Georgia Hospital Association Summary

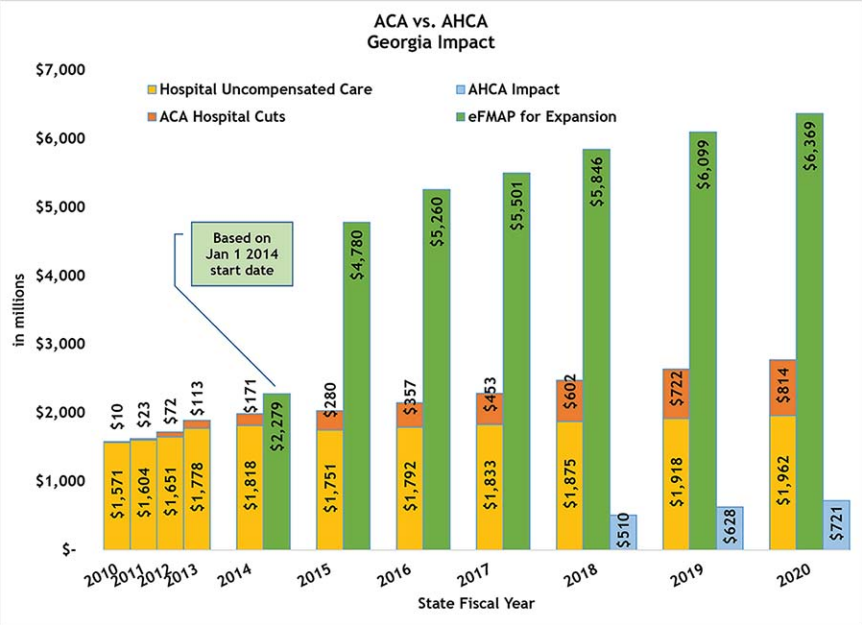
American Health Care Act

Updated May 24, 2017

GHA Executive Summary

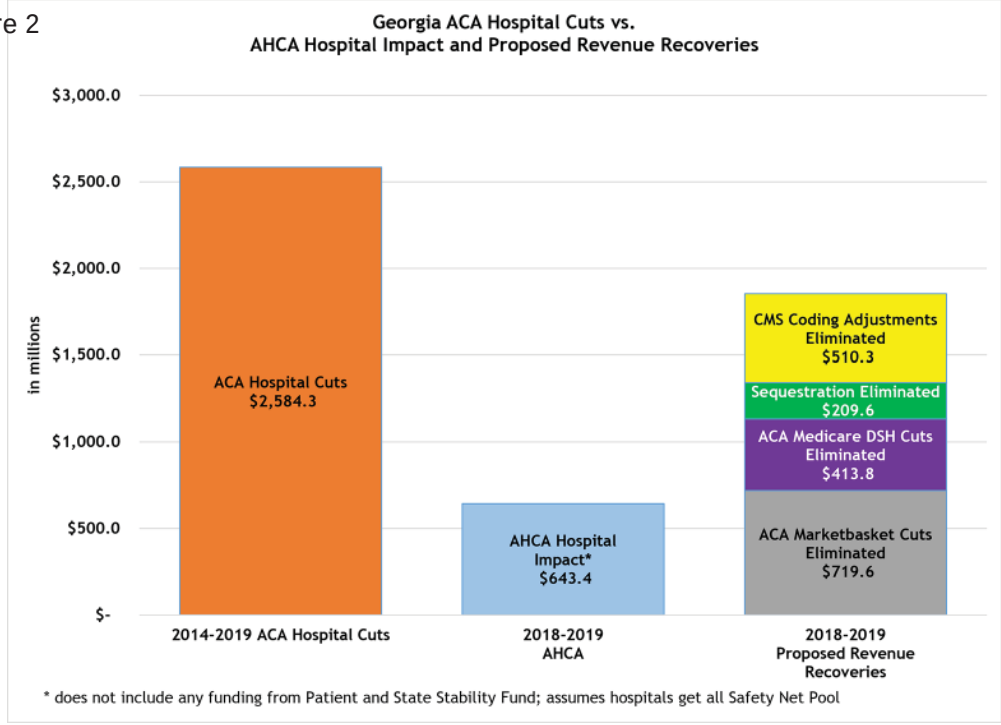
AHCA funding made available to Georgia (and other non-expansion states) is significantly less than the enhanced federal ACA funds available for Medicaid expansion as well as the cost of uncompensated hospital care and ACA cuts to hospitals.

Figure 1



Non-expansion states, like Georgia, need additional federal funds to cover the ACA hospital cuts. In addition to the current provisions of AHCA, Congress could partially accomplish this by eliminating most ACA cuts, CMS coding adjustments, and sequestration cuts for non-expansion states. Even doing so, non-expansion states still experience a net-negative outcome without any additional federal funding to address the significant amounts of uncompensated hospital care provided to the uninsured and underinsured.

Figure 2



For more information, please contact the Georgia Hospital Association at 770-249-4500.

GHA Summary
American Health Care Act - Status

On March 6, 2017, the U.S. House Energy and Commerce Committee and Ways and Means Committee released the initial draft of the *American Health Care Act* (AHCA) that includes provisions related to repeal and replacement of the Patient Protection and *Affordable Care Act* (ACA), including Medicaid restructuring and insurance market changes. After subsequent amendments by the House Rules Committee, the House passed the bill on May 4, 2017.

While GHA continues to analyze the sweeping changes to the health care delivery system proposed in the bill, the following summary provides a high-level overview of what these changes would mean for Georgia.

