



The Updated American Health Care Act

April 28, 2017

On April 26th, the House GOP revived the American Health Care Act (AHCA) with amendments that would appease the conservative House Freedom Caucus and bring some (but not all) support from the centrist GOP Tuesday Group.

Leadership is clear that a vote won't happen unless they know there are enough GOP votes to pass it. The GOP can lose up to 22 votes and still pass the bill. No Democrat is expected to vote for the bill. House leadership will continue working to find votes and it is just better than even that they will have a vote before the end of May.

Here's a summary, with links) of what is now in the AHCA --

The underlying bill– with amendments already considered as adopted into the bill – would:

- Provides states the option of block grants for 10 years for Medicaid or per-capita payments. It would also give states the option to require work requirement for the program. The amendment would remove a number of taxes that were put in place by the ACA.
- Eliminates the ACA's requirement that insurers cover essential health benefits, leaving it up to the states to determine standards.
- Adds \$15 billion to the Patient and State Stability Fund solely devoted to States for maternity coverage and newborn care, and mental health and substance use disorders.
- Increases the annual inflation rate for elderly and disabled Medicaid populations from CPI-U Medical to CPI-U Medical +1
- Prevents new states from opting in to Medicaid expansion.
- Provides states with the ability to implement work requirements – similar to those used for the Temporary Assistance for Needy Families (TANF) program. Includes a 5% FMAP bump for states that institute the new requirements.
- Accelerates the repeal of ACA taxes to 2017 (from 2018) and extends the relief from other taxes (like the Cadillac tax) by an additional year.
- Provides a dedicated pool of money to help older Americans purchase insurance by allowing a deduction of medical expenses from taxes at 5.8% of income rather than the current 10% threshold. According to the Committee, this provides the Senate with the ability to enhance tax credits for those ages 50 to 64.
- Delays the repeal of the additional .9 percent Medicare tax on high-income earners, require states to establish their own essential health benefits standards for purposes of the premium tax credit.

- Creates a \$15 billion risk sharing program to help states lower premiums for health coverage offered in the individual market.

[Click here](#) for a lengthy summary from Kaiser Family Foundation.

The new amendment agreed to yesterday is expected to gain approval before the bill goes to a vote on the House Floor. Its main provisions:

MacArthur Amendment ([click here for text](#), and [here](#) for a summary from the amendment author)

- Allow states to establish their own age rating band beginning 2018. The ratio is now 3 to 1. It is expected to be allowed to increase to 5 to 1.
- Starting in 2020, allow states to apply for exemptions from certain Title I provisions of the ACA if they can prove the changes will reduce average health insurance premiums, expand enrollment in the marketplace, stabilize prices in the insurance market or premiums for people with preexisting conditions, or increase the choice of health plans.
- Starting in 2019, allow states to let plans underwrite based on health status if an enrollee has not complied with the law's continuous coverage provision. States seeking this waiver must have a high-risk pool or reinsurance program.
- Allow states to request a waiver to opt out of the ACA's essential health benefits package.

In order to receive any of the above waivers, states must attest that the purpose of their requested waiver is for one or more of the following:

- Reduce average premium costs,
- Increase enrollment in health insurance,
- Stabilize the market for health insurance,
- Stabilize premiums for people with pre-existing conditions, or
- Increase the choice of health plans.

The 10 Essential Health Benefits under the ACA:

1. Ambulatory patient services (Outpatient care). Care you receive without being admitted to a hospital, such as at a doctor's office, clinic or same-day ("outpatient") surgery center. Also included in this category are home health services and hospice care (note: some plans may limit coverage to no more than 45 days).
2. Emergency Services (Trips to the emergency room). Care you receive for conditions that could lead to serious disability or death if not immediately treated, such as accidents or sudden illness. Typically, this is a trip to the emergency room and includes transport by ambulance. You cannot be penalized for going out-of-network or for not having prior authorization.
- 3 Hospitalization (Treatment in the hospital for inpatient care). Care you receive as a hospital patient, including care from doctors, nurses and other hospital staff, laboratory and other tests, medications you receive during your hospital stay, and room and board. Hospitalization coverage also includes surgeries, transplants and care received in a skilled nursing facility, such as a nursing home that specializes in the care of the elderly (note: some plans may limit skilled nursing facility coverage to no more than 45 days).
4. Maternity and newborn care. Care that women receive during pregnancy (prenatal care), throughout labor, delivery, and post-delivery, and care for newborn babies.

5. Mental health services and addiction treatment. Inpatient and outpatient care provided to evaluate, diagnose and treat a mental health condition or substance abuse disorder. This includes behavioral health treatment, counseling, and psychotherapy. (note: some plans may limit coverage to 20 days each year. Limits must comply with state or federal parity laws. Read this document for more information on mental health benefits and the Affordable Care Act).

6. Prescription drugs. Medications that are prescribed by a doctor to treat an illness or condition. Examples include prescription antibiotics to treat an infection or medication used to treat an ongoing condition, such as high cholesterol. At least one prescription drug must be covered for each category and classification of federally approved drugs; however, limitations do apply. Some prescription drugs can be excluded. “Over the counter” drugs are usually not covered even if a doctor writes you a prescription for them. Insurers may limit drugs they will cover, covering only generic versions of drugs where generics are available. Some medicines are excluded where a cheaper equally effective medicine is available, or the insurer may impose “Step” requirements (expensive drugs can only be prescribed if a doctor has tried a cheaper alternative and found that it was not effective). Some expensive drugs will need special approval.

7. Rehabilitative services and devices – Rehabilitative services (help recovering skills, like speech therapy after a stroke) and habilitative services (help developing skills, like speech therapy for children) and devices to help you gain or recover mental and physical skills lost to injury, disability or a chronic condition (this also includes devices needed for “habilitative reasons”). Plans have to provide 30 visits each year for either physical or occupational therapy, or visits to the chiropractor. Plans must also cover 30 visits for speech therapy as well as 30 visits for cardiac or pulmonary rehab.

8. Laboratory services. Testing provided to help a doctor diagnose an injury, illness or condition, or to monitor the effectiveness of a particular treatment. Some preventive screenings, such as breast cancer screenings and prostate exams, are provided free of charge.

9. Preventive services, wellness services, and chronic disease treatment. This includes counseling, preventive care, such as physicals, immunizations, and screenings, like cancer screenings, designed to prevent or detect certain medical conditions. Also, care for chronic conditions, such as asthma and diabetes. Note: please see our full list of Preventive services for details on which services are covered.

10. Pediatric services. Care provided to infants and children, including well-child visits and recommended vaccines and immunizations. Dental and vision care must be offered to children younger than 19. This includes two routine dental exams, an eye exam and corrective lenses each year.