

Summary and Analysis of American Health Care Act

Passed by the US House of Representatives on May 4, 2017

On Thursday, May 4, 2017, House Republicans passed an amended American Health Care Act (AHCA) by a slim margin of four votes. 20 Republicans and all of the House's 193 Democrats opposed the bill (all 14 Republican House Members from California supported the bill). The version that passed the House on May 4 is a slightly tweaked version of the AHCA that was pulled last March ([see full analysis here](#)) due to lack of support from conservative and moderate Republicans. Between March and the final passage in May, the bill was amended several times in order to win over the conservative Republicans who are members of the House Freedom Caucus.

After passing the House, the bill now moves to the Senate, where it has scant support. Republican Senators have promised to scrap the bill and develop their own ACA repeal legislation. Once their legislation is complete, they can afford to lose no more than two Republican votes unless they are able to earn some Democratic support – an unlikely scenario. Further, the Congressional Budget Office (CBO) has yet to score the amended AHCA, but given the similarities between this bill and the March version of the AHCA, we expect the score to reflect dramatic increases in the number of uninsured. In short, the AHCA still has many hurdles before it reaches the President's desk, and we expect major changes to any repeal and replace legislation coming out of the Senate. Both versions of the bill will have to go through a Conference Committee process that resolves the differences between the Senate bill and the House-passed AHCA such that both the House and Senate can pass the final bill.

Overview

The final version of the bill essentially combines the [original AHCA](#) from March with amendments offered by Representative Tom MacArthur (R-NJ) and Congressman Fred Upton (R-MI), as well as some Manager's amendments that impact the Medicaid program. The Manager's amendments provide states the option of block-granting their traditional Medicaid populations of low income children, pregnant women, and parents and caretakers, and essentially eviscerates federal oversight of Medicaid quality and access standards for those populations. The amendments also allow states to impose a work requirement on nondisabled, non-elderly, non-pregnant adults as a condition of Medicaid coverage, and offer a 5% administrative funding bump to help states cover the extensive administrative overhead of implementing this requirement. The manager's amendment provides an alternative option for states who do not want to implement the original AHCA's per-capita cap proposal, and instead allows states to make even more draconian cuts to Medicaid that promise leave millions of low income Americans without insurance coverage in the future.

The other two amendments were offered in an attempt to win over conservative Republicans in the House while trying to quiet the negative press coverage about the bill's treatment of people with pre-existing conditions. Neither the MacArthur amendment, which allows states to opt for a waiver to waive the ACA's EHB requirements, community rating requirements, and 1-to-5 age ratio requirements, nor the Upton Amendment, which added \$8 billion in funding for states that opt out of pre-existing condition requirements to fund high risk pools or lower out of pocket costs for high-cost beneficiaries, does anything to reduce the harm contemplated in the original AHCA. Rather, these two amendments go even further in removing important consumer protections for enrollees in the individual and small group markets.

Short and Simple: The house-passed bill would be devastating for California and, like the original AHCA, still includes a massive reduction in federal investment for Medi-Cal that will result in millions losing coverage. Under the revised AHCA, states have the option to elect to implement even more severe cuts to their Medicaid programs and rescind many of the consumer protections offered by the ACA to enrollees in the individual and small group markets.

Quick Summary of Critical Issues

- Maintains the original AHCA's proposal to:
 - Establish a per capita cap for Medicaid based on 2016 Medicaid enrollees.
 - Roll back the enhanced federal match (FMAP) for newly eligible Medicaid enrollees after December 31, 2019. For persons enrolled before December 31, 2019, who do not experience a gap in coverage, states will continue to receive the enhanced rate.
 - Tighten eligibility requirements for Medicaid after December 31, 2019, including provisions that require states to re-evaluate eligibility every 6 months, and removes the 5% income disregard used to prevent "churning" in and out of coverage for those whose incomes fluctuate on a month to month basis.
 - Prohibits Medicaid and other federal funding to go to Planned Parenthood for one year. The one year funding, estimated to be \$422 million, will be reallocated to Federally Qualified Health Centers.
- In addition, adds a proposal that allows states to:
 - Elect to block-grant traditional Medicaid populations of children and non-expansion adults while removing essentially all federal oversight over services to those populations.
 - Impose work requirements on nondisabled, nonelderly, non-pregnant adults as a condition of Medicaid coverage.
 - Elect to waive certain important provisions for the individual and small group markets, including EHB requirements, annual and lifetime benefit limits, caps on out of pocket costs, and insurance underwriting, which allows insurers to charge higher amounts to cover people with pre-existing conditions who experience a lapse in coverage over 63 days.