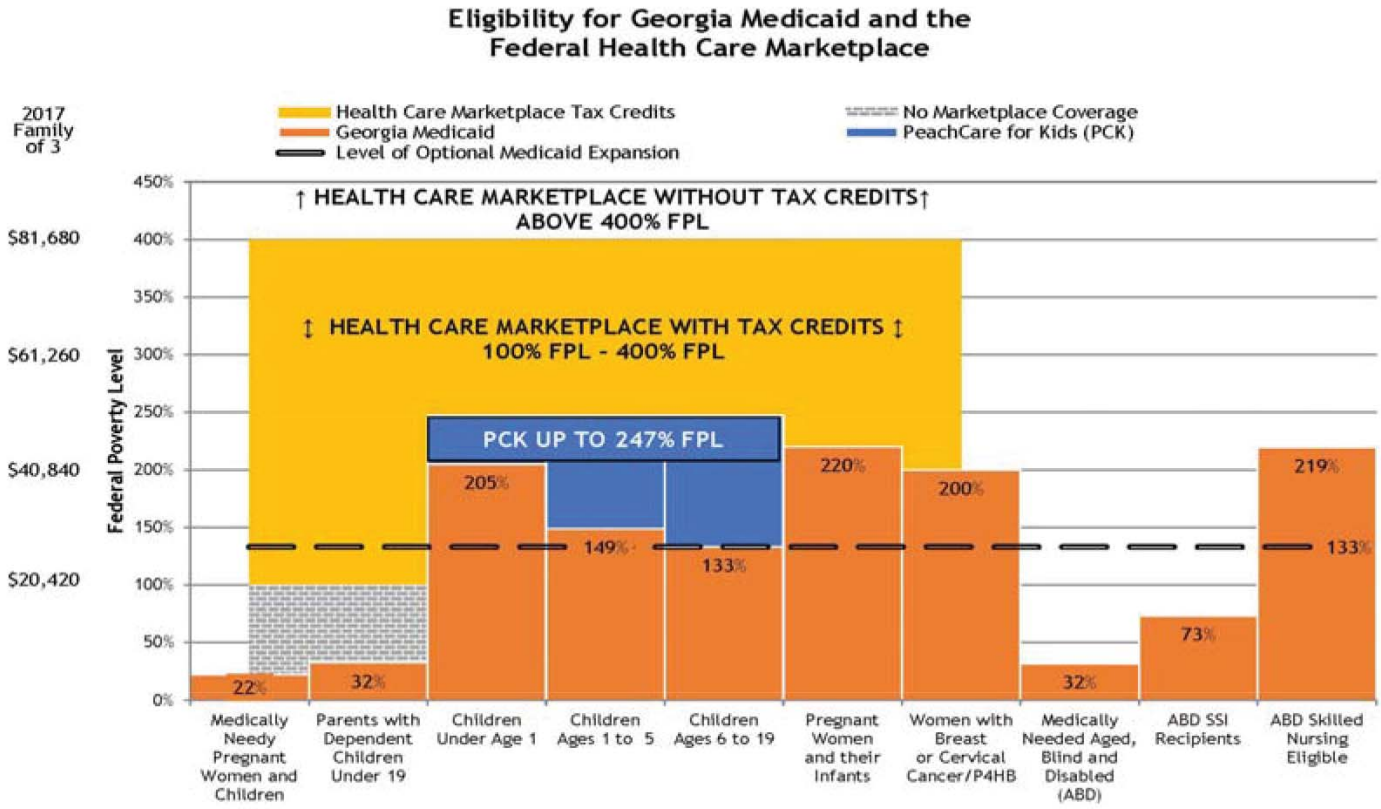
Georgia's Health Care Delivery System Today

The ACA created a complex framework to provide health care coverage for the uninsured. States have the option of expanding their Medicaid programs to cover adults with incomes up to 133% of the federal poverty level (FPL). Individuals with incomes between 100% and 400% of the FPL are eligible for varying federal subsidies to help cover the cost of insurance coverage purchased through a federal or state health insurance marketplace.

Currently, the Medicaid program is funded through a matching arrangement between the state and federal governments. The federal medical assistance percentage (FMAP) or "the match rate" differs for certain categories of expenditures, but generally in Georgia the match rate is approximately 69% — meaning the federal government pays approximately 69% of the costs of the program, while the state pays approximately 31%. This is often referred to as "the regular match rate." For states that expanded their Medicaid programs as allowed by the ACA, an "enhanced match rate" is provided for "newly eligible" individuals. This enhanced match rate started at 100% for years 2014 through 2016 — meaning the federal government paid the full costs of those newly eligible individuals during that period. The enhanced match rate under the ACA phases down to 90% in 2020 and beyond.

Georgia chose not to expand its Medicaid program due to concerns over the long-term rising costs of the program. With few exceptions, childless adults are not currently eligible for Medicaid in Georgia. This has created a health care coverage gap in the state, because under the terms of the ACA, individuals with incomes below 100% of the FPL are not eligible for federal subsidies to help with the cost of health insurance purchased on the federal marketplace. *(See Figure 3 for Georgia's income thresholds for Medicaid eligibility.)*

Figure 3



GHA Summary
American Health Care Act - Medicaid Restructuring

Per Capita Allotment

The AHCA drastically changes the current financing arrangement for the Medicaid program by capping future federal funding beginning in federal fiscal year 2020 (which starts on October 1, 2019). A state-specific cap would be established based on each state's per capita expenditures for Medicaid in a base year (federal fiscal year 2016) and then increases over time based on a set growth rate. The growth rate is defined as the medical component of the Consumer Price Index (CPI) for most Medicaid populations, and the medical component of the CPI plus one percent for the elderly and disabled populations.

The total cap is calculated based on separate expenditures for various Medicaid population groups. The population groups include children (excluding children funded through the Children's Health Insurance Program or CHIP); elderly; blind and disabled; expansion enrollees (defined as those enrollees for whom some states are receiving an enhanced match under the ACA); and other nonelderly, nondisabled, non-expansion adults. Some other Medicaid expenditures, such as administrative expenses, are exempt from the cap.

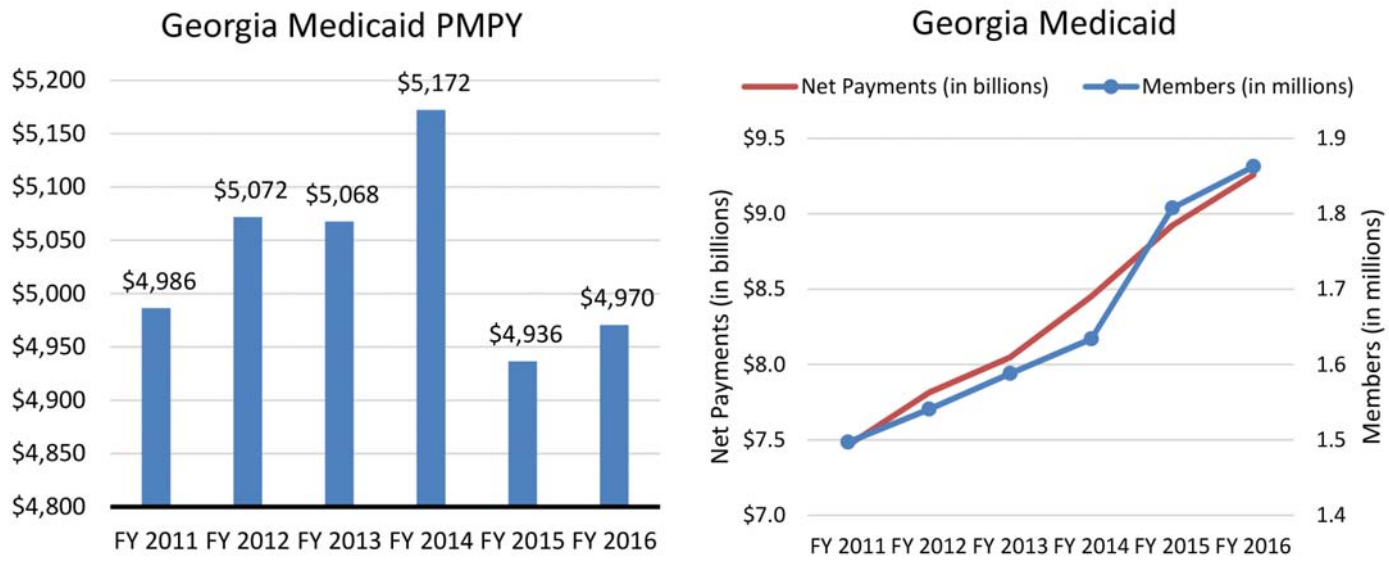
Based on CY 2015 information, Georgia is 48th in per capita spending.

