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House Passage of American Health Care Act, Outlook for Senate Action and Discussion

I. Introduction:

On May 4, 2017, the House of Representatives narrowly passed H.R. 1628, the American Health Care Act (AHCA) by a vote of 217-213, with all Democrats and 20 Republicans opposing the bill. The legislation traversed a perilous journey in the past two months, and appeared to be in jeopardy of never coming to a vote only six weeks ago. However, a variety of changes were made after the bill was pulled from the House floor on March 24th. The legislation now moves to the Senate where it faces a very ambiguous future. Assuming united Democratic opposition, the Republicans can afford to lose the support of no more than two of their senators. And both conservative and moderate Republicans have expressed concerns about different aspects of the House legislation. It is possible that the Senate will start fresh with their own approach to "repeal and replace" the Affordable Care Act (ACA) rather than work from the House bill.

This memorandum reviews the major policy issues that challenged and divided House Republicans (and will similarly confront the Senate Republicans) in their quest to "repeal and replace" the ACA. The memo also reviews the major concerns with the legislation that have been expressed by its opponents. It then presents what has changed from the original underlying House bill and what remains the same. You may find it useful to reference our prior memorandum of March 8, 2017 which provided an analysis of the legislation as it existed at that time. It then provides some perspective on now pending Senate action, and a general discussion of the issues, policy, politics and outlook going forward.

II. House Action on AHCA:

A. Development of AHCA: Issues Within and Beyond the House Republican Conference:

Earlier this year, the bicameral congressional Republican leadership indicated that they would approach the repeal and replacement of the ACA in three steps: (1) repeal and replace through the so-called "budget reconciliation" process; (2) administrative actions to the extent permitted by federal law; and (3) separate legislation for policy changes or other priorities that cannot be accomplished through the budget reconciliation process. Enactment of the AHCA would fulfill the first prong of this approach. The budget reconciliation process, however, places limits on the changes that the Republicans can make to the ACA –2 the changes must have a direct relationship to spending or revenue. Administrative changes by the Trump Administration pursuant to the second prong, particularly with regard to stabilizing the insurance market, are already underway. If the GOP should be successful in enacting a reconciliation bill, it is unknown whether the Democrats would then engage in a bipartisan effort to address remaining issues.The Republican conference began working to bridge the gulf between its conservative and moderate factions after the bill was pulled from the floor in March. After numerous fits and starts, a number of proposed changes began to emerge to address some of the concerns raised within the conference.

Among the House Republicans, some of the major disputes have included:

- ***Patient Protections and Pre-existing Conditions.***

Whether to continue ACA requirements that insurers be required to issue policies to individuals with

pre-existing conditions without charging higher premiums as well as other "patient protections" included in the ACA.

❖ ***Essential Health Benefits (EHBs)***. Whether to modify, eliminate or defer to the states on the ACA's requirement that all policies in the individual and small group market cover 10 defined categories of EHBs.

❖ ***Medicaid Expansion***. Whether states that expanded their Medicaid programs to cover low income childless adults could continue this coverage, whether they would continue to receive enhanced federal matching dollars for this population and, if not, how and when this enhanced match would be phased out.

❖ ***Individual Coverage and Cost***. How to change the ACA's state exchanges, regulations and tax credits with respect to individuals insured in (and outside) those exchanges to alter how middleand lower-income Americans are subsidized and incentivized to purchase insurance.

❖ ***State Autonomy***. The extent to which states should be able to regulate their insurance markets versus the federal mandates imposed by the ACA.

❖ ***Insurance Market Stabilization***. How to stabilize the individual- and small-group insurance market, lower the cost of insurance, and incentivize participation without a federal tax penalty mandate on individuals and employers to purchase or provide coverage
.

❖ ***Choice***. How to enable meaningful choice of plans and providers.