Full Summary and CCHC Analysis

Medicaid Funding: Per Capita Cap or Block Grants

This bill would allow states to elect either a straight ‘per capita cap’ model or a mix of per capita cap and block grants as the basis for their federal Medicaid contribution. The purpose of this change is to limit federal spending and incentivize states to reduce Medicaid costs. Under this model, states could elect to handle their different Medicaid eligibility categories in different ways:

- All states would transition to a per capita cap for their aged, blind and disabled population.
- All states who elected to expand Medicaid under the ACA will transition to a per capita cap for the Expansion population, subject to the changes outlined in the “Medicaid Expansion” section below.
- As early as October 2017, states would have the option to elect to cover children, pregnant women, and parents/caretakers up to 133% FPL under a block grant option rather than per capita cap.
- If states elect the block grant option, they receive enormous flexibility in administration of their Medicaid program. States utilizing the block grant option can:
 - Elect to put all children, pregnant women, and parents/caretakers into the block grant, and provide coverage only to children and pregnant women – cutting coverage for parents and caretakers for whom coverage is now mandatory.
 - Cut benefits and coverage for all populations covered under the block grant. Only a few minimum benefit classes are required under the amendments: hospital care; surgical care and treatment; medical care and treatment; obstetrical and prenatal care and treatment; prescribed drugs, medicines, and prosthetic devices; other medical supplies and services; and “health care” for children under 18 years of age.
 - Not meet Medicaid’s current coverage standards, including its requirement that coverage levels be reasonable; its detailed definition of what constitutes medical assistance; and its cost-sharing rules.
- States that elect the block grant option can keep any federal funds they receive in excess of their Medicaid costs, further incentivizing states to cut services and eligibility categories.
- The block grant will be adjusted for inflation by the consumer price index (CPI), not the medical consumer price index (M-CPI), creating further cost pressures for states that elect this option.

Health Center Analysis:

The original March version AHCA was bad for the Medicaid program – and the version that passed the House in May is much, much worse. Not only does this version remove the federal and state commitment to funding the Medicaid program as an entitlement, regardless of cost or enrollment, but it allows for states to stop coverage for a traditional Medicaid population – low income parents and caretaker relatives. Both the per capita cap proposal and the block grant option put pressure on states to reduce Medicaid costs by cutting benefits and/or eligibility.

The Center on Budget and Policy Priorities estimates that Medicaid costs per beneficiary are expected to rise about .2 percentage points faster each year than the states' per capita capped amounts based on the M-CPI, meaning that this per capita cap proposal is not only a cap, but a cut to federal Medicaid funding to states, and the cut will grow each year. In addition, this cost-shift to states also includes any cost growth or demographic changes that the per-capita cap wouldn't account for, such as an epidemic, new and expensive pharmaceuticals or treatments, or growth in spending as baby boomers age. As more of the costs are shifted to the state, states will have to either contribute much more of their own funding or cut eligibility, benefits, and provider payments to make up the difference.

The block grant option gives states enormous flexibility in cutting benefits, accessibility, and eligibility, in exchange for a lower inflation index. While California is unlikely to take this route, states seeking to minimize Medicaid programs may take this opportunity to cut Medicaid as much as possible and keep excess funds provided under the block grant.

By delinking federal Medicaid funding from the actual cost of providing care to vulnerable Americans, Republicans are setting a dangerous precedent that makes the Medicaid program highly vulnerable to more cuts in the future. Once Medicaid funding is no longer tied to actual Medicaid spending, there is no reason that future policymakers couldn't take more funding from the program – perhaps by lowering per-capita cap payments - to pay for other priorities.