Georgia Impact: Creating arbitrary federal spending caps limits Georgia's ability to modernize its Medicaid program. Demand for Medicaid is driven by social and economic factors that are often beyond the control of an individual, a state or a health system. And there are components of Medicaid, including coverage for the elderly and disabled, advances in medicine (e.g., specialty pharmaceutical-based treatments for Hepatitis C), and outbreaks of infectious diseases that will continue to be expensive and often unpredictable. Unlike the federal government, Georgia is constitutionally mandated to balance its budget every year. An inflexible federal expenditure cap will likely force Georgia to reduce payments to hospitals and other safety net providers, eliminate valuable services, and/or cut needy populations from its Medicaid program. While Medicaid funding has historically been a federal/state partnership, the AHCA spending caps create a national standard and move all the financial risk to the states.

Establishing separate amounts based on Medicaid population categories as proposed in the bill is an important step for recognizing the costs associated with various population groups, and most notably the elderly and disabled. It is also positive that the growth rate is based on the medical component of the CPI, instead of the overall CPI. However, GHA is concerned that the growth rate may not fully account for program costs, and the use of 2016 as a base year for per capita calculations is problematic for states, like Georgia, that were slow to recover from the Great Recession and who are just now restoring Medicaid cuts or funding more reasonable provider payment levels. Since FY 2016, Georgia has added Medicaid program improvements worth over $200 million in federal funds that would not be included in the cap.

Additionally, Georgia has seen a reduction in the per capita Medicaid expenditures since FY 2014. This growth is largely due to the "woodwork effect" when individuals who were previously eligible for, but had not enrolled in, the Medicaid program were referred to Medicaid via their applications for insurance through the federal Health Insurance Marketplace. CMS reported that over 235,000 people applying for Health Insurance Marketplace coverage were referred to Medicaid in Georgia during open enrollment for plan years 2014 through 2017. These individuals are typically determined eligible based on their income level and generally have less expensive costs than the more stable, but more expensive, elderly and blind and disabled populations. Thus, the state's enrollment is growing faster than its total expenditures, which dilutes per capita expenditures. (See Figure 4 for the Georgia Medicaid enrollment and per capita spending changes from FY 2011-FY 2016.) The end result is that, under the AHCA capped funding formula, Georgia is penalized for its historic fiscal responsibility in the operation of its Medicaid program.

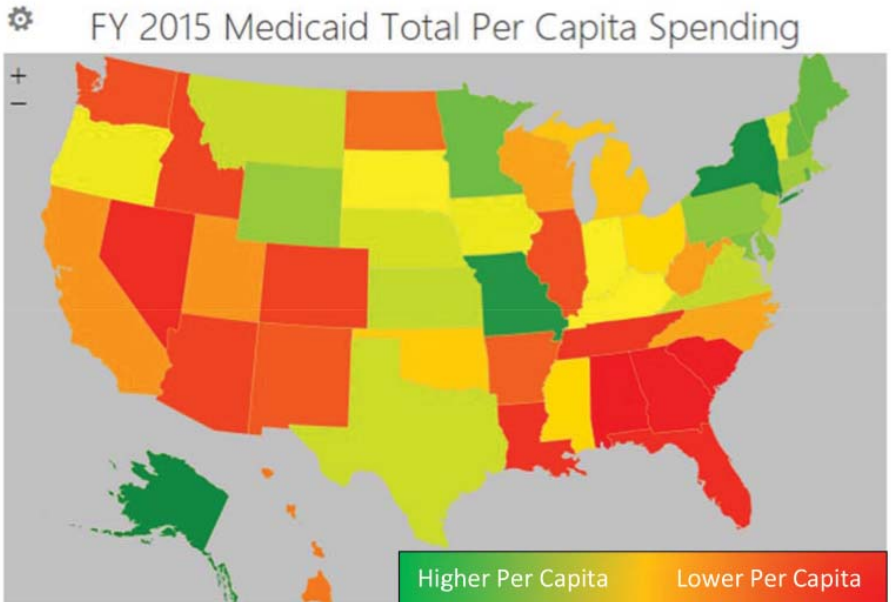
Figure 4



It is not just Georgia that is penalized under the proposed capped funding formula. Conservative southern states as a whole have lower per capita spending.[1] (See Figure 5 for FY 2015 Medicaid Total Per Capita Spending by state.) Furthermore, states that do not already have a waiver designed to help transform the health care delivery system or respond to the ongoing opioid crisis will have no incentive to apply for such a waiver moving forward, because no additional funding would be available for these projects. Without a waiver, states are severely limited in crafting a state-specific solution for delivery system reform.

[1] Source: MACPAC, 2016, analysis of CMS-64 FMR net expenditure data as of May 24, 2016; CMS October-December 2015 MBES Medicaid Enrollment Report

Figure 5



2015 Total Per Capita Spending
Average: $7,090
Maximum: $10,176 (AK)
Minimum: $5,038 (AL)
Georgia: $5,167

Block Grant

The AHCA creates a new option for states to receive a flexible block grant of funds for a period of 10 years, rather than a per capita allotment, for the traditional adult and children populations. This new option would be available beginning in FY 2020. Funding for the block grant amount is based on the same calculation used for the per capita allocation for the eligible population, multiplied by the number of enrollees in the year prior to adopting the block grant. Funding will increase by growth in the CPI but will not be adjusted for changes in the Medicaid eligible population. States would be able to roll over any unused funds at the end of the fiscal year, and such funds will remain available to the state as long as the state has a block grant.

Georgia Impact: This option creates the same issues for Georgia as previously discussed under "Per Capita Allotments." If Georgia were to choose this Medicaid funding option, it would allow for greater flexibility in the design of its Medicaid program; however, it would also add significant financial risk to the state because the block grant would not take into account increases or other changes in the covered population. The cost of any unusual growth in enrollment (e.g., increased enrollment due to an economic recession) as well any unanticipated increase in the cost of care would be borne solely by the state.

Suggestions for Improvement/Change to Medicaid Financing:

- Utilize a more robust and actuarially sound funding formula, similar to the process currently required to establish rates for Medicaid managed care organizations.

- If a per capita cap model is utilized for Medicaid funding, the following options should be considered in establishing the base rate and subsequent growth:

  Establishing a Base Rate

  — For Medicaid base rates, use a five-year per capita average and allow states to adjust this amount for subsequent program enhancements funded by the state before June 30, 2017. Georgia's most recent annual Medicaid per capita spending fluctuated from a low of $4,936 in FY 2015 to a high of $5,172 in FY 2014 with a $5,039 five-year average. *(See Figure 4 for Georgia's Medicaid per capita annual spending from FY 2011- FY 2016.)*

  — Establish a per capita cap using a national average on Medicaid spending. Under this approach, federal spending would still be linked to state Medicaid expenditures so that in states like Georgia the cap may not be reached, especially in the early years. However, it would provide needed cushion for Georgia to get back to pre-recession spending.

  — Federal per capita funding should be limited to a pre-defined essential health benefits package plus an additional per capita discretionary amount, equal across all states, to be used at the state's discretion to help pay for optional benefits; states that want to provide more than an essential benefits package would cover such services at 100% state cost above the discretionary funds.

  — Only cap those states with per capita program growth over medical CPI. States like Georgia, whose historical per capita spending growth has been below medical CPI shouldn't be punished for other states' excessive Medicaid spending. *(See Figure 6 for Georgia's annual growth rates compared to medical CPI.)*

  Implementation

  — Phase in populations for per capita cap funding. Start with low-income Medicaid first, and then bring in sub populations of the aged, blind and disabled over time.

