HEALTH INSURANCE MARKET REFORMS

Provision	Affordable Care Act (Current Law)	American Health Care Act (House Proposal)	Impact of the AHCA on Ohio
Coverage Mandates	**Individual mandate:** Requires all US citizens and legal residents to have health coverage. Assesses a penalty on those lacking coverage. **Employer mandates:** Requires all employers with more than 200 employees to automatically enroll employees in health insurance plans. All employers with more than 50 employees are assessed a fee if they have at least one employee who receives a premium tax credit.	**Repeals individual and employer mandates:** Eliminates penalties associated with the requirements that most people obtain health insurance coverage and that large employers offer their employees coverage that meets specified standards, effective retroactively to 12/31/15. **Creates a continuous coverage requirement:** Requires insurers to apply a 30% surcharge on premiums for people who enroll in insurance in the non-group or small-group markets if they have been uninsured for more than 63 days within the past year.	**CBO estimates** 14 million more Americans (about 500,000 Ohioans) would be uninsured in 2018 under the AHCA compared to current law, mostly as a result of repealing the penalties associated with the individual mandate.
Individual Market Affordability Assistance	**Advance Premium Tax Credits (APTC):** Refundable credits, which can be paid in advance, are given to individuals and families with incomes between 100-400% of the FPL to be used for the purchase of coverage through a state or federal health insurance exchange. **Cost Sharing Reduction:** Direct reimbursement is given to issuers for individuals with income between 100-250% FPL who enroll in a Silver level plan. These reimbursements increase the actuarial value of coverage so it is equal to a Gold or Platinum plan.	**Repeals ACA APTC and cost sharing reductions in 2020.** **Age Adjusted Tax Credits:** Creates an advanceable, refundable tax credit for the purchase of state-approved major medical health insurance. The credits are adjusted by age, from $2,000 under age 30 to $4,000 over age 60, and are additive for a family up to a cap of $14,000. The credit phases out by $100 for every $1,000 in income above $75,000. **Creates a new Patient and State Stability Fund:** Provides states with $15 billion annually 2018-2019 and $10 billion annually 2020-2026 to make coverage more affordable in the individual market. Phases in a state matching requirement beginning in 2020.	**CBO estimates** the AHCA would increase average premiums 15-20 percent in the non-group market prior to 2020 and then lower average premiums to roughly 10 percent lower than under current law by 2026.[1] **CBO estimates** for the period 2017-2026 the value of the subsidies for coverage through marketplaces under the ACA would be $673 billion and the value of the tax credits and Patient and State Stability Fund combined would be $441 billion under the AHCA, resulting in $232 billion less federal funding over the period to make health insurance coverage more affordable.[2] In general, the AHCA is less generous than the ACA below $40,000 and more generous above. For example, a Franklin County, Ohio resident age 60 with income below $30,000 ACA credit = $6,550 and AHCA = $4,000.[3]

[1] Congressional Budget Office, CBO Cost Estimate of the American Health Care Act (page 3).
[2] CBO, Table 3: Net budgetary Effects of the Insurance Coverage Provisions of the AHCA (page 33).
[3] Kaiser Family Foundation, Tax Credits under the Affordable Care Act vs. the American Health Care Act.

MEDICAID REFORMS

Provision	Affordable Care Act (Current Law)	American Health Care Act (House Proposal)	Impact of the AHCA on Ohio
Medicaid Expansion	**Coverage expansion:** Expanded Medicaid to all non-Medicare-eligible individuals under age 65 with incomes up to 138% FPL based on modified gross adjusted income (a U.S. Supreme Court ruling made the expansion optional for states). **Enhanced federal match:** States expanding Medicaid for the newly-eligible population received 100% federal match for 2014-2016 gradually phasing down to 90% federal match in 2020.	**Repeals enhanced federal match:** Reduces the federal matching rate for adults made eligible for Medicaid by the ACA to equal the rate for other enrollees in the state, beginning in 2020. States would continue to receive enhanced match for individuals enrolled under the expansion prior to January 1, 2020. After December 31, 2019, the state could only enroll newly eligible individuals at the state's traditional FMAP.	**CBO estimates** the AHCA would reduce Medicaid spending $880 billion over the 2017-2026 period. **Ohio Medicaid estimates** the following coverage and state spending impacts under three scenarios: 1. Phase out expansion: ***750,000 Ohioans*** lose coverage; total Ohio Medicaid spending 2018-2026 is reduced $37 billion (state share *decreases* $3.7 billion). 2. Keep expansion at regular FMAP: ***123,000 Ohioans*** lose coverage; total Ohio Medicaid spending 2018-2026 is reduced $6.4 billion (state share *increases* $7.8 billion). 3. Expand to 100% FPL at regular FMAP: **284,000 Ohioans** lose coverage; total Ohio Medicaid spending 2018-2026 is reduced $14 billion (state share *increases* $4.9 billion).
Convert all Medicaid to a Per Capita Allotment	**No provision.** Under the current law, the federal government and state governments share in the financing and administration of Medicaid. In general, states pay health care providers for services to enrollees, and the federal government reimburses states for a percentage of their expenditures. All federal reimbursement for medical services is open-ended, meaning that if a state spends more because enrollment increases or costs per enrollee rise, additional federal payments are automatically generated.	**Converts the entire Medicaid program into a per capita allotment:** Starting in 2020 (using 2016 as the base year) federal payments to states for the Medicaid program will be calculated on a per capita basis by category of enrollee, including elderly, disabled, children, non-expansion adults, and expansion adults. The per capita cap increases annually by medical CPI. **Provides some state flexibility to manage Medicaid:** Repeals the requirement that Medicaid plans must provide "essential health benefits," repeals presumptive eligibility for non-pregnant adults, reduces Medicaid retroactive coverage from three months to one month, and requires eligibility redetermination every six months for expansion populations.	**CBO estimates** the per capita allotment under the AHCA will grow 3.7% on average (medical CPI).[4] For comparison, Medicaid drug prices, which states do not control, increased 13.6% in 2015.[5] **Ohio Medicaid estimates** spending under the cap for the first few years but, without additional flexibility to manage the financial risk that the AHCA shifts to the state, Ohio Medicaid spending will exceed the cap from 2025 forward. Significant additional state flexibility is needed to manage spending within the proposed cap. Republican Governors have agreed on the design of a workable per capita cap, including a detailed list of state authority and flexibility that is required to manage within the cap.

[4] Congressional Budget Office, CBO Cost Estimate of the American Health Care Act (page 10).
[5] Centers for Medicare and Medicaid Services (CMS), National Health Expenditure Tables: Medicaid Prescription Drug Expenditures (2014-2015).