B. Opponents Concerns:

Fierce opposition to AHCA been expressed by a united Democratic party, major health industry associations, patient organizations and others. Opponents have focused on two key areas of concern:

➢ ***Loss of Quality, Affordable Coverage in the Non-Group Market***. The Congressional Budget Office
(CBO) estimated that the version of AHCA that was under consideration on March 24th would result in 24 million Americans losing coverage -- either through Medicaid, the exchanges, or the loss of employer-provided insurance. Among the key objections raised by opponents include:

- The AHCA repeals the ACA's cost-sharing subsidies at the end of 2019. Although the bill provides a refundable tax credit, concerns abound with regard to whether the new age3 based credit is sufficient to enable affordable coverage for low- and middle-income Americans. CBO's estimates suggest that for older, lower income persons, the level of tax credit would be sharply lower than under the ACA. And the new credit would not be adjusted based on income or geographic location.
- AHCA imposes a 30 percent penalty on individuals who do not maintain continuous coverage for a period of more than 63 days in a 12-month period. And prior to passage, the bill was amended to allow states to seek a waiver to allow their insurers to charge such individuals premiums based on their medical condition. There is great concern that these continuous coverage requirements would adversely impact beneficiaries.
- As amended, the AHCA also allows a state to seek to develop its own definition of EHBs and to allow insurers great leeway to vary premiums by age. Critics believe this could lead to the return of "mini-med" policies that cover very little and premiums that price older beneficiaries out of the market.

➢ ***Medicaid Changes****.* The legislation includes significant budgetary limitations and reforms of Medicaid:

- Eliminates the 90 percent federal match for expansion states with grandfathering of current eligible beneficiaries and pre-ACA matching for new enrollees. CBO estimates that over several years very few childless adults would still qualify for the enhanced 90 percent matching funding. They also estimate that only about one-third of the adult population now covered as a result of the ACA expansion would remain in Medicaid.
- Shifts Medicaid from an open-ended entitlement program to a per capita allotment (cap) system, whereby beneficiaries are grouped into five enrollment categories. Additionally, via an amendment added to the bill before it was passed by the House, states could opt for a block grant of funds and with freedom from most federal coverage and beneficiary protection mandates.

- According to CBO, chiefly as a result of the per capita allotments and expansion phaseout, the bill would provide $880 billion less to the states than under current law over a ten-year period (2017-2026).
- Allows states the option to implement work requirements for Medicaid recipients. Eliminates the requirement that a state program cover EHBs.

C. AHCA Provisions in the Original Bill and Subsequent Changes:

1. Original AHCA Provisions:

The bill that was introduced on March 7th was passed through the House Energy & Commerce, Ways & Means and Budget Committees. It then went to the Rules Committee prior to being considered by the House. On three different occasions, the House Rules Committee met and approved amendments to the bill that were incorporated into the text. For the most part, the major provisions of the AHCA as the bill stood on March 7th remain in the final bill, with some modifications reflected below:

❖ ***Repeal of Mandates****.* Repeal of the ACA's employer and individual mandates (effective retroactively to December 31, 2015). As an alternative to the individual mandate, AHCA imposes a one-year, 30 percent surcharge on the premium of an individual who has a break of over 63 days in coverage.

❖ ***Refundable Tax Credits****.* Replacing the ACA tax credits and cost-sharing reductions with new refundable tax credits that vary by age for use by individuals who otherwise lack access to coverage (e.g. through an employer), and are phased out based on income. The credits do not vary by income (with lower income individuals getting more in credits) and are not based on the cost of insurance in a given area.

❖ ***Repeal of Taxes****.* Repeal of the ACA's various taxes, including the medical device, pharmaceutical and health insurance taxes, as well as delay of the tax on high-value employer-sponsored health plans (known as the "Cadillac" tax). Subsequent amendments accelerated the repeal of some of the ACA taxes, such as the repeal of the net investment income tax, to 2017 (from 2018), while further delaying the repeal of certain other taxes, such as an additional repeal delay of a year for the Cadillac tax and an additional delay from 2017 to 2023 of the 0.9 percent additional Medicare tax.

❖ ***Medicaid Expansion****:*

- Eliminates the mandatory ACA requirement for states to expand Medicaid to 133 percent of the federal poverty level (FPL).
- Sunsets the ability of states to cover above 133 percent of FPL as of December 31, 2017.
- Preserves the ability of states to cover childless, non-disabled, non-elderly, non-pregnant adults at the state's regular matching percentage.
- Grandfathers expansion enrollees enrolled prior to December 31, 2019 at the 90 percent match rate for as long as they remain enrolled.
- Limits enhanced federal match for grandfathered expansion enrollees to states that expanded as of March 1, 2017, thus prohibiting new states from expanding at the 90 percent match rate.

