

Summary Analysis of the American Health Care Act 2017

The House Energy and Commerce Committee and the House Ways and Means Committee released on March 6, 2017 concurrent budget reconciliation bills, referred to together as the American Health Care Act (AHCA). The legislation grew out of a January House budget resolution instructing the Energy and Commerce and Ways and Means Committees – the two primary committees with jurisdiction over health care – to draft legislative recommendations that the House Budget Committee would compile into a single reconciliation package. This summary gives details on legislative recommendations included as of Monday March 6, 2017.

The concurrent bills:

- Do not align with ANA priorities for health care transformation.
- Slash Medicaid funding, potentially jeopardizing access to health care for millions of Americans.
 - State budgets will be enormously impacted, as states will be forced to make the stark choice to either replace federal funding with state dollars or to reduce eligibility, services provided or provider payments.
- Change how healthcare is financed, particularly for those without employer-sponsored health care coverage.
- Offers Health Savings Accounts with higher allowable contributions; however, these forms of coverage will only be useful to high earners or those with extra savings to spare. ([Read more about Health Savings Accounts here](#)).
- Rollback employer-mandated health insurance by eliminating the ACA’s requirement that employers with more than 50 employees pay for coverage.
- Defund Planned Parenthood
 - Despite the proposed increase in funding for Federally Qualified Health Centers, cuts to Planned Parenthood will severely impact the ability of millions of women to access preventive and reproductive health services.

The provisions above are in deep conflict with [ANA’s Principles for Health System Transformation](#). In addition, the AHCA lacks specifics on important health policy issues and is silent on key ANA priorities such as Health IT, Telehealth, Care Coordination, and Health Care Workforce. The bill also leaves unanswered the question of the role of the nurse in the health care delivery system. While the plan proposes to increase funding for “safety net providers” in certain states, the safety net provider is undefined—begging the question as to whether or not nurses will be included as safety net providers.

Analysis of the House Energy and Commerce Committee Bill

The provisions under consideration by the House Energy and Commerce Committee will negatively impact the gains achieved under the ACA. ([Table 1](#)) The proposal is not in alignment with the American Nurses Association's core principles. [ANA has opposed the plan.](#)

The bill restricts access to a standard package of essential health care services for all citizens and residents. It gradually eliminates the ACA's Medicaid expansion and implements a per capita cap funding mechanism for state Medicaid programs, jeopardizing access to health care for the 11 million Americans who gained coverage through expansion. The bill restricts access to critical mental health and substance use disorder services in the midst of the nation's opioid crisis. It also prohibits federal funding to Planned Parenthood for at least one year, greatly restricting access to preventive, reproductive and family planning services. Finally, the bill creates a Patient and State Stability Fund with a \$100 billion appropriation through 2026 for states to stabilize their health insurance markets and to create high risk insurance pools. While this will somewhat alleviate the cuts noted above, the funding available is grossly inadequate and will create a separate insurance market for high risk individuals who often have chronic and complex health conditions.

The bill reduces the ability to optimize primary, community-based preventive services. While it provides for a \$422 million increase in funding for Federally Qualified Health Centers in FY 2017, it eliminates the Prevention and Public Health Fund and removes its nearly \$1 billion annual appropriation after FY 2018; this includes roughly \$325 million in funding for immunization programs and \$160 million in funding for Preventive Health and Health Services Block Grants. The bill also reinstates Disproportionate Share Hospital payments in non-Medicaid expansion states. This provides payments for uncompensated care costs to hospitals which see a high number of uninsured patients but does not replace the Medicaid funds paid to hospitals on behalf of hospitalized patients in the population covered under Medicaid expansion.

The bill also moves away from the economic use of health care services and does not provide adequate supports for those who do not have the means to share in costs. It eliminates cost-sharing subsidies for low-income individuals and families and replaces premium subsidies with age-based refundable tax credits. The elimination of cost-sharing subsidies may increase the likelihood that some individuals defer preventive services due to their being unaffordable. This in turn will lead to poor health outcomes and greater reliance on costly emergency care. The age-based refundable tax credits will significantly decrease low-income seniors' financial assistance and impact their ability to receive care. The expanded use of Health Savings Accounts (HSAs), meanwhile, mainly benefits middle- and upper-class individuals and families who have the means to set aside money for these HSAs and who have a higher tax burden.