The bill does not address how the federal requirements to make FQHC services available to Medicaid enrollees will be handled under the per-capita cap scenario, nor does it contemplate the federal requirement that states pay FQHCs their cost-based PPS rate. Many of the details about the per capita cap and block grant options would be articulated through regulations and sub-regulatory guidance, both of which can be issued by HHS with almost no oversight.

Medicaid Expansion

The Manager's amendment to the AHCA contained one change to the treatment of the Medicaid expansion – it prohibits additional states from electing to take the expansion option, while the original version of the AHCA allowed states to expand Medicaid until the end of 2019.

Like the March version, the bill makes reductions to the Medicaid program by ending the enhanced federal funding for new enrollment in the Medicaid expansion as of January 1, 2020. Traditionally, the federal government pays for between half and 70% of Medicaid costs based on a formula articulated in the original Medicaid law in 1965. This is referred to as the Federal Medical Assistance Percentage (FMAP). California, along with 14 other states, has an FMAP of 50%, which is the lowest rate in the country. This means that the federal government and the state of California usually split the costs of the Medi-Cal program 50/50. Under the ACA, California (and other states who elected to expand Medicaid) receive a much higher FMAP for the Medicaid expansion population. The Medicaid expansion FMAP started at 100% in 2014, (meaning that the federal government paid 100% of the cost of insuring the expansion

population), and drops slowly over time until 2020 when the federal FMAP caps out at 90%. Under the ACA, the FMAP for the expansion population remains at 90% permanently.

Under the AHCA as passed, starting in 2020, states would receive only their regular FMAP for those who newly enroll or re-enroll in the Medicaid expansion, meaning that California would have to cover 50% of the cost of these beneficiaries, rather than just 10%. States could continue to receive the enhanced match for people who are already enrolled as of January 1, 2020, and who don't experience a gap in coverage of more than one month. For those who enroll after January 1, 2020, or drop out of coverage and try to re-enroll after that date, the state will no longer receive the enhanced FMAP for that individual and will receive only their usual 50% FMAP. The bill also tightens eligibility requirements, thereby increasing the likelihood that beneficiaries will fall out of coverage with the enhanced FMAP and be eligible only for regular FMAP coverage.

Health Center Analysis:

Currently, California receives a 95% FMAP, which is set to ratchet down to 90% by 2020. If California were to receive only a 50% FMAP for the entire Medi-Cal expansion population the state would lose \$10 billion per year in federal funding. With such a large cut in federal funds, it would be difficult for California to maintain Medi-Cal up to 138% Federal Poverty Level (FPL), and the state would likely be forced to cut benefits, eligibility, and provider reimbursement rates. Reductions in Medi-Cal will have a negative impact on health centers bottom line, and an even greater impact on patients as they will be left without the comprehensive coverage provided through Medi-Cal.

The ACA has had an incredible impact on FQHCs in California. Since 2012, 1.2 million more CCHC patients are covered by Medi-Cal, largely due to the Medi-Cal expansion and easing of enrollment processes. A recent Capital Link report has estimated that rolling back the Medicaid Expansion will contribute to a 42% decline in patients, and 1.5 million fewer FQHC patients covered by Medi-Cal.

Additional Medicaid Eligibility and Plan Changes

The AHCA proposes revisions to Medicaid eligibility which make it more difficult for individuals to get into Medicaid, and easier to fall out of coverage. These changes make it likely that after January 1, 2020, more and more beneficiaries over time will fall out of coverage with enhanced FMAP and either lose coverage entirely or be re-enrolled at the lower FMAP, presumably with severely curtailed benefits. The new eligibility restrictions include:

- A requirement that states who have implemented the Medicaid expansion re-determine eligibility for Medicaid every 6 months.
 - *In California, renewals (eligibility redeterminations) are only required one time per year for an individual to remain on Medicaid. Between renewal periods, individuals are expected to notify Medi-Cal of any changes that may impact their eligibility (for example, a change in household size). Because renewals require action on the part of the beneficiary, this change is likely to cause more*

beneficiaries' coverage to lapse, pushing them out of the 90% FMAP and onto 50% FMAP if and when they re-enroll.

