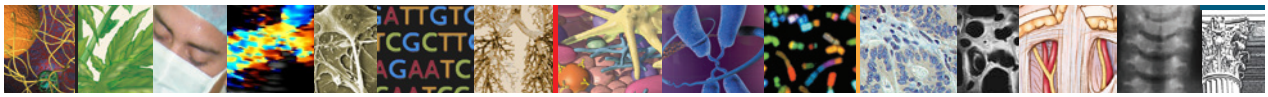

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Perspective

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Moving in the Wrong Direction — Health Care under the AHCA

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On May 4, the U.S. House of Representatives resurrected Republican efforts to enact major health care legislation by narrowly passing the American Health Care Act (AHCA). A growing body of analytic work, including a Congressional Budget Office (CBO) assessment delivered on May 24,[1] paints a dismal picture of how the AHCA would affect the health care system. The CBO analysis shows that the legislation would reduce the number of people with insurance coverage by 23 million, while narrowing coverage or increasing its cost for millions more. The resulting budgetary savings would finance tax cuts that would accrue disproportionately to high-income families. These effects contrast starkly with President Donald Trump's promises that health care legislation would cover more people while lowering costs for families.

The AHCA would change the health care system in five major ways. Two would primarily affect Medicaid. The legislation would substantially reduce federal support to states that expanded Medicaid under the Affordable Care Act (ACA) to nonelderly individuals with incomes up to 138% of the federal poverty level. The AHCA would not only roll back the ACA's Medicaid expansion, but would also cap the amount of federal funding that states could receive per Medicaid enrollee. The cap would be updated annually on the basis of a health care price index that would not accurately capture either national trends in per capita health costs or trends in any particular state, resulting in large reductions in federal funding for many states, particularly in the long run.[2]

The other three major provisions would primarily affect private insurance. The AHCA would immediately repeal the ACA's requirement that individuals who do not qualify for specified exemptions show that they have health insurance or pay a penalty. It would also repeal the ACA's premium tax credit and cost-sharing reductions for people purchasing coverage on the individual insurance market. These subsidies would be replaced with a new tax credit that would be less generous overall and that, unlike the ACA's subsidies, would not adjust for differences in the local cost of coverage, would not fully adjust for differences in premiums based on age, and would not vary with income (except for phasing out at high income levels). Many lower-income people, older people, and people living in high-cost areas would receive much less assistance, while some higher-income people, younger people, and people in low-cost areas would receive more assistance.[3]

Finally, the AHCA would allow

states to waive the ACA's requirement that individual and small-group plans cover a basic set of "essential health benefits" and its individual-market community-rating provisions, which bar insurers from varying premiums on the basis of health status. The AHCA community-rating provision would ostensibly apply only to people with a recent gap in coverage, but both the CBO and a prior Brookings Institution analysis concluded that states could use such waivers to unravel community-rating protections marketwide, including for people with no gap in coverage.[4]

The CBO estimates that half the U.S. population resides in states that would adopt waivers of one or both provisions, but the effects of waivers of essential health benefits could cross into nonwaiver states. The ACA's ban on annual and lifetime coverage limits and its requirement that plans cap out-of-pocket spending apply only to services designated as essential health benefits, so as the definition of such benefits narrows, the scope of these requirements narrows, too.[5] People covered by individual and small-group market plans in states that narrow the definition of essential health benefits would be affected directly. However, the much larger population covered by large employer plans could be affected nationwide, since such plans are permitted to use any state's definition of essential health benefits for the purposes of these provisions.

The CBO estimates that the AHCA's policy changes would dramatically and immediately reduce insurance coverage. The number of people with coverage would drop by 14 million in 2018, owing primarily to immediate repeal of the individual mandate, and the decrease would reach 23 million in 2026 as other provisions took effect. Eighteen percent of the nonelderly population would be uninsured in 2026, approximately the same proportion as when the ACA was enacted. The CBO predicts that many more people would receive less generous coverage, particularly in states that narrowed the definition of essential health benefits.

The AHCA would reduce both public and private insurance coverage. The population covered by Medicaid would fall by 14 million, a decline largely reflecting both the CBO's expectation that many states would discontinue their Medicaid expansions and the effects of the AHCA's overall cap on per-enrollee Medicaid spending. Reductions in enrollment in private insurance would account for the remaining 9 million who would lose coverage under the AHCA, reflecting the net effect of repeal of the individual mandate, reductions in subsidies for purchasing coverage, and other changes.