❖ ***Medicaid Reform****:*

- Implements in 2020 a per capita allotment funding approach across five beneficiary categories (children, blind & disabled, elderly, adults, and expansion adults).
- Allows a state the option to implement a block grant for specific populations (children and non-elderly, non-disabled, non-expansion adults).
- Repeals the ACA requirement that state Medicaid plans cover the entire EHBs packages, effective December 31, 2019.
- Retains the repeal of hospital disproportionate share cuts for non-expansion states effective Fiscal Year (FY) 2018 and for expansion states effective FY 2020.
- Added a state option for a work requirement for non-disabled, non-elderly, non-pregnant adults, subject to certain requirements, effective FY 2017.
- Repeals the cuts in Medicaid Disproportionate Share Hospital (DSH) funding.

❖ ***Safety-Net Funding for Non-Expansion States****.*

Beginning in 2018, provides $10 billion in safetynet funding over five years to Medicaid non-expansion states. These states would receive an increased match rate of 100 percent for 2018-2021 and 95 percent in 2022 for services provided by safety-net providers. The allotment per state would be based on the number of individuals with incomes below 138 percent of the federal poverty level (FPL) in the state in 2015, based on the American Community Survey.

❖ ***Federal Insurance Regulations****.*

The bill does not repeal or alter many of the ACA's regulations on commercial insurance, including coverage of preventive services without cost sharing, allowing a dependent to remain on their parent's policy up to age 26, no lifetime or annual policy limits, and medical loss ratios requirements. It did not alter the requirements for guaranteed issue and renewal, the prohibition on pre-existing condition exclusions. AHCA did change the ACA limitations on age-based variations in premiums from a maximum of 3:1 to 5:1. And it did not eliminate the EHBs requirement except with regard to Medicaid expansion enrollees. However, both the age-based premium and the EHBs requirements could be impacted by the MacArthur Amendment (discussed below). That amendment could also impact the ACA's prohibition on pricing policies based on the insured's medical condition, which is otherwise not changed by AHCA.

❖ ***"Pro Life" Provisions****.* The bill cuts off Medicaid funding to Planned Parenthood for one year. It

also does not allow the tax credit for purchasing insurance to be used on a plan that covers abortions.

2. Changes Made by Rules Committee Amendments:

As mentioned previously, a number of changes were made to the bill subsequent to its introduction on March 7th. The key to reviving the bill after it was pulled from the House floor on March 24th was a compromise offered by moderate Rep. Tom MacArthur (R-N.J.), which was further modified by an amendment from Rep. Fred Upton (R-Mich.), the former Chair of the Energy & Commerce Committee, and Rep. Billy Long (R-Mo.). With these and other major amendments, this is what is now included in AHCA:

❖ ***Patient and State Stability Fund (PSSF)***. As unveiled, the AHCA included a Patient and State Stability Fund designed to provide states $100 billion in flexible funding to states to stabilize their insurance market, provide payments to providers, subsidize high-risk pools or patients with high cost conditions or undertake other activities that the state deems necessary and appropriate to meet the needs of its citizens in obtaining affordable coverage and access to health care. H.R. 1628 appropriates $15 billion in each of 2018 and 2019 and $10 billion in each year from 2020 to 2026 for the PSSF. In an attempt to address major concerns about ensuring coverage and access for individuals with pre-existing and high cost conditions, several amendments were incorporated into the PSSF, bringing the total amount of funding to $138 billion.

- *$15 billion for Federal Invisible Risk Sharing Program (FIRSP)*. The Palmer/Schweikert amendment added a $15 billion appropriation for 2018 to 2026 to be used for FIRSPs. An invisible risk sharing program provides a subsidy to insurers for high-cost patients without segregating those patients into a separate high-risk pool. This would initially be established as a federal program in which the Centers for Medicare and Medicaid Services (CMS) provides payments to health insurance issuers to lower premiums in the individual market. Beginning in 2020, states may elect to implement the program. FIRSP participation is mandatory for a state that receives a health-underwriting waiver (see discussion below).
- *$15 Billion for Maternity, Newborn and Mental Health*. $15 billion was added that is solely devoted to either maternity coverage and newborn care or mental health and substance abuse disorders in 2020.
- *$8 Billion for Pre-Existing Conditions*. Under the Upton amendment, an additional $8 billion is provided from 2018 to 2023 to states granted an approved health-underwriting waiver under the MacArthur Amendment (see discussion below).