- The bill repeals states' expanded authority to make presumptive eligibility determination for the Medi-Cal expansion population. States would still be allowed to make presumptive eligibility determinations for children, pregnant women, and breast cancer and cervical patients.
 - *Through the Hospital Presumptive Eligibility (HPE) Program, qualified hospitals are all able to provide temporary, no Share of Cost Medi-Cal benefits during a presumptive period to individuals determined eligible on the basis of preliminary patient information. Hospitals, for example, are able to treat patients under presumptive eligibility and bill Medi-Cal even when the patient has not gone through the MC eligibility process. This bill will eliminate the Hospital Presumptive Eligibility program for the expansion population, which is bad for patients and providers. With the real-time determination, during the PE eligibility window, patients can more easily access care and providers can more easily get reimbursed for that care. Hospitals are likely to see an increase in bad debt, and patients will experience more barriers to access, especially when transitioning out of the hospital.*
- Limits the effective date for retroactive coverage of Medicaid benefits to the month in which the applicant applied starting October 2017.
 - *Under the ACA, individuals who incurred medical expenses in any of the three months (90 days) prior to the month of Medi-Cal application could apply for coverage for those months. With a rolling back of retroactive coverage, patients and providers will suffer as bills go unpaid and debts grow.*
- Requires Medicaid applicants to provide documentation of citizenship and lawful presence before obtaining coverage.
 - *Currently, the law allows applicants a "reasonable opportunity" period to provide documentation of citizenship or immigration status, during which time the individual is enrolled in Medicaid. With this change, applicants will be unable to enroll until after they've provided their documentation, creating a barrier and potentially a long delay before Medicaid benefits are realized. Whole households may simply choose not to apply.*
- Would repeal the authority for states to elect to substitute a higher home equity limit that is above the statutory minimum in law, applicable 180 days after enactment of this legislation.
- Re-calculate the way in which lottery winnings are counted as income for purposes of MAGI determination. Any lottery winnings above \$80,000 would be counted over multiple months, even if paid in a single month, to prevent a recent winner from getting back on Medicaid after the month of their payout. A hardship exemption could be considered by the Secretary of HHS.
 - *These are both additional examples of tightening eligibility in hopes of rolling beneficiaries off of 90% FMAP and onto 50% FMAP.*
- The bill reverts mandatory Medicaid income eligibility level for children back to 100% FPL. States could cover this population in their CHIP programs.

- *The bill reverts mandatory Medicaid income eligibility level for children back to 100% FPL. States could cover an expanded population of children in their CHIP programs, but that may come with the reduction of benefits and an increase in cost-sharing.*
- The bill repeals the requirement that state Medicaid plans provide the same “essential health benefits” (EHB) that are required by plans on exchanges.
 - *This will allow states to provide “thin” benefit packages that no longer cover the full breadth of services used by Medi-Cal beneficiaries. While California’s robust EHB benefits have been adopted into state law and will not necessarily be impacted by this federal change, states that stand to see a large state-cost increase in their Medicaid program will have the opportunity to reduce benefit packages as a cost-saving measure.*

Individual and Small Group Markets

One of the key goals of the ACA was to ensure that health coverage is affordable for everyone, including people with pre-existing conditions. Prior to the ACA, health insurance carriers participated in the practice of “underwriting,” or evaluating a potential enrollee’s medical or health information to determine whether to offer or deny coverage and what to charge as an insurance premium. People with expensive health conditions – or who were expected to have expensive health conditions due to genetic factors, lifestyle factors, or age – were often priced out of the insurance market, as their premiums were astronomically high, if they could get coverage at all. The ACA disallowed the practice of underwriting and forced insurance companies to vary premiums by only three factors – age, geographic location, and, optionally, tobacco use. Further, the ACA allowed that premiums could vary by age by no more than a 3-to-1 ratio. This means that a very expensive-to-cover, older person with pre-existing conditions could pay no more than three times the amount paid by an inexpensive-to-cover, young individual in the same geographic area. This created a pressure on insurance companies to keep premiums as low as possible, and created a de facto subsidy, with the healthy and inexpensive paying much higher premiums, subsidizing those with pre-existing conditions and other risk factors, who are paying much less. The individual mandate, which requires every person in the United States to acquire health insurance coverage that meets a minimum standard or pay a penalty, ensured that the inexpensive healthy individuals still had to buy insurance, even though the cost of that insurance was substantially increased under the ACA.

