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Whitepaper: The American Health Care Act (AHCA)
The House of Representatives narrowly passed this bill in early May, by a margin of 217 to 213, with 20 Republicans voting against and no Democrats voting in favor. It is the Republicans' first step toward their seven-year promise to repeal and replace the Affordable Care Act (ACA) that was passed by the Democrats in 2010 with no Republican support.

The Process
The House celebrated its passing of the AHCA, but we are far from a replacement. The House bill is now in the Senate, which is expected to make its own changes; some Senators have stated they may start from scratch. Then members of both the House and Senate will meet in conference to work out final details before it is voted on again. If it passes, it will then be sent to President Trump for his signature.

Who Would Be Affected by the AHCA?
176 million Americans have health insurance that is provided through their employers. The Congressional Budget Office (CBO), who analyzed the financial impact of the AHCA, found that 14 million people would lose their insurance within the first year. Of that 14 million, approximately 5 million fewer people will be covered under Medicaid, 2 million fewer will be covered through their employer, and 6 million fewer will obtain coverage on the individual market. By 2026, an additional 7 million fewer people will be enrolled in employer-based insurance, according to the CBO. Much of the reduction comes from the AHCA repealing the individual mandate penalty. There have been revisions to the AHCA that have not yet been scored by the CBO, so these numbers could improve. Also, it is anticipated that the Senate will make major revisions to the AHCA that may also impact the CBO's numbers.

It is important to note that when people are required to buy insurance, this helps keep rates reasonable for people who are sick or have pre-existing conditions. The insurance markets set up through the ACA depend on a group of younger, healthier people blending into a diverse pool with older, sicker people. This type of blending (healthy people with unhealthy people) is intended to bring down the overall costs of insurance.

Key provisions
Here are some of the main provisions in the bill as it now stands. Remember, these are likely to change at any point in the process.

- The mandates are gone. The individual mandate that required every person to have insurance or face fines is eliminated. So is the employer mandate which forced employers with at least 50 employees to provide healthcare coverage. Under the ACA, some employers had reduced employee hours and/or not hired more workers due to the costs of insurance.
- Insurers may apply a 30% surcharge to customers who let their coverage lapse for more than 63 days in the past year.
- Taxes on net investment income, insurers, drug makers and medical device manufacturers are gone.
- ACA's income-based subsidies are replaced with age-related tax credits. These range from $2,000 to $14,000 per year for individuals and households.
- Insurers can charge higher premiums for older persons or persons with disabilities.
- The tax-free annual contribution to Health Savings Accounts doubles.

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- Grown children up to age 26 can stay on their parents' plans.
- Insurance companies would no longer be required to cover "essential" health services. The ACA currently requires coverage of essential health services in 10 areas: Outpatient care, emergency room trips, in-hospital care, pregnancy, maternity and newborn care, mental health and substance abuse disorder services, prescription drugs, rehabilitative services and habilitative services (including treatment for kids with autism or cerebral palsy), lab tests, preventative services (including vaccines and cancer screenings), and pediatric services (including dental and vision care for children).

Elimination of Essential Health Benefits
No longer requiring insurance companies to cover the 10 essential health services listed above could cause series harm to seniors and persons with disabilities. Prescription drugs alone can be financially devastating to a person with a disability, regardless of age. Aside from covering prescriptions, insurance companies often negotiate discounts, and without that negotiation individuals could be left with a large bill, or be forced to go without needed medication.

While eliminating mandatory coverage for the essential health benefits will lower premiums (in theory), many may not be able afford a higher premium and could go without needed care because outpatient or in-patient care would not be covered, nor would rehabilitative services. A potential result of this piece of AHCA would be millions who would be under insured, or go without needed medical services or prescriptions. Interestingly, the CBO found that removing the necessity of covering essential benefits would save less money than keeping them.

Pre-Existing Conditions
Individuals who have a pre-existing condition and currently have health insurance, whether through an individual policy or Medicaid, will not pay more for their insurance as long as they have continuous coverage. If they let their coverage lapse for more than 63 days, insurers will be allowed to charge them 30% more than someone the same age without a pre-existing condition—but only if their state asks for and receives a waiver and sets up a high-risk pool to help cover people with serious, expensive-to-treat illnesses or diseases. $8 billion has been added to the AHCA over the next five years to help states finance their high-risk pools.

Medicaid Reforms
More than half of the 20 million people who gained coverage under ACA did so through Medicaid expansion, which allowed more people over the poverty line to be covered. Under the House bill, $880 billion will be cut from Medicaid over the next 10 years. It ends Medicaid expansion, limiting it to states that have already implemented it, and changes Medicaid from an open-ended program that covers beneficiaries' costs to one that gives states fixed amounts of money annually, called per capita caps. This is a way to shift costs from the federal government to the states, who would be given a set amount of Medicaid funds per beneficiary. When the money runs out, states would either pay, or deny Medicaid eligibility to individuals who would otherwise qualify.

Additional Medicaid reforms include eliminating a state's right to allow over $750,000 in home equity caps for unmarried applicants and eliminating the three month retroactive coverage rule, forcing individuals to file an application and supporting documentation the same month they are seeking eligibility. For younger Medicaid applicants, states would be allowed to impose work requirements on able-bodied individuals.