❖ ***State Waivers.***

Pursuant to the MacArthur amendment, states may apply for three different kinds of waivers.

- *Age-Rating Ratio.* For plan years beginning on or after January 1, 2018, a state could seek a waiver to establish its own age-rating bands. The ACA did not allow premiums in the individual market to vary by more than 3 to 1. AHCA would change this to 5 to 1 (unless a state waived this change subject to certain conditions). The waiver language does not define any limit on the number of age rating bands a state could implement. Prior to the ACA, it was not unusual for states to allow age-related premium variations of 10 to 1 or more.
- *Define EHBs.* After January 1, 2020, a state could develop its own definition of EHBs.

- *Health Status Rating.* As mentioned previously, AHCA would impose a one-year, 30 percent penalty on individuals who have a break in coverage of more than 63 days in a 12-month period. Under the third waiver option, a state could permit its insurers to engage in health-status underwriting (i.e. premiums adjusted for medical condition) for those who have such a lapse in coverage. A state could not opt for this waiver unless it used its PSSF to provide for a program of financial assistance to high-risk persons and to implement a premium stabilization program or to participate in the FIRSP. The Upton Amendment (above) added an additional and more specific requirement that such a state would be required to access and utilize a portion of a new $8 billion fund to reduce premiums for out-of-pocket costs for those who experience a monthly premium rate increase as a result of being subjected to health underwriting.

In order to receive any of these waivers, a state would need to indicate in its application how the proposed waiver would advance one or more of the following objectives:

- ✓ Reduce average premium costs
- ✓ Increase enrollment in health insurance
- ✓ Stabilize the market for health insurance
- ✓ Stabilize premiums
- ✓ Increase the choice of plans

❖ ***Other Amendments***. Technical and policy changes to AHCA:

- A manager's amendment was adopted that made a series of minor technical changes. First, it struck the requirement that insurance companies impose a 30 percent penalty for individuals who do not maintain continuous coverage in the small group market. The penalty remains in the individual market. Second, it rewrote the section of the bill providing a refundable tax credit for the purchase of health insurance.
- A subsequent manager's amendment made policy changes including to:

✓ Allow states to establish their own EHB standards for purposes of the premium tax credit.

✓ As mentioned above, provide states the option of block granting their Medicaid programs for a ten-year period as an alternative to the per capita allotment approach. It also gave states the option to impose work requirements under the same terms as those imposed by the Temporary Assistance for Needy Families (TANF) program.

✓ As mentioned above, accelerate repeal of many of the ACA tax provisions to 2017, with a few exceptions. The effective date of the repeal of the employer mandate and the individual mandate would remain 2016. The repeal of the 0.9 percent Medicare tax on high-income earners was not accelerated but rather pushed back until 2023 (rather than 2018 as originally proposed). In addition, there is one additional year of relief from the "Cadillac" tax.

✓ Lower the threshold for deducting medical expenses from 7.5 to 5.8 percent. The ACA raised the threshold from 7.5 to 10 percent and the underlying bill had brought it back down to 7.5 percent.

✓ Revise the language in the bill phasing out the Medicaid expansion to clarify that if a state expands its Medicaid program in the future to cover childless adults, it would not receive enhanced federal matching payments.

✓ Increase the annual inflation update for the elderly and disabled Medicaid populations under the per capita allotment reform from the consumer price index for all urban consumers (CPI-U) Medical to CPI-U Medical +1. Notably, this enhanced inflationary

update would not apply to children (other than disabled children) or childless adults in Medicaid.

III. Outlook for Senate Action:

Passage of the House bill is a significant step forward for the Republicans to fulfill their promise to repeal and replace the ACA. However, the prospects for enactment of legislation remains tenuous. Now, it is the Senate's turn to act. As the “deliberative body,” their approach -- both in process and substance -- is expected to be dramatically different than that of the House for many reasons. Most Senators serve broader constituencies than most House members. Further, the Senate process is different: the Senate utilizes an open-amendment process that gives the minority party the opportunity to be heard, and for this legislation they must operate within budget reconciliation rules that allow the minority to strike provisions from the bill that do not meet the requirement to be directly budget-related.