The bill is largely silent on nursing workforce issues or staffing levels. It does, however, increase federal funding for “safety net providers” in states that did not expand Medicaid. This could presumably include APRNs, though this is not specified in the bill’s language.

Analysis of the House Ways and Means Committee Bill

This summary gives a close review and analysis of the Ways and Means Committee bill. Because the Ways and Means Committee is primarily tasked with tax-related issues, the bill and the content of this document primarily focuses on how the bill would change health care financing, and the implications of those changes if the ACA is repealed. This summary also provides a side-by-side comparison of the bill and ANA’s principles. ([Table 2](#))

As of Wednesday, March 8, when this document was prepared, the Ways and Means bill had not been scored by the Congressional Budget Office (CBO). Without a CBO score, it is difficult to assess the full potential economic costs and effects of the bill; however, this much is sure: if it becomes the law, the AHCA could result in significant coverage losses and greatly reduce access to health care. ANA remains steadfast in its [health policy priorities](#) and [stands in opposition to the AHCA](#).

AHCA tax provisions benefit wealthy taxpayers, health insurers and providers. State Medicaid programs and Medicaid beneficiaries could face severe cuts in federal funding to Medicaid and potential coverage losses. Seniors and individuals with chronic illnesses or who live in areas where care is costly also have cause for concern. While the AHCA tax credits should help these groups afford [low actuarial value](#) health care coverage, they would likely be unable to afford the high deductibles and other out-of-pocket costs that come with those plans. By contrast, individuals with high incomes and younger people stand to gain much under the AHCA’s provisions. Tax credits the bill implements would help these groups better afford coverage than they could under the ACA, and would cushion their out-of-pocket costs via the more aggressive Health Savings Accounts (HSAs) that the AHCA creates.

The AHCA repeals all of ACA taxes, and eliminates the penalties for individual and employer responsibility provisions. Other ACA taxes the bill would remove include the:

- tanning tax
- branded prescription drug tax
- health insurance tax
- Medicare tax imposed on unearned income for tax payers earning more than \$200,000 (\$250,000 for couples filing jointly)
- Cadillac Tax
- small employer tax

- prohibitions on paying for over-the-counter drugs with tax subsidized funds
- penalties for using tax subsidized funds to pay for non-medical purposes
- requirement that employers reduce their deduction for expenses allowable for retiree drug costs without reducing the deduction by the amount of the retiree drug subsidy
- the level of medical expenses that must be incurred to claim a tax deduction
- Medicare percent tax surcharge on tax payers with incomes exceeding \$200,000

All of these taxes would be eliminated by the end of 2017.

The [Joint Committee on Taxation](#) projects that repeal of ACA taxes would result in costs totaling nearly \$600 billion over the next 10 years. Researchers at [Brookings Institute](#) have reported that repeal of ACA taxes would make it impossible to pay for an ACA replacement, and would worsen the fiscal problems facing Medicare. In January 2017, the [Centers for Medicare and Medicaid issued a statement](#) noting that ACA repeal would move forward Medicare Trust Fund depletion to 2025. Echoing these findings, the [Kaiser Family Foundation](#) similarly reports that repealing ACA taxes would leave seniors, and individuals with low-incomes particularly disadvantaged in their ability to access health care.

Despite these vast changes, the AHCA leaves some of the ACA's taxes intact. Current taxes on high-cost, employer-sponsored health plans and the penalty for special business arrangements that exist only to avoid paying taxes remain.

Two changes stand out amidst the AHCA provisions to alter ACA taxes. Premium tax credits can still be used to pay for health plans available off the exchanges or catastrophic plans, but unlike the ACA, the bill sets specific guidelines prohibiting the use of federal funds to pay for coverage that includes abortions. Plans offering abortion coverage must only do so in cases of rape, incest, or events threatening the life of the mother. Plans receiving federal funds could include coverage for infections, injuries, disease, or disorders caused by abortions. Consumers could opt to buy insurance plans that offer abortions, but they could not use their federal subsidies to pay for the procedure. In essence, AHCA prohibits the use of federal funds or subsidies to cover plans that include abortions or abortion services, regardless of whether or not a consumer chooses to get an abortion. This particular aspect of the bill not only singles out women's reproductive rights for attack, but shrinks the number of low- or middle-income families who could afford abortion coverage. Further, insurers could altogether drop abortion coverage from their plans, giving individuals and families even less access to abortion coverage.