  — Phase-in the blending of the regular match rate funding and per capita cap funding application to allow a gradual shift in 100% of risk to the states. (e.g., year 1 – federal funds = 75% FMAP based and 25% per capita based; year 2 – federal funds = 50% FMAP based and 50% per capita based)

Alternate Approaches

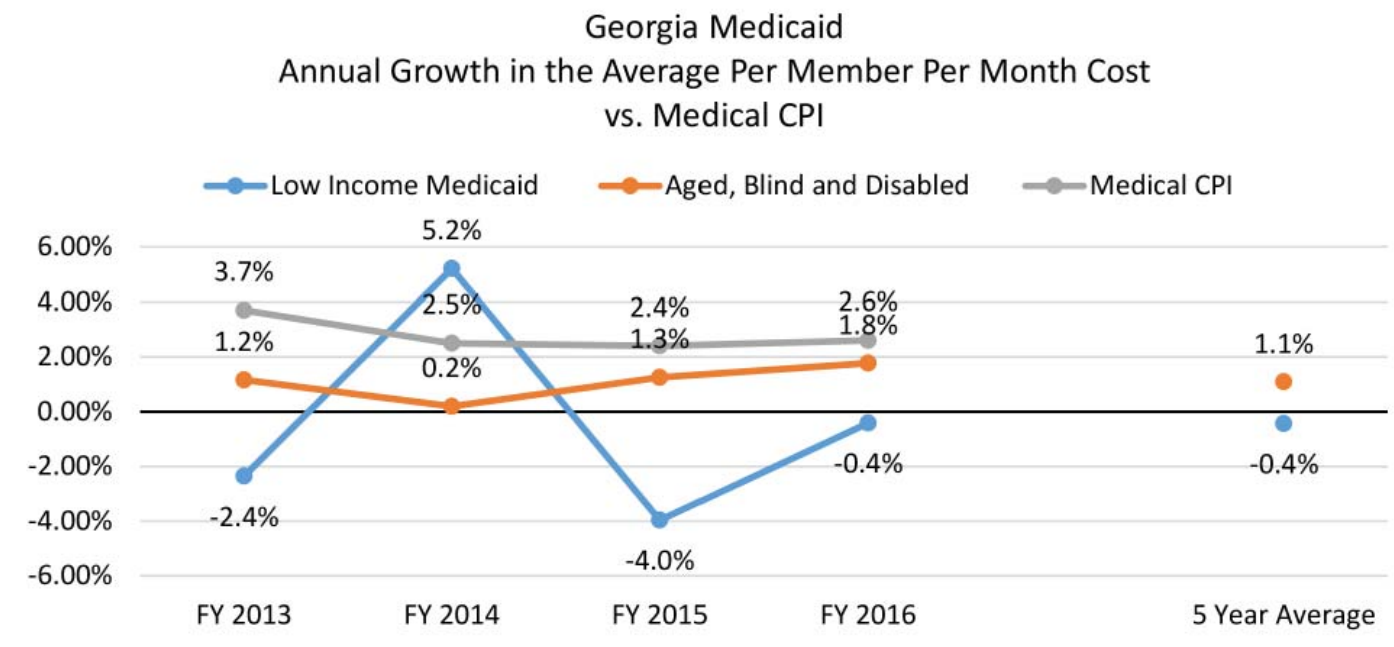
— For low-income, able-bodied adults under 100% FPL, provide states with per capita cap funding based on the enhanced match rate, but require program design components that mandate employment activities and promote consumerism and healthy behaviors.

— Use financial incentives, such as higher match rates, eligibility for additional block grant funds or gain sharing, rather than penalties to keep spending in check. CMS should consider using savings targets to incentivize states to reduce costs in the Medicaid program instead of per capita caps.

- States expanding coverage up to 100% of the federal poverty level should continue to receive the enhanced matching rate past 2020 for this population. It is unlikely this population will ever be able to afford private market health care insurance without significant subsidies.

- Provide adequate federal funding to cover the states' cost of any mandated Medicaid systems changes, including changes to enrollment systems and new data reporting requirements.

Figure 6



Expansion vs. Non-Expansion

The AHCA limits the enhanced match rate for newly eligible individuals with incomes up to 133% FPL to only those states that expanded coverage under the ACA as of March 1, 2017. States like Georgia that have not expanded by March 1, 2017 could still expand Medicaid to adults with income up to 133% FPL, but would only receive the state's regular match rate. Effective December 31, 2017, states would no longer have the option of using Medicaid to cover adults with income above 133% FPL.

For expansion states, newly eligible individuals with income up to 133% FPL would continue to receive the enhanced match for these individuals enrolled before December 31, 2019 (and who continuously stay on the Medicaid rolls after that).[2] For anyone newly enrolled on January 1, 2020 or later, the state would receive the regular match rate.

Non-expansion states would be eligible to receive a portion of the newly created "safety net funding for non-expansion states" which is budgeted at $2 billion per year for five years. The amount awarded to each of the 19 non-expansion states would be based on each state's share of the population with income below 138% FPL, regardless of how many people are covered by the state's Medicaid program or other insurance. Any state that is currently a non-expansion state but chooses to expand will no longer be eligible for any share of the $2 billion.[3] This safety net funding can only be used by the states to enhance Medicaid provider reimbursement rates up to the cost of providing care to Medicaid and uninsured patients. States would draw down their share of the $2 billion as costs are incurred.

Georgia Impact: GHA's modeling shows that as a non-expansion state, Georgia would be allocated about $177 million per year (the third largest amount) of the $2 billion set aside for non-expansion states. (See Figure 7 for allocations by state.) Funding is not based on how many people are uninsured but on the size of the state's low income population. The larger the state, the more funding the state would receive.

These funds appear to be an attempt to create "equity" between expansion and non-expansion states since the bill allows expansion states to receive higher base funding compared to non-expansion states. However, this funding falls far short of what Georgia would receive if Georgia had expanded Medicaid up to 133% FPL under the ACA. Based on an analysis conducted by the Georgia Chamber of Commerce, increased coverage funded by enhanced federal matching Medicaid funds would bring an additional $4.3 billion in federal funds to Georgia in 2018 and up to $6 billion annually by 2023.

The enhanced federal match rate of 90% would be worth $1.4 billion annually for Georgia's expansion population (as compared to federal funds available to Georgia under their regular federal match rate of around 69%.)[4] Since Georgia did not expand coverage by March 1, 2017, the AHCA reduces the amount of federal funds available to the state should it make a future decision to expand coverage for low-income Georgians. This provision of the bill is inherently inequitable to states that took a more fiscally conservative approach to health care policy.

