthy people from the insurance "pool," the average cost goes up and drives costs up for all participants, which would destabilize the market.
Tax penalty for large employers who do not provide health benefits would be reduced to zero, retroactive to January 2016.	Without a tax penalty serving as a disincentive, some large employers may choose to withdraw health benefits for employees, who then would have limited options to turn to for health insurance.
AHCA would repeal ACA tax credits for small business effective 2020.	Repealing tax credits for small businesses creates new barriers for businesses to be enrolled and may translate into fewer insured small business employees, which will result in a disincentive for small business employment.
Open enrollment would continue to occur only once a year, and a late enrollment penalty would be incurred if a person does not have continuous coverage. Specifically, a gap of 63 days during the prior twelve months would result in an increase of 30% of the premium going forward.	While we appreciate the need to stabilize the insurance market and prevent "gaming" of the system, we think a 30% permanent premium increase is too punitive and could reduce the ability for people to afford insurance, while increasing the number of the underinsured.

MISCELLANEOUS CHANGES

AMERICAN HEALTH CARE ACT	OUR PERSPECTIVE
Taxes on tanning beds, health insurers, pharmaceutical manufacturers and excise tax on sale of medical devices would be repealed.	Any real change to the health care system will need funding supports, and without these taxes, we question how the changes would be fiscally viable. However, we have no opinion on the specifics of these taxes.

NO PERCEIVABLE CHANGES FROM THE AFFORDABLE CARE ACT

AMERICAN HEALTH CARE ACT	OUR PERSPECTIVE
• Pre-existing condition exclusions would continue to be banned. • Adult coverage on parents plans until age 26 would continue. • Qualifying event protections would continue. • Ten essential benefit categories for the individual health market would not be changed. • Prohibition on lifetime and annual dollar limits would not be changed. • Requirement for preventative care with no cost-sharing would not be changed.	As long as we continue what has been begun with the ACA, we support these components. However, we recognize that these components have been possible with other supportive factors, such as the individual mandate. Without the individual mandate, the market share could shrink and costs could rise, which means it'd be difficult to continue to ban pre-existing condition exclusions, for example.
• Wellness incentives under ACA would not be changed. • There are no provisions related to self-insurance and "stop loss" coverage. • There is no mention of Medicare eligibility. • There is no mention of Electronic Health Records. • There are no provisions related to interstate compacts.	We support the continuation of these components.

• There are no changes to Centers for Medicare and Medicaid Innovation (CMMI).	There continues to be a need for thoughtful and productive change in our health care system, which will not happen without the investment of CMMI. CMMI has provided for essential innovations in Colorado, such as the State Innovation Model, which is funding the better integration between behavioral health and primary care. We have invested our state time and funding in partnering with CMMI. We appreciate the continuation of this important function.

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