AHCA also changes the current applicable percentages used to set the standard for income a taxpayer must spend to qualify for premium tax credits. Percentages would be defined based on age. Age based subsidies would have a negative effect on millions of working class and low-income families. Under the ACA, individuals and families were eligible for subsidies to help pay for premiums, deductibles and other out-of-pocket costs. ACA subsidies were based on household income. The shift away from adjustable, income-based subsidies to flat rate age-based tax credits would expose individuals across age groups to premium increases and higher health care costs.

More than repealing or changing to the ACA tax requirements, the AHCA also creates new tax credits. Beginning in 2020, taxpayers not offered employer-sponsored health insurance, or not eligible for government sponsored health insurance through Medicaid or Medicare, would be able to access the new tax credit. The new credit would be refundable and advanceable on a monthly basis through an insurance company, and could be used to pay for individual market premiums. The tax credit is age adjusted, and can be determined by adding up the total number of people eligible in a household to determine the credit amount. Children and adults younger than 30 can get a credit of up to \$2000; 30 to 39 year olds can get a credit of up to \$2500; 40-49 year olds can receive a credit of up to \$3000; 50 – 59 year olds can get a credit of up to \$3500; and 60 years old up to Medicare recipient age would receive up to \$4000. The maximum amount available is \$14000, and only the five oldest people in a family could be counted towards the calculation. Income eligibility for the new tax credits begin to phase out at \$75,000 for individuals and \$150,000 for couples filing jointly.

Following the AHCA tax credit model, a family of four with two adults and two children could earn a tax credit of up to \$10,000: \$3000 for each parent and \$2000 for each child. If that same family chose a plan costing \$12,000 per year, or \$1000 per month, that family would have to pay \$2000 out of pocket, or \$167 per month. The tax credit would reduce the premium dollar for dollar paid up front each month. The family in the above example would still receive the tax credit even if they have zero tax liability.

The bill's provisions for new tax credits also come with many stipulations. Taxpayers who do not claim enough of a credit during the year would be eligible for a tax credit when filing their income taxes for that year. On the other hand, taxpayers claiming too much of a tax credit during the year, would have to pay it back when filing a return for that year.

Other stipulations include requirements that only U.S. citizens and legal residents, and individuals not receiving Medicare or Medicaid could be eligible for the tax credits. Prisoners or other individuals awaiting disposition of charges would be ineligible for the tax credit.

The AHCA uses Health Savings Accounts (HSAs) to fundamentally change how health care would be financed, particularly for individuals not offered health insurance coverage through an employer. HSAs are not new. They predate, and were included in the Affordable Care Act. Each of the previous Republican ACA replacement plans included HSAs to subsidize health care, and help consumers pay out-of-pocket costs. Funds in health savings accounts are intended for use in the

event of a catastrophic or unexpected medical emergency until health insurance kicks in. Unspent money can be rolled forward and ultimately serve as savings accounts.

Under the ACA, individuals and families could contribute a maximum of roughly \$3550 for individuals and \$6700 for families, but the amount of those contributions nearly double in the proposed bill. The promise of the health savings accounts might seem like a good deal; however, in reality many Americans lack the extra savings to contribute to HSAs. Further, the HSA scheme offers no immediate benefits for people with chronic conditions such as diabetes or hypertension, or a cancer patient who may drain his HSA account to pay for costly care only to later discover he needs another round of costly treatments.

For a low-income family with little or no tax liability at all, HSAs have no value. In the event these families face a catastrophic or unexpected medical event, the American Health Care Act does not offer enough coverage. Ultimately HSAs and the new, higher allowable contribution limits weigh in favor of those with the means to make contributions.