These coverage losses would be concentrated among lower-income people, although many middle-income people would be affected as well. According to the CBO, about 1 in 6 nonelderly adults with incomes below 200% of the federal poverty level would lose coverage by 2026, a reflection of the sharp cuts in programs that help lower-income people obtain coverage; about 1 in 22 nonelderly adults with higher incomes would also lose coverage. In states that waived community rating, the seriously ill would be at particular risk of losing coverage, since they would face dramatically higher individual-market premiums, sometimes so high as to be functionally equivalent to an outright denial of coverage.

The AHCA's deep cuts to Medicaid, reduced individual-market subsides, and other provisions affecting insurance coverage would generate substantial federal savings, totaling $783 billion over 10 years. Most of these savings would finance the repeal of various taxes imposed by the ACA, including taxes on high earners and taxes on medical devices, health insurance, and pharmaceuticals, leaving a net deficit reduction of just $119 billion over 10 years. According to calculations by the Center on Budget and Policy Priorities, using estimates from the Urban-Brookings Tax Policy Center, when these tax cuts were fully in effect, about three quarters of their benefits would accrue to families with incomes exceeding $200,000 per year. The average annual tax cut would be roughly $5,000 for each family in this group and would exceed $50,000 for families with annual incomes above $1 million.

The health care debate has now moved to the Senate, where Republicans hold 52 seats. Several Republican senators have expressed concerns about the depth of the AHCA's cuts to Medicaid and its reductions in financial assistance for people purchasing individual market coverage. The Senate will also consider the AHCA through the "budget reconciliation" process in order to avoid a filibuster that would require 60 votes to end. That strategy may require the Senate to drop certain provisions included in the House-passed bill, including the one granting states the option to define essential health benefits and waive community rating, be-

cause they do not bear directly on spending or taxes.

But there is no guarantee that the Senate will remedy the AHCA's flaws, much less reject it outright. The Trump administration and Senate Republican leaders remain committed to enacting legislation that shares most of the key features of the House-passed bill — a position that reflects both ideological conviction and fear of a backlash from their conservative base if they do not keep their "promise" to repeal the ACA. Indeed, although the AHCA is quite unpopular with voters overall, many more Republican voters support the legislation than oppose it. Wary Republican senators will therefore face strong pressure to fall in line as the debate unfolds. Similar pressure was effective in the House, where many Republicans who expressed misgivings about the AHCA ultimately voted for it. Stay tuned.

An audio interview with Dr. Fiedler is available at NEJM.org

Disclosure forms provided by the authors are available at NEJM.org.

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The First Hundred Days for Health Care

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Like my predictions about what a Republican win in the 2016 election would mean for U.S. health policy,[1] my expectations about the ease and speed of passing an Affordable Care Act (ACA) replacement bill during President Donald Trump's first 100 days in office have not exactly come to fruition. But given the Republican focus over the past 7 years on "repealing and replacing" the ACA and Trump's promise to make health care reform an early focus of his administration (at one point, he suggested having Congress meet even before his inauguration), Congress's attention to the issue has not been surprising — even if it's not directly in line with Trump's dominant campaign theme of "making America great again." Indeed, it's been argued that the economy and jobs would have been a politically easier first target than health care — an argument that was made retrospectively for the Obama administration as well.

After an initial hiccup, the House of Representatives passed H.R. 1628, the American Health Care Act (AHCA), on May 4 by a vote of 217 to 213. Twenty Republicans and all Democrats voted against the bill. The legislation's major provisions include advanceable, refundable tax credits for purchasing health insurance coverage that are based on age (rather than income); increased limits on health spending accounts for high-deductible health plans; a 30% insurance surcharge for people who don't maintain continuous coverage; elimination, after 2020, of the ACA's enhanced federal funding rate for states' coverage of new Medicaid enrollees; conversion of Medicaid into a per capita block-grant program; and establishment of a $100 billion "Patient and State Stability Fund." The tax credits would range from $2,000 to $4,000, depending on age, and would start to phase out at an annual income of $75,000 for individuals and $150,000 for families.

Representative Tom MacArthur (R-NJ), coleader of the moderate Tuesday Group, helped craft amendments designed to increase