The AHCA repeals the individual mandate only to replace it with a “continuous coverage requirement.” The Republican bill attempts to incentivize people into maintaining coverage through a 30% surcharge added onto premium costs if they had a lapse in coverage for more than 63 continuous days, and then try to re-enroll. In that sense, Republicans would replace a penalty for not having insurance with a new penalty for allowing insurance to lapse. Another difference between the penalty and the surcharge is that the penalty was assessed like a tax and went to help pay for other parts of the ACA; the surcharge goes to the insurance companies. The tax penalty associated with the individual mandate is assessed every year no matter how long an individual is without coverage; under the AHCA, the 30% surcharge would

be assessed in the same manner whether someone has been without coverage for 63 days or several years.

The MacArthur amendment gives states the option to make additional significant changes to the individual and small group markets under three separate waivers. One of the waivers directly addresses the 30% surcharge for not maintaining continuous coverage. Under this waiver, states could allow insurers to underwrite the cost of coverage for enrollees who had a 63-or-more day lapse in coverage, rather than charging them the flat 30% increase. Allowing insurers to underwrite the cost of coverage for these individuals may raise their cost of coverage substantially, or result in denied coverage. The underwriting would only be allowed for the duration of the enforcement period, and not allowed permanently for that individual.

The 30% surcharge or potential underwriting penalty would be greater for older people since premiums vary with age. The Republican bill allows a 5-to-1 variation in premium cost, meaning that older (and ostensibly more expensive) enrollees can pay up to 5 times more than younger ones. Under the ACA, premium variation is limited to three-to-one, so under the GOP plan we would likely see younger people see their premium rates lower a little, while older Americans see their costs rise. This is complicated by the bill's changes to actuarial value requirements, which allow that plans no longer have to meet ACA standards that require plans to offer benefit packages with actuarial values of 60%-90%, based on metal level. The repeal of the actuarial values (AV) levels would allow plans to be sold with AVs of less than 60 percent, although the maximum out-of-pocket limit in the ACA is retained so insurers would not be able to sell plans less generous than the current catastrophic plans. They would also be able to sell plans with AVs of more than 90 percent, and anything in between.

The MacArthur amendment offers an additional waiver option that exacerbates the already increased costs that older and sicker Americans will have to face under the AHCA's 5-to-1 ratio requirement. With the amendment, states have the option to set a ratio "higher" than the 5-to-1 ratio allowed under the AHCA more generally, which will further drive up costs for older and sicker Americans in the states that elect to implement this waiver.

Lastly, the MacArthur amendment gives states the option of implementing a waiver of the EHBs for the individual and small group markets, starting in 2020. Under this provision, states have the opportunity to change the required categories of benefits, services, and the formulary that counts as EHBs, potentially creating a market for plans with much 'thinner' health benefits. Because the prohibitions on lifetime and annual limits and the ACA's cap on out of pocket costs only apply to EHBs, states with thinner EHB coverage could see a dramatic rise in out of pocket costs for enrollees in the individual and small group market.

Health Center Analysis:

Like the Medicaid provisions, the amendments to the AHCA have done nothing but make the bill much worse for low income consumers, especially the elderly and those with pre-existing conditions. It seems unlikely that the "continuous coverage requirement" will work as effectively as the individual mandate in ensuring that the young and healthy maintain coverage.

If the young and healthy don't see a point in maintaining coverage, health insurance premiums will likely rise considerably as the risk pools skew towards sicker and older patients who utilize more and more expensive health care. For those who are ill, a 30% surcharge may be a small price to pay, but for those who are healthy, a surcharge may be a disincentive to enroll. Under the MacArthur amendment, a state can allow health plans to underwrite those who would otherwise be subject to the 30% surcharge, which, if they are ill, may effectively block them from receiving coverage that year.