In summary, the American Health Care Act is a plan that does not deliver on the Republican promise to increase access, choice, and control for individuals, families, and states. The plan in its current form severely cut ACA taxes, and eliminates ACA subsidizes that allowed millions of people to pay for health care premiums, deductibles, and other out-of-pocket costs. As of Wednesday, March 7 the bill had not been scored by the Congressional Budget Office. In January 2017, the CBO warned that ACA repeal could be devastating and lead to enormous coverage losses and higher costs for millions of people. House Republicans have ignored CBOs warnings, and instead have written a health care path that could have devastating implications for millions of people, our health care financing system, and our economy.

Table 1. Side-by-Side Comparison of ANA Principles and the American Health Care Act 2017

ANA Principles	House Energy and Commerce
<p>I. Ensure universal access to standard package of essential healthcare services for all citizens and residents.</p>	<ul style="list-style-type: none"> • Reduces coverage options for low-income populations by reducing Medicaid coverage eligibility and funding. • Creates the Patient and State Stability Fund with a total appropriation of \$100 billion through 2026 to stabilize insurance markets. • Prohibits federal funding to Planned Parenthood for at least one year.
<p>II. Optimize primary, community based preventive services while supporting the cost effective use of innovative, technology driven acute hospital based services.</p>	<ul style="list-style-type: none"> • Defunds the Prevention and Public Health Fund - which includes funding for immunizations and tobacco cessation – after FY 2018 • Increases funding for Federally Qualified Health Centers by \$422 million in FY 2017 • Reinstates Disproportionate Share Hospital payments for non-Medicaid expansion states to pay for costs of uncompensated care
<p>III. Ensure mechanisms to stimulate economic use of health care services while supporting those who do not have the means to share in costs.</p>	<ul style="list-style-type: none"> • Repeals cost-sharing subsidies beginning in 2020 • Replaces premium subsidies with age-based refundable tax credits and creates a penalty for lapses in insurance coverage • Expands the use of Health Savings Accounts to pay for medical expenses
<p>IV. Ensure sufficient supply of a skilled workforce to providing high quality healthcare services.</p>	<ul style="list-style-type: none"> • Provides no specific language on nursing, workforce, or staffing levels. • Increases federal funding for safety net providers in states that did not expand Medicaid.

Table 2. Side-by-Side Comparison of ANA Principles and the American Health Care Act 2017

ANA Principles	House Ways and Means
<p>I. Ensure universal access to standard package of essential health care services for all citizens and residents.</p>	<ul style="list-style-type: none"> • Repeals federal subsidies for out-of-pocket health care expenses such as co-pays and deductibles. • Changes the way premium subsidies are distributed by using a new method of calculating how much people would receive. Calculations are based on age rather than income, and capped at \$14,000 per year. • Ends the requirement that employers offer a standard package of health care benefits.
<p>II. Optimize primary, community based preventive services while supporting the cost effective use of innovative, technology driven acute hospital based services.</p>	<ul style="list-style-type: none"> • Implements restrictions on use of federal funding to provide abortions other than in cases of rape or incest or to save the life of the mother. • Prohibits the use of federal tax subsidies to pay for health plans that include abortion coverage. • Delays initiation of the Cadillac Tax until 2025.
<p>III. Ensure mechanisms to stimulate economic use of health care services while supporting those who do not have the means to share in costs.</p>	<ul style="list-style-type: none"> • Beginning in 2018, permits people to put away double the ACA allowable amount into tax free health savings accounts. Under ACA people could put away \$3,400 for individuals, and \$6,700 for families, but those amounts would double to \$6,550 for individuals, and to \$13,100 for a family. • Beginning in 2020, creates new adjusted, refundable tax credit for individuals purchasing insurance in the market. • Delays initiation of Cadillac Tax until 2025. • Empowers the Internal Revenue Service (IRS), Department of Health and Human Services (HHS), Department of Homeland Security, and Social Security Administration, to develop their own programs resembling ACA programs for administering tax credits, with the exceptions for off—exchange coverage of certain administrative functions that can be delegate to agents, insurers, and brokers.
<p>IV. Ensure sufficient supply of a skilled workforce to providing high quality health care services.</p>	<ul style="list-style-type: none"> • Provides no specific language on nursing, workforce, or staffing levels. • Increases federal funding for safety net providers in states that did not expand Medicaid.