---

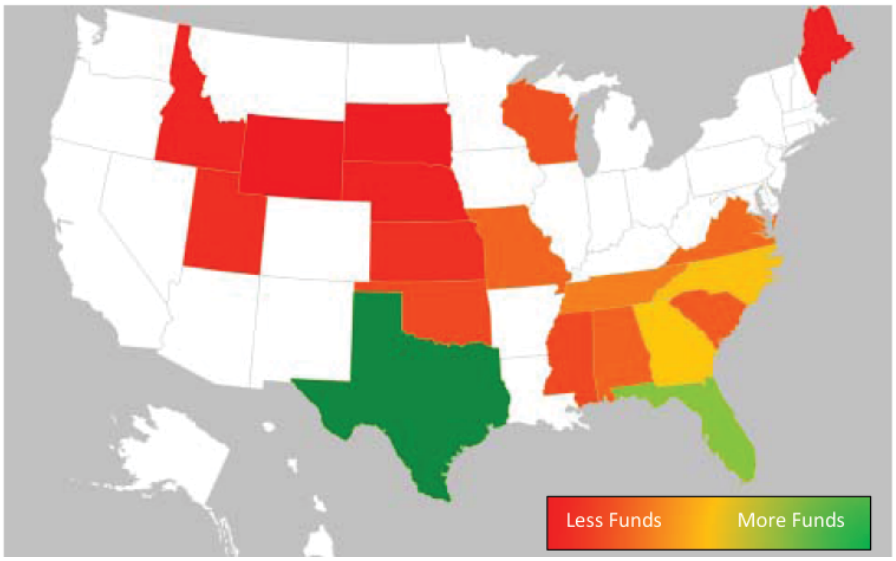
[2] Under the new administration, states may be able to obtain a waiver from the U.S. Department of Health and Human Services (HHS) that would allow them to limit their Medicaid expansion to individuals with incomes below 100% of the FPL. However, even if HHS is willing to grant such waivers, it is not clear whether states would be treated as expansion or non-expansion states under the AHCA.

[3] It is not clear from the text of the bill whether a state that expands and only gets the regular match rate would be treated as an expansion or non-expansion state for purposes of the safety net funding.

[4] Based on the Georgia Chamber of Commerce's analysis of estimated 2023 expenditures.

Figure 7

Safety Net Pool Fund Distribution



Suggestions for Improvement/Change to the Safety Net Pool:

- Because hospitals are, by far, the main safety net providers for the uninsured population and have been hurt the most by reimbursement cuts under the ACA, any funding received by non-expansion states from the safety net funding pool should be used exclusively for uncompensated costs incurred by hospitals.
- Fund distribution should be based on the number of uninsured under 138% instead of the total population. States with disproportionate numbers of uninsured should get a bigger allotment. For Georgia, this would increase the state's annual allocation by $24 million.
- If expansion states can continue their expansion programs even if only for a transition period, non-expansion states should receive the same amount of federal dollars to cover the cost of the uninsured. This would equalize funding for non-expansion states to stabilize hospitals and other providers for treating the uninsured.

Other Medicaid Eligibility Changes

The bill makes a number of changes regarding how states determine Medicaid eligibility, including the repeal of the expanded authority given to states and hospitals under the ACA to make presumptive eligibility determinations; new limitations on the ability for states to make eligibility retroactive; requiring recipients to renew eligibility every six months instead of annually; and reverting the mandatory Medicaid income eligibility level for poverty-related children back to 100% FPL (states could cover the population above 100% under their State Children's Health Insurance Program.)

States would have the option of instituting a work requirement in Medicaid for non-disabled, non-elderly, non-pregnant adults as a condition of receiving coverage under Medicaid. Work requirements are modeled after the requirements and exemptions that exist in the current Temporary Aid to Needy Families (TANF) program. Any state that chooses to institute a Medicaid work requirement will receive a 5% increase in its match rate for its administrative expenses.

Georgia Impact: As a provider organization, GHA is concerned about the change in some of the eligibility provisions. For example, GHA partnered with the state to promote a presumptive eligibility program so that hospitals can help get people signed up for Medicaid at the point of service. Otherwise, people without coverage simply become indigent or charity care for the hospital. Elimination of the presumptive eligibility program will likely increase the amount of uncompensated care provided by hospitals.

Assuming the federal matching rate for the State Children's Health Insurance Program would ultimately revert back to the non-ACA enhanced federal medical assistance percentage (eFMAP) Georgia's current program, PeachCare for Kids, would require $94 million in state matching funds as the eFMAP would move from 100% to 78% for this population.[5]

Eliminating Medicaid DSH Cuts

The Medicaid Disproportionate Share Hospital (DSH) program provides funding to hospitals to help offset their uncompensated costs from providing services to Medicaid and uninsured patients. The ACA included significant cuts to this program based on the assumption that Medicaid expansion and coverage gained through the state or federal health insurance marketplace would reduce hospitals' uncompensated care for these populations. Originally slated to begin in 2014, a series of subsequent federal legislation postponed these cuts until 2018. The Medicaid DSH cuts are currently scheduled to occur regardless of a state's decision to expand Medicaid. The AHCA repeals the Medicaid DSH cuts for non-expansion states beginning in 2018, and for expansion states beginning in 2020.

Georgia Impact: Georgia's hospitals provided an estimated $1.9 billion in uncompensated care for the Medicaid and uninsured population in FY 2017. Georgia's share of available federal Medicaid DSH funds for FY 2017 was $295 million, leaving $1.5 billion in remaining uncompensated care after considering $23 million in state contributions toward the required matching funds (public hospitals provided $117 million in intergovernmental transfers to provide most of the required state matching funds).

As a non-expansion state, Georgia would avoid estimated cuts of $49 million in 2018 (17% reduction) and $73 million in 2019 (25% reduction). Medicaid DSH cuts under the ACA will eventually reflect a 50% reduction and for 2020-2025 are estimated to total $930 million. It's important to note that while these cuts are avoided under AHCA, the funding restoration should not be considered new or increased funds to the state. The AHCA simply maintains the Medicaid DSH payments at the status quo. The avoidance of these cuts is critical for Georgia's hospitals that provide over $1.9 billion in uncompensated care to the Medicaid and uninsured populations annually. Georgia's current federal DSH allotment of $295 million is insufficient to cover the entire cost of uncompensated care. Escalating reductions to that amount are untenable and would leave many hospitals, particularly safety net and rural hospitals, financially vulnerable.

Suggestion for Improvement/Change to Medicaid DSH:

- Maintain the restoration of the Medicaid DSH cuts, especially for non-expansion states.

[5] Based on AFY 2017 Total Fund Appropriations for PeachCare for Kids and the FFY 2018 eFMAP of 77.95%.

GHA Summary
American Health Care Act - Insurance Markets

Repeal of Current Income-Based Tax Credits and Establishment of New Age-Based Tax Credits

Under the AHCA, effective January 1, 2020, the ACA's cost-sharing and premium subsidies are repealed.

In exchange, the bill provides for advanced, refundable tax credits based primarily on age instead of income. The tax credits range from between $2,000 and $4,000 per individual per year (based on age) and are capped at $14,000 per year for a family.[6] The amount of the credits increases each year by the percentage increase in the CPI plus one percentage point.

2017 Georgia Population Profile of People Enrolled in the Health Care Marketplace

- 46% with incomes between 100 – 150% FPL ($16K to $25K annually for a family of two)
- 45% between the ages of 45 and 64
- 75% of individuals enrolled live in counties with more than 100,000 population

The full amount of the credit would be available to individuals with annual incomes up to $75,000 ($150,000 for joint filers) and phases downward by $100 for every $1,000 in income above these thresholds. While the credit is only available to individuals that purchase health insurance coverage, it is not tied to purchasing coverage on a state or federal health insurance exchange, unlike the current premium subsidy.

The bill also eliminates the current cost-sharing subsidies that are allowed for individuals with incomes below 250% FPL. Under the ACA, insurers are required to offer plans with lower cost-sharing, which are funded through subsidies paid to the insurer. The cost-sharing subsidies would be repealed beginning in 2020.