Finally, while the media typically focuses on the divisions between the parties, disagreement and competiveness between the House and Senate chambers can also be very significant, even when both bodies are controlled by the same party. This is especially true around a seminal piece of legislation like the AHCA. It is to be expected that the Senate Republicans will want to put their fingerprints on the contours of legislation to replace the ACA.

If the margin of error in the House was narrow around AHCA passage, the margin in the Senate is razor thin. As in the House, it is unlikely that any Democrats will support legislation that aims to repeal the ACA.

With only 52 Republican Senators, and Vice President Mike Pence available to break a tie vote, it will be quite difficult to thread the needle of passage. There is a substantial and vocal constituency that is intensely opposed to the House-passed bill or any other bill to repeal the ACA. Following House passage, the chorus of voices – both pro and con – will be even louder. As a consequence, many Republican and Democratic senators will become more emboldened and entrenched in their respective philosophical and political viewpoints.

In at least one respect, the House and Senate have a similar challenge in adopting repeal and replace legislation: the substantive rift between hardline conservatives and moderates within the Republican majority that delayed House passage of the AHCA for six weeks will be equally challenging for the Senate Republicans. Presently, a handful of very conservative Republican senators have expressed concerns with the legislation as have several moderate Republican senators – each group for very different reasons. Many of the intraparty "flashpoints" will be the same – including funding changes affecting states with Republican governors, concerns regarding whether a new health insurance tax credit is appropriate or workable, and provisions respecting coverage of abortions and funding for Planned Parenthood. Any of these could ignite into major disputes. Whether any of these senators will ultimately oppose passage of repeal and replace legislation remains to be seen.

Substantive Policy Issues.
Several key areas of potential variation in approach between the chambers include the following:

❖ ***Medicaid Expansion***. The House approach in grandfathering existing expansion enrollees, and allowing continued coverage of childless adults up to 133 percent of FPL at a regular match rate, may not be quite as appealing in the Senate, where half of the Senate Republicans herald from expansion states. The push from governors in one direction or another relative to expansion is likely to play a stronger role in the Senate than in the House. Senators Bill Cassidy (R-La.) and Susan Collins (R-Maine) introduced legislation, *The Patient Freedom Act (S.191)*, that essentially allows states to choose to retain the fiscal benefits of Medicaid expansion. Under this bill, states could elect to keep major ACA provisions in place in their jurisdiction, including Medicaid expansion with enhanced matching payments. Alternatively, they could opt to receive the same amount of federal funding they have or would have received for expanding Medicaid to implement programs that automatically enroll uninsured residents into standard high-deductible health plans. Conversely, a number of Republican senators from non-expansion states – such as Senators Lindsey Graham (R-S.C.) and Marco Rubio (R-Fla.) – have expressed a strong desire to ensure that non-expansion states are not disadvantaged. And conservatives such as Senators Ted Cruz (R-Texas), Mike Lee (R-Utah) and Rand Paul (R-Ky.) have philosophical objections to the Medicaid expansion that run counter to those of the more moderate Republican Senators. The bottom line is that the Senate may opt for a considerably altered pathway on the expansion issue.

❖ ***Affordability of Coverage***.
The House-passed AHCA provides refundable premium tax credits for purchase of insurance, but does so primarily based on age, with a phase out at certain income levels and with no geographic- or income-based adjustments. It also allows insurers to vary insurance premiums by age by up to five fold, which presumably will impact older, often sicker individuals. Many analysts and the CBO have concluded that the premium tax credits and agerating bands in the House bill do not align – the tax credits are not generous enough for older, sicker insureds. This issue drew substantial fire from Democrats, the health care industry and patient advocacy constituencies during House consideration. The Senate may take a very different approach to address concerns about affordability of coverage, especially for low-income individuals and those with high costs or pre-existing conditions.

