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The Good, The Bad & The Ugly of the American Health Care Act

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Note: All of the mass media is focusing on the same aspects of the American Health Care Act (AHCA). This article focuses on a few of those aspects which are not being reported in the media, but which are of significant importance.

(1).Pre-existing Conditions.

The Good is that the AHCA does continue the protection that insurance carriers cannot exclude pre-existing conditions from coverage when purchasing a health insurance policy.

The Bad, or perhaps even the Ugly, are other, little discussed provisions of the AHCA which, for many, will probably render this protection meaningless because the premiums will be unaffordable, particularly for older Americans

First, without addressing all the details of how insurance carriers calculate premiums, the AHCA allows states to submit an application which would permit insurance companies in that state to give greater weight to an individual's age and, most importantly, to the individual's health status (i.e.; their pre-existing conditions) in deciding the premium rate.

Secondly, if an individual has a break in insurance coverage, insurance carriers are permitted to charge a 30% premium surcharge. This provision is more likely to apply to individuals who have pre-existing conditions, particularly if they have waited to purchase health insurance until after they have a health problem.

(2). Reduced Funding for Medicaid.

Definitely Ugly is the AHCA's reduced funding of Medicaid.

Medicaid is partially funded by the federal government and partially by the states to provide healthcare for the indigent and poor population. The Affordable Care Act (ACA) greatly expanded the eligibility for Medicaid and offered additional federal funding for those states which opted to accept this expansion. Over 8 1/2 million low come Americans obtained healthcare through the ACA Medicaid expansion.

The AHCA reduces federal funding for Medicaid in two ways. First, the nonpartisan Congressional Budget Office estimated that over the next decade federal funding for Medicaid will be reduced by $880 billion dollars.

Under Medicaid the federal government pays a certain amount of matching funds to the states for each individual who is participating in it. Under the ACA the amount of the matching fund was increased for each individual who was participating under the ACA expansion of Medicaid. This increased funding is completely eliminated by the AHCA.

(3). Reduced Coverage & Benefits.

Under the ACA effectively all insurance plans had to provide coverage for "essential health benefits". These included: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health services, prescription drugs, rehabilitative services and devices, lab services, preventive care, and pediatric services.

Most probably Bad, is that under the AHCA states are allowed to waive the essential health benefits requirement under the ACA, and they are permitted to establish their own, more limited definitions of essential benefits. If states opt to do so this may result in insurance plans which provide such limited coverage that they amount to effectively little or no coverage; or insureds will have to pay higher premiums for an insurance plan which provides covered benefits that are beyond the more limited definition of essential benefits.

Further, the ACA prohibited insurance plans from imposing annual or lifetime dollar limits on coverage for essential health benefits. If states do establish narrower definitions of essential benefits, this may permit large – group insurance plans and self – insured plans to impose such limits on the benefits they do provide which are outside of a narrower definition of essential health benefits.

(4). Premium tax credit.

A premium tax credit is essentially a federal government subsidy to allow low or moderate income individuals or families to purchase healthcare insurance.

Probably a Good is that the AHCA has reworked the premium tax credit under the ACA so that it is now based on age, with a maximum tax credit of $4,000 for individuals over 60 years old, with a gradual phase – out of the credit for families earning over $150,000 in taxable income and $75,000 for an individual.

(5). Expansion of HFSAs and HSAs.

Health Flexible Spending Account (HFSA) and Health Savings Accounts (HSA) essentially permit employers and their employees to establish accounts which permit employees to pay for eligible medical expenses, such as co-– pays and deductibles under their health insurance plans, with funds that are free from federal and state income taxes.

Previously these types of accounts were subject to fairly low dollar limits per year. A definite Good under the AHCA is that the annual contribution limitations for HFSA accounts is completely eliminated and the annual contribution limit for HSA accounts has been significantly increased to $6, 550 for an individual and $13,100 for a family. (One caveat to this definite Good is that these dollar amounts are meaningful only if the insured has an insurance plan with deductibles and co-pays which, in any year, are not in excess, or are only mildly so, of these amounts.

(6). Retaining Patient – Friendly Provisions of the ACA.

A definite Good of the AHCA is that retains many of the patient – friendly provisions of the ACA. These include:

• The requirement to cover dependent children through age 25;

• The prohibition on waiting periods in excess of 90 days;

• The prohibition against lifetime or annual dollar limits on essential health benefits coverage (except for the "loopholes" discussed above);

• The annual cap on out-of-pocket expenditures for essential health benefits;

• Uniform coverage of emergency room services for in- network and out -of-network visits;

• Required first – dollar coverage of preventive health services;

• The prohibition of exclusions for pre-existing conditions (except for the "loopholes" discussed above).

Expected Impacts of the AHCA.

Obviously, the most dramatic impact of the AHCA is on those individuals who are insured through Medicaid, particularly through the expansion of Medicaid. What is less obvious is the impact of this reduced federal funding on hospitals which serve a large low income population, and on insurance carriers and other third-party administrators who are contracted by the states to manage their Medicaid programs.

The ACA mandated that individuals had to purchase health insurance, or be subject to a tax.The financial theory underpinning the ACA was that the premiums paid by younger, healthy individuals would, in effect, subsidize insurance carrier payments for the healthcare of older, sicker insureds.

It is generally accepted that this theory has not worked quite as expected in the actual operations of the ACA. With the AHCA's elimination of the individual mandate, it is expected that many younger individuals will stop buying health insurance, thereby resulting in even higher premiums for older individuals buying insurance on thee ACA state healthcare marketplaces.

Many small employers, those with less than 50 employees under the ACA, are not subject to the penalty tax for failing to provide health insurance for their employees. Often, these small employers rely on their employees purchasing individual insurance plans through the marketplaces.

Under the AHCA states may opt -out of requiring that insurance carriers offer plans which cover the ACA mandated 10 essential health benefits. Employees of these smaller employers may find plans on the marketplace with reduced benefits, and higher premiums for plans which do not reduce benefits.

The AHCA also eliminates the tax penalty for large employers which do not provide health insurance for their employees. It remains to be seen how many of these employers will simply eliminate health insurance for their employees.

In those states which opt - out of the ACA 10 essential health benefits, larger employers, who decide not to eliminate health insurance, will have the ability to offer their employees insurance plans with reduced benefits and another plan which retains all 10 benefits at a higher premium. They may also have the ability to offer plans which impose yearly or lifetime monetary caps on payments for those benefits which are in addition to the more restricted list of essential health benefits adopted by their opting –out states

Conclusion.

It was a conscious decision of the author to discuss three Bad or Ugly provisions of the AHCA, and three Good provisions. It appears doubtful that the AHCA will be enacted by the Senate without some, or perhaps major, revisions. Even some Republican senators have said that they expect the Senate to do so. So this is truly an unfinished story of the Good, the Bad & the Ugly in federal health care law.

Dennis Alessi is a Member of Mandelbaum Salsburg P.C. and Co-Chair of its Healthcare and Employment & Labor Law Practice Areas. Mr. Alessi has over two decades of experience in representing various types of healthcare and related companies, as well as individual professionals, including management and billing service providers, third party administrators, industry trade associations, group purchasing organizations, surgical and imaging centers, laboratories and all other types of licensed healthcare facilities, medical groups, physicians, and other healthcare professionals.