In order to provide some additional tax relief for individuals with high health care costs, the bill reduces the qualifying adjusted gross income threshold for the Medical Expense Income Tax Deduction from 10% to 5.8%. This is expected to provide additional tax relief for lower income Americans with high health care costs.

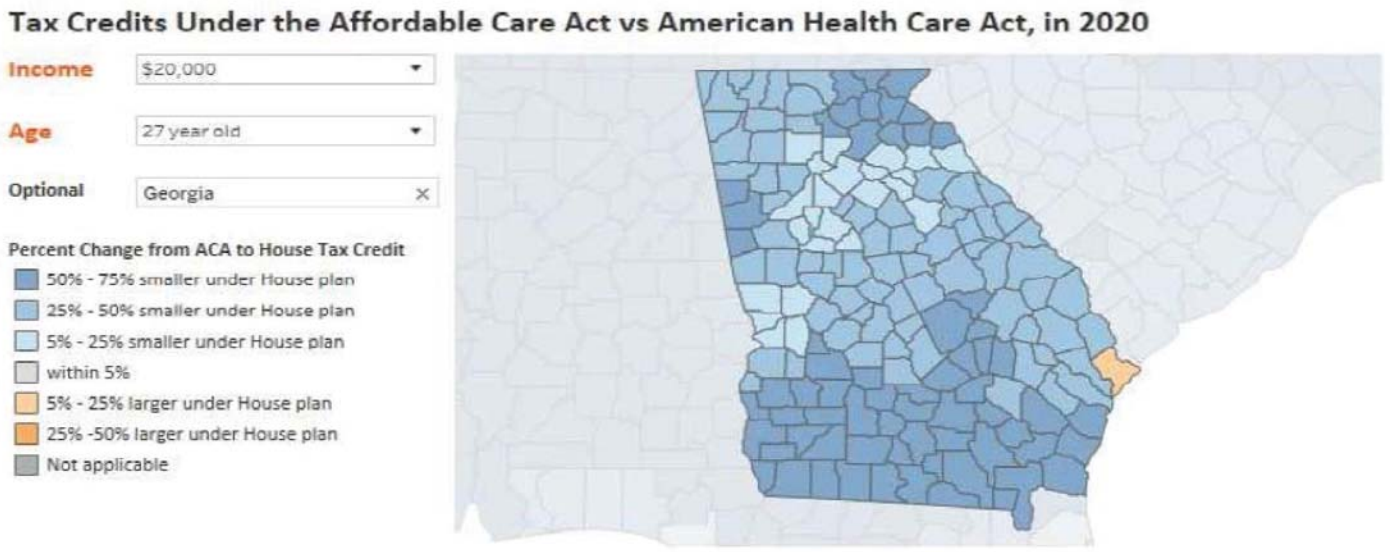
Georgia Impact: GHA is concerned that the tax credit level would have a significant impact on a state like Georgia that relied on these credits to help low income individuals purchase coverage through the federal Health Insurance Marketplace. Providers are put at additional risk without cost-sharing subsidies that help offset deductibles and copayment requirements for low-income individuals. Under the ACA, hospitals have seen an increasing amount of bad debt from patients who have insurance, but cannot afford their high deductibles or other cost-sharing amounts.

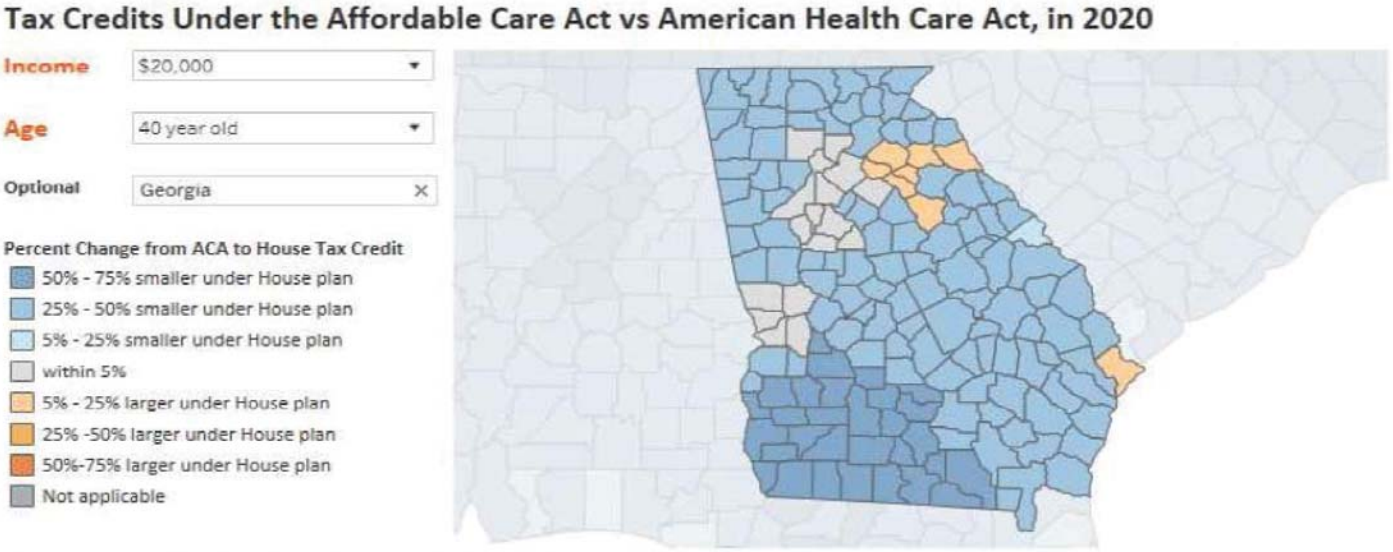
[6] Total family tax credits are calculated based on the ages of the oldest family members (up to 5 members).

The current credit averages around $4,300 per year per person in Georgia.[7] The proposed level of $2,000 likely would not be sufficient to help low income and younger individuals afford coverage. (See Figure 8 for the changes to Georgia's tax credits under the AHCA.)

Georgia relied on these subsidies being available and sufficient for low-income individuals to afford coverage. As a non-expansion state, not only would we not receive enhanced Medicaid funding under the AHCA, but we would be disadvantaged even further by the loss of affordable subsidies. The following maps show how tax credits would change under the AHCA based on an individual with a $20,000 annual income (166% of the FPL) at ages 27, 40 and 60.[8] Even with the other changes to the insurance markets discussed below, which are intended to help lower the cost of coverage, the subsidies contained in the AHCA are likely not enough to make health insurance affordable to many Georgians, and hospitals will have to continue to provide uncompensated care to the sick and injured.