❖ ***Medicaid Reform***.
The House leadership utilized ACA repeal and replace legislation as an opportunity to dramatically reform Medicaid. House Republicans did not have to propose per capita allotments and block grants to fulfill their promise of repeal and replace – they elected to do so. Prior to the ACA, Medicare exceeded Medicaid in the number of beneficiaries and in cost. Eight years later, Medicaid has 70 million enrollees (one in five Americans). And total federal and state Medicaid spending was about $532 billion in FY 2015. A major impetus for the dramatic opposition to AHCA from the hospital, physician and provider communities stems from the projected $880 billion in reduced Medicaid funding over ten years. This is a striking amount, even by Washington, DC, standards. From the Republican perspective, this is a necessary reform to reign in Medicaid spending. From the Democratic perspective, these are draconian cuts that will drastically reduce state budgets and harm millions of Americans who depend upon Medicaid for life-saving care. Whether Senate Republicans elect to attempt fundamental Medicaid reform is unclear. The Senate could opt to deal only with the Medicaid expansion issue and forego

Medicaid entitlement reform in the interest of reducing opposition and gaining moderate Senate Republican votes.

❖ ***The Tax Credit-Medicaid-Tax Repeal Balance.*** According to CBO, over ten years, the House AHCA bill repeals about $900 billion in revenues and creates a net spending reduction of about $1.2 trillion. This results in about $300 billion in deficit reduction that, presumably, could be put toward a future tax reform bill. The House bill also repeals about $670 billion in ACA insurance subsidies and replaces them with about $200 billion less in tax credits and stability funding. Further, the net reduction in Medicaid spending is projected at $880 billion, the majority of which is related to phasing out the enhanced expansion match and most of the rest of which is related to per capita allotments. The Senate will need to decide how it wants to shape the budgetary mixture of tax repeal, new tax credits and Medicaid reductions. Because a reconciliation bill must at least make a slight dent in the deficit, there are complicated trade-offs involved.

❖ ***Poison Pills***. No issue may be more problematic in threading the needle in the Senate than funding for Planned Parenthood. Pro-life groups strongly support the one-year cut-off of Planned Parenthood from Medicaid, as well as other pro-life provisions contained in H.R. 1628, but several pro-choice Republican senators have already indicated their strong opposition to cutting off funding for Planned Parenthood or otherwise addressing abortion-related matters in this legislation.

Unique Senate Process.

Senate action is expected to be very different than the House process. It is unclear whether the Senate will go straight to the floor with legislation (a manager's amendment to the House bill) or first move its legislation through the committee process. However, initial public statements from key leaders indicate that they will craft their own bill, drawing upon the House-passed AHCA to the extent they support particular approaches or provisions. Senate Majority Leader Mitch McConnell (R-Ky.) has convened a working group among several of his colleagues to seek consensus on the SenateRepublican approach. Both Senate Finance Committee Chairman Orrin Hatch (R-Utah) and Senate Health, Education, Labor, and Pensions (HELP) Committee Chairman Lamar Alexander (R-Tenn.) bring decades of experience in health care policy, politics and deal-making.

Either way, significant changes from the House bill, as well as numerous amendments, should be expected as the process moves forward, whether in committee or on the Senate floor. And as this legislation is being considered in the context of budget reconciliation, any amendments are subject to the Byrd Rule (requiring that they have a direct relationship to spending or revenue) and may be struck on points of order.

Another wrinkle is that the House passed the AHCA before release of an updated Congressional Budget Office (CBO) 'score' or analysis of the bill's budgetary and coverage impacts. The Senate will not move forward with the AHCA until CBO releases an updated score, which is expected to be released the week of May 22. This score will – as it did in the House – have implications for the support the bill will receive.

IV. Discussion:

Passage of AHCA by the House has re-invigorated a passionate debate about health care and health care reform. One aspect of this debate is that the ACA has altered the political paradigm. The discussion now centers on how to provide coverage and not whether to do so. And it is generally agreed that going back to allowing individuals to be excluded from insurance on the basis of a pre-existing condition is unacceptable. Certainly, there remain dramatic philosophical differences between Republicans and Democrats, but those differences have narrowed in the past eight years. Public consensus appears to

have formed around some basic obligation to extend coverage for the most vulnerable and to protect consumers in the insurance marketplace. This is why a simple repeal bill cannot be passed in either of the Republican-controlled legislative chambers. And it is also why the Republicans are struggling to repeal $900 billion in taxes, $740 billion in Medicaid expansion funding and $670 billion in individual insurance subsidies and replace it with something that does not add to the deficit while providing affordable health care options.

The ACA relied upon three pillars to expand coverage: Medicaid, subsidization of private insurance through the exchanges, and the individual and employer mandates. It is noteworthy that, to some degree, the House legislation retains aspects of these three pillars. First, the AHCA retains the authority for states to expand Medicaid coverage to non-pregnant childless adults – states may opt to provide coverage up to 133 percent of the federal poverty level albeit only at regular federal matching rates starting in 2020.