A typical American purchasing coverage under the House-passed AHCA may not see an immediate jump in premium rates, even with a skewed risk pool, because under this plan they will be able to buy coverage that is significantly less comprehensive than the coverage they were required to maintain under the ACA. While the premiums may be as high, the out of pocket costs of buying coverage that does not have at least a 60% AV will come later. While the initial March version of the AHCA attempts to mitigate this issue through maintaining the annual and lifetime limits under the ACA, the MacArthur amendment allows states to waive these basic protections and leave enrollees in the individual and small group market with enormous out of pocket costs and limited coverage.

The move from a 3-to-1 to a 5-to-1 premium variation ratio – or even higher under the MacArthur amendment - will have a devastating effect on the elderly. For example:

- **ACA: 3-to-1 ratio**
Under the ACA's 3-to-1 ratio, if a 21-year-old woman's premium is \$200 a month for a particular health plan, a 64-year-old woman's premium for that same health plan cannot be more than \$600 a month ($\$200 \times 3 = \600).
- **AHCA: 5-to-1 ratio**
Under the AHCA's 5-to-1 ratio, the same 21 year old's premium remains \$200 a month for a particular plan. The 64-year-old woman's premium for that plan can be five times higher - \$1000 per month ($\$200 \times 5 = \1000).

Clinics who care for patients in the individual and small group market should be prepared for a rise in accounts receivable and bad debt. In general, clinics should be prepared to see the number of uninsured patients rise, especially among those currently receiving subsidies for Covered California. Those who keep commercial insurance will likely be older and sicker than the general population.

Subsidies to Buy Insurance

For those over 133% FPL who are ineligible for the Medicaid expansion, the ACA offers income-based subsidies to buy full scope insurance plans on Health Benefit Exchange Marketplaces, which is known here as Covered California. Subsidies in the form of advance tax credits are available for individuals and families up to 400% FPL, with greater subsidies for those with lower incomes. The tax credits under the ACA can only be used to buy plans on Exchanges like Covered California, and those plans must be full-service plans that offer all essential health

benefits and meet actuarial value requirements. The AHCA repeals the ACA's income-based tax credits after 2019 and replaces them with new Advance Premium Tax Credits which differ from those in the ACA in several important ways.

Starting in 2018, the AHCA offers Advance Premium Tax Credits which can be used to purchase plans on the exchange, off-exchange plans and catastrophic plans – basically, plans with much 'thinner' benefits than those offered through the ACA's Exchanges. Plans purchased with tax credits cannot cover abortions, but may cover infections, injuries, diseases or disorders caused by abortions. Individuals with tax credits may purchase separate abortion coverage out of pocket. The tax credit is refundable and advanceable on a monthly basis to pay for individual market premiums.

The amount of the tax credit that each consumer is eligible for will change under the Republican proposal as well. Rather than being based solely on income, the Republican Advance Premium Tax Credits will vary based on age as well as percentage of federal poverty level. The amount of tax credit is set at the lesser of the actual amount paid for coverage for individuals or families for the year (up to \$14,000 or 5 family members), or \$2,000 for an individual under 30, \$2500 for those age 30 to 39, \$3,000 for those age 40 to 49; \$3,500 for those age 50 to 59, and \$4,000 for those age 60 and over. The tax credit begins to phase out when a taxpayer's modified adjusted gross income reaches \$75,000 (\$150,000 for joint filers), and phases out slowly above that income level.

Even though the AHCA's Advance Premium Tax Credits do not require consumers to purchase plans on Exchanges, the plans that provide coverage for tax credits must file returns identifying their plans as qualified health plans (QHPs) and providing benefit, cost, and coverage information to the federal government. Under this bill, individuals can only qualify for the tax credit if they are enrolled in a qualified health plan, not eligible for employer coverage or government programs, are citizens or qualified aliens, and are not incarcerated other than pending disposition of charges.