Figure 8

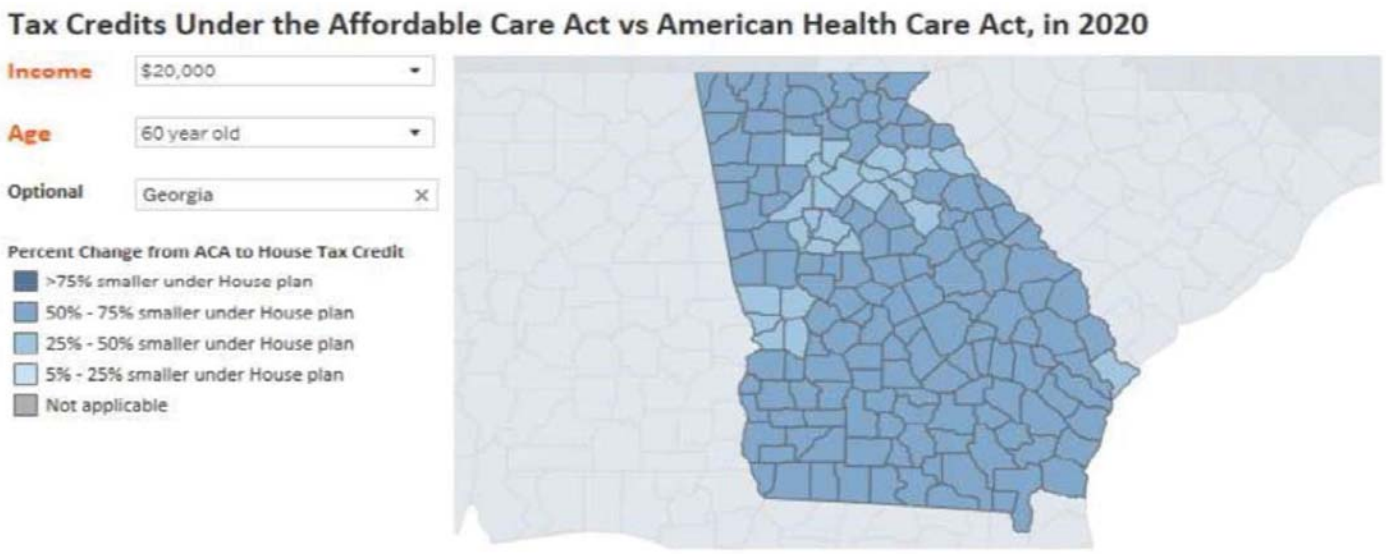




[7] Addendum to the Health Insurance Marketplaces 2017 Open Enrollment Period: January Enrollment Report. For the period: November 1, 2016 – December 24, 2016. January 10, 2017. Department of Health & Human Services, Centers for Medicare & Medicaid Services.

[8] Maps courtesy of http://kff.org/interactive/tax-credits-under-the-affordable-care-act-vs-replacement-proposal-interactive-map/

Figure 8



Patient and State Stability Fund and Federal Invisible Risk Sharing Program

The AHCA establishes two new programs to help states stabilize their insurance markets and cover the cost of high-risk or chronically ill individuals. The "Patient and State Stability Fund" provides funding to states based on an allocation formula, totaling $100 billion over 10 years. Eighty-five percent of the funds would be distributed according to the share of that state's insurance claims as a percentage of the nation. The remaining 15 percent of the funds would be distributed to states that either have seen an increase in the number of uninsured from 2013 to 2015 living below poverty and/or have less than three participating health insurers selling coverage in their exchange market in 2017. The stability funds would be distributed to states on a yearly basis.

States may use these funds to use for high risk pools, reducing cost of coverage for individuals with a high utilization rate, promoting participation in the individual and small group markets, promoting access to certain services, and helping with out-of-pocket costs. Beginning in 2020, the state would have to make financial contributions in a "matching" type arrangement beginning at 7% and increasing to 50% by 2026. An additional $15 billion is appropriated to the Patient and State Stability Fund to be used solely for maternity coverage, newborn care, and mental health and substance use disorders.

The "Federal Invisible Risk Sharing Program" provides funding for payments to health insurers to help cover the cost of high risk individuals and lower premiums in the individual market. $15 billion is appropriated to help finance the Program, covering calendar years 2018 through 2026. Additional funds will come from a percentage of the premiums paid by eligible individuals and any unallocated funds from the Patient and State Stability Fund. Beginning in 2020, states may take over the operation of the Program.

Georgia Impact: While GHA has not computed its own estimates of Patient and State Stability Fund allocations by state, other healthcare consulting entities have published research that show Georgia's allocation could range from $247 million (Avalere)[9] to $698 million per year (Oliver Wyman Health).[10]

[9] SOURCE: http://avalere.com/expertise/life-sciences/insights/ahca-state-stability-fund-would-give-more-money-to-states-with-limited-insu

[10] SOURCE: http://health.oliverwyman.com/transform-care/2017/03/estimating_stateall.html

Additional Provisions Intended to Stabilize the Insurance Markets

The AHCA sets the penalty for not complying with individual and employer mandates at zero and makes several changes to insurance market coverage:

- Establishes a 30% premium surcharge for those who do not maintain continuous coverage. This provision is intended to replace the individual mandate and provide an incentive to individuals to enroll in coverage during the open enrollment period.

- Allows premiums in the individual market to vary by age from a ratio of 5:1. This means premiums for younger individuals would be set five times lower than for the highest age bracket.

- Repeals the ACA actuarial value requirements and plan levels or "metal tiers" (e.g., gold, silver, bronze) in the individual market.

Georgia Impact: GHA is concerned about insurance coverage provisions and the impact on providers. Reducing the actuarial value of health plans, for example, would result in increased cost-sharing requirements for enrollees and thus increased burden for providers. A high-risk pool could provide additional access to coverage and care for high risk individuals and may help stabilize the overall insurance market, but will likely require significant financial investment from the state to be sustainable in the long term.

State Flexibility to Waive Certain ACA Requirements for Community Rating and Essential Health Benefits

The legislation gives the option to waive certain requirements regarding community rating and essential health benefits, both of which are factors in determining how much a particular health plan costs:

- Beginning in 2018, states may waive the community age rating rules required by the ACA and amended by the AHCA. Currently, insurers are prohibited from charging older consumers more than three times what they charge younger consumers (a 3:1 ratio). As noted above, the AHCA raises this ratio to 5:1.

- Beginning in 2019, states may waive the 30% premium surcharge for those who do not maintain continuous coverage. States choosing to waive this requirement would essentially return to pre-ACA medical underwriting standards, which allow insurers to charge significantly higher premiums for individuals with pre-existing conditions who do not maintain continuous coverage.

- Beginning in 2020, states may also waive the essential health benefit (EHB) requirements created by the ACA and instead establish state-specific EHB standards.

In order to be eligible for one of the waivers, states must specify how the waiver will help achieve one of the following goals: (1) reducing average premiums for health insurance coverage; (2) increasing enrollment in health insurance coverage; (3) stabilizing the market for health insurance coverage; (4) stabilizing premiums for individuals with pre-existing conditions; or (5) increasing the choice of health plans. In addition, for waivers of the community age rating or premium surcharge requirements, states must have a high-risk pool or other type of reinsurance program in place or be participating in the Federal Invisible Risk Sharing Program established under the AHCA. An additional $8 billion has been added to the Patient and State Stability Fund described above to be used for states that have been granted a waiver from the ACA community rating requirements. The fund may be used to provide assistance to reduce premiums or other out-of-pocket costs for individuals who may have an increase in such expenses because they reside in a state with an approved waiver, have a pre-existing condition, are uninsured because they have not maintained continuous coverage, and purchased health insurance in the individual market.