Second, low- and middle-income Americans otherwise without access to government- or employersponsored coverage will receive advanceable, refundable tax credits to purchase insurance. The new credits are different in their structure in that they are age-based and not geographically adjusted. The only income-based adjustment is a phase out for higher income Americans. Finally, in place of the individual mandate tax, the AHCA adopts an approach based more on "personal responsibility" – if you do not maintain coverage, you will incur a 30 percent premium surcharge and potentially the risk of being medically underwritten. While the Senate bill is not expected to follow the House approach, it is unlikely they will be able to avoid some version of the three pillar approach. While the politics of repeal and replace are running hot, the real question for the Senate Republicans is whether the House-passed bill can achieve certain goals, chiefly thwarting the detested "Obamacare" taxes, stabilizing the cost and availability of non-group insurance, and treating Medicaid non-expansion and expansion states with parity while taking some of the sting out of the roll back of enhanced matching payments. Many analysts do not believe that AHCA will accomplish its objectives because the tax credits

and stability funding are poorly designed and insufficient and because the Medicaid changes, including the long-term potential impact of a per capita allotment approach, would upend state finances. If so, the Senate will need to either find a different approach or risk the consequences of inaction.
And contributing substantially to the "heat" the Senate will face are several emotional aspects of the House-passed bill. The proposed per capita allotment approach to Medicaid would be a historically significant change to a 50 year old entitlement program. And the notion that states could opt to return to a world where at least some individuals in poor health could be charged much higher premiums on policies with less than robust coverage is unacceptable to many. Finally, as the Republicans attempt to capitalize on their majority status to move forward with several anti-abortion changes, one can expect the level of opposition anger to increase (and not only from Democrats).

Should the Senate be successful in passing its version of AHCA, and the House is not willing to accept this bill, a conference committee will be necessary to resolve differences between the chambers. Many a bill has died in conference (such as the Patient's Bill of Rights in the 1990s). Republicans will have to navigate the policy and political needs of each chamber in carefully calibrating a conference committee agreement that will then be able to be approved by both the House and Senate. Given the varying perspectives within the Republican party, and between the chambers, this would be no easy feat. Meanwhile the ACA remains the law of the land. This means the status quo continues for the Medicaid program while the state exchanges and the small group and individual markets in many locations are in

disarray. The cost sharing reduction (CSR) subsidies that most insurers consider vital to market stability continue to be the subject of legal action. The U.S. House of Representatives filed a lawsuit (*House v. Burwell*) to block the subsidies, noting that the Obama administration violated the Appropriations Clause by offsetting funds that were never appropriated by Congress. A district court judge last year ruled that the subsidies were illegal and must stop. However, she stayed her decision while the Obama administration appealed. Now that the White House has changed hands, the parties have asked the appellate court to continue to hold the case in abeyance. Recently, as part of negotiations over the FY 2017 Omnibus Appropriations bill, the administration indicated it would continue the CSR payments. But whether and for how long they will do so remains unclear. Also unclear is whether the administration will move forward with a second "market stability" regulation to address some insurer concerns. As it is unlikely that any legislation will impact the 2018 insurance plan year, some decisions need to be made by the Trump administration as to how it will approach these issues with insurer rate filings due this summer.

V. Conclusion:

As stated at the outset of this memo, enactment of legislation to repeal and replace the ACA is far from certain. The Senate will not simply adopt H.R. 1628, and appears headed toward its own approach. Even if some version of repeal and replace legislation were to be enacted, it would not be the final word on this subject. As mentioned, it is expected that the Trump administration will make a number of changes in regulations and guidance that will also impact public and private health coverage. And additional legislation would likely be proposed and advanced in the process.

It should be noted that in addition to the dramatic legislative and regulatory environment surrounding AHCA, there remain a variety of other major issues confronting the Congress and the administration. On the immediate horizon, these include reauthorization of the Food and Drug Administration (FDA) user fee agreements, the Medicaid DSH cliff, the community health center funding cliff, reauthorization of the Children's Health Insurance Program and the expiration of numerous Medicare "health extender" provisions, all of which must be dealt with in the next few months.