Health Center Analysis:

California stands to lose under this proposal. Unlike the ACA, the Republican plan's tax credits are not adjusted to reflect geographic differences in health care and premium costs, so consumers in California's relatively high-priced markets would end up paying more of their income toward their premiums than consumers in other areas.

Further, the poor and the elderly will be much worse off under the AHCA's Premium Tax Credits than with the subsidies available under the ACA. Even though the tax credits vary by age and income, at the most, the elderly only receive twice what the young receive in tax credits. However, the premium cost for elderly can be as high as 5 times more than the young. The two-for-one age adjustment in the tax credits falls far short of making up for the 5 to 1 ratio allowed in premium variation.

Finally, Covered California is a flagship Exchange created under the ACA which offers standardized benefit designs and consumer protections that are not available in the individual market. If the Republican plan allows individuals to purchase 'thin' and catastrophic plans on the individual market, there may be a move out of Covered California's robust full-coverage plans and toward plans with cheaper premiums and less generous benefits. This could dismantle Covered California while strengthening the off-Exchange market.

Planned Parenthood

The bill proposes a one-year freeze on mandatory funding to Planned Parenthood from Medicaid, CHIP, Maternal and Child Health Services Block grants, and Social Services Block Grants.

Health Center Analysis:

Planned Parenthood serves a vital role in the safety net, ensuring access to reproductive care for millions of women nationwide through a network of approximately 700 health centers. This bill blocks about \$500 million in federal funding for Planned Parenthood, endangering a provider that offers a range of services to women beyond abortion.

FQHC Funding

FQHCs would receive \$422 million in additional funding in 2017 under the legislation. This funding comes from what is currently Planned Parenthood funding.

Health Center Analysis:

It is CPCA's position that health centers cannot absorb the patients or offer the services of Planned Parenthood – they are an irreplaceable part of the safety net. While the destruction of the ACA does require additional investment in health centers, taking the funding of another essential provider is not the way to do it.

Patient and State Stability Fund For Reinsurance

The original March AHCA created a "Patient and State Stability Fund" and appropriated \$15 billion per year for 2018 and 2019, and \$10 billion per year each year until 2026, for a total of \$100 billion, which is set aside to provide reinsurance for health plans or out-of-pocket cost relief for individuals with unaffordable costs. In response to public outcry around losing the popular coverage for pre-existing conditions that is available under the ACA, the Upton amendments promise an additional \$8 billion per year from 2018 through 2023 to be given to states that utilize the MacArthur amendment that allows insurers to underwrite individuals who have had a gap in coverage. The money will be used to provide "assistance to reduce premiums or other out-of-pocket costs of individuals who are subject to an increase in the monthly premium rate for health insurance coverage as a result of such waiver."

The Patient and State Stability Fund requires a 7% state match. States can use these funds for a variety of programs, including:

- Assisting high-risk individuals in purchasing coverage or reducing the cost of coverage for high risk enrollees;
- Providing reinsurance to stabilize individual market insurance premiums;
- Promoting participation and health insurance options in the individual and small group markets;
- Promoting preventive, dental, vision, and behavioral health services;
- Contracting with providers for the provision of services, and
- Reducing out of pocket costs.

States must apply for the funding, but applications will be automatically approved if not denied within 60 days. Once a program is approved it will remain approved for all subsequent years until 2026. The funding will be allocated among that states based on national incurred claims, reported medical loss ratios, increases in uninsured individuals under 100% FPL during the time of the ACA, and states with fewer than three QHPs.

Health Center Analysis:

California is likely to receive a larger portion of funds under this program than any other state, but there's no way to slice \$15 billion 50 ways that gives California enough money to even come close to providing financial stability or patient relief with an individual insurance market as big as ours. California's Medicaid spending in 2015 was approximately \$85.5 billion, Covered California subsidies equaled approximately \$5 billion, and with a \$2.5 trillion economy, whatever comes to California from this fund will be a negligible amount. Our best bet for a stabilized health care sector in California is to try to keep as many elements of the ACA as possible alive in the individual market. California might try to retain guaranteed issue requirements, a 3-to-1 ratio for premium variation, and other ACA market stabilization techniques so that we don't have to depend on this small and likely ineffectual fund for market stability.