Georgia Impact: GHA is concerned that the waivers do not provide enough protections to ensure that individuals with pre-existing conditions have access to affordable health coverage. A significant increase in premiums or cost-sharing for this population will likely lead to a higher number of uninsured seeking care in hospital emergency rooms. Any waiver of the EHB requirements also poses a concern for hospitals. While limiting the services covered under a health plan may make the plan more affordable, it also increases the likelihood that patients will forego necessary treatment because it's not covered. Without the appropriate protections, it is typically those important, but expensive, services (e.g., behavioral health and substance abuse services) that are excluded from health plans.

Repeal of Taxes

The AHCA eliminates many of the health care related taxes that were included in the ACA. These include: the tax on health insurance premiums; the medical device tax; the tax on over-the-counter medications; the 0.9% Medicare surtax on taxpayer income over $200,000 for individuals/$250,000 for couples; and the excise tax on indoor tanning.

In addition, the AHCA delays the effective date of the "Cadillac tax" on high value health insurance plans until 2026.

Georgia Impact: The elimination of the tax on health insurance premiums would benefit Georgia's Medicaid program. During the one-year moratorium, the Medicaid program saved $32 million in state funds because it did not have to pay higher capitation payments to the Medicaid managed care plans to cover the cost of the tax.

Suggestions for Improvement/Change to the AHCA Insurance Market Provisions:

- Consider anticipated patient cost-sharing amounts when determining the affordability of health plans.
- Raise the tax credits to a level that makes comprehensive health insurance truly affordable for all Georgians.
- Preserve protections for pre-existing conditions and essential health benefits.

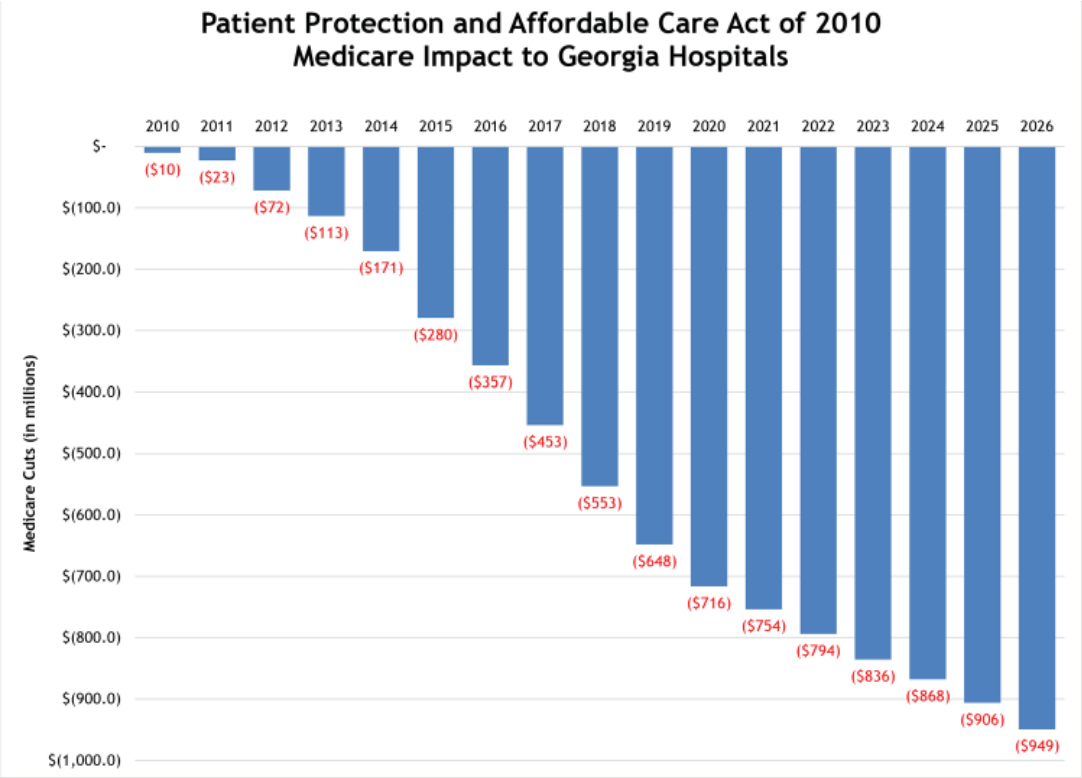
GHA Summary
American Health Care Act - Medicare Provisions

Medicare Cuts

The AHCA does not repeal the Medicare cuts for hospitals that were instituted under the ACA.

Georgia Impact: GHA is concerned that the bill does not repeal the Medicare cuts for hospitals. These Medicare reductions have already amounted to just over $1 billion from 2010 to 2016 and are expected to escalate to almost $1 billion annually by 2026. (See Figure 9) These cuts were intended to fund the coverage expansions incurred under the ACA. If the Medicare cuts remain and the AHCA Medicaid funding provisions and changes to the premium subsidies move forward, Georgia will be at an even greater disadvantage.

Figure 9



Reduction in Insurance Coverage Impacting Medicare DSH

Because the insurance coverage provisions of the legislation would increase the number of uninsured people and decrease the number of people with Medicaid coverage relative to the numbers under current law, the Congressional Budget Office (CBO) estimates that Medicare spending would increase by $43 billion over the 2018-2026 period.

Medicare makes additional DSH payments to facilities that serve a higher percentage of uninsured patients. Those payments have two components: an increase to the payment rate for each inpatient case and a lump-sum allocation of a pool of funds based on each qualifying hospital's share of the days of care provided to beneficiaries of Supplemental Security Income and Medicaid.

Under the AHCA, the decreased enrollment in Medicaid (in expansion states) would slightly reduce the amounts paid to hospitals, per CBO estimates. However, the increase in the number of uninsured people would substantially boost the amounts distributed on a lump-sum basis.[11]

Georgia Impact: Medicare DSH payments in Georgia annually total $185 million for the lump-sum allocation and are variable for the increase for each inpatient case. Based on the estimated increases to the national lump-sum allocation provided by CBO, Georgia's Medicare DSH payments are estimated to increase by $37 million in 2018 and eventually grow by $299 million annually in 2021 and after, largely resulting from an increased uninsured population.

Suggestions for Improvement/Change to the AHCA Medicare Provisions:

- Fully restore the Medicare payment cuts to hospitals, including the cuts resulting from sequestration, coding adjustments, market basket updates, and the reduction in Medicare DHS funding.

[11] Courtesy of Congressional Budget Office Cost Estimate. American Health Care Act. March 13, 2017.

GHA Summary
American Health Care Act - Public Health Funding

The ACA established the Prevention and Public Health Fund to provide expanded and sustained national investments in prevention and public health, to improve health outcomes, and to enhance health care quality. To date, the Fund has invested in a broad range of evidence-based activities including community and clinical prevention initiatives; research, surveillance and tracking; public health infrastructure; immunizations and screenings; tobacco prevention; and public health workforce and training.

Under the AHCA, Prevention and Public Health Fund appropriations from fiscal year 2019 onward will be repealed, and unobligated funds remaining at the end of FY 2018 will be rescinded.

Georgia Impact: Various Georgia entities have received $155 million from this fund since 2012. The biggest benefactor has been the Georgia Department of Public Health, which has received $47 million to date. These funds are supporting a wide range of public health activities, including immunization, preventive health block grants, and breastfeeding promotion and support.[12]

[12] SOURCE: https://pphf.hhs.gov

Notes

1675 Terrell Mill Road
Marietta, GA 30067
770-249-4500
www.gha.org