Initial Analysis of House Legislation to Overhaul ACA

On March 6, 2017, the leadership of the U.S. House of Representatives introduced long-awaited legislative text intended to repeal and replace the Affordable Care Act (ACA) utilizing budget reconciliation, the fast-track legislative procedure that only requires a simple majority vote in the Senate. The two bills were drafted by the U.S. House committees with jurisdiction over healthcare: the Energy and Commerce and the Ways and Means Committees (Energy and Commerce text can be found here and Ways and Means text here). Both committees are marking up their bills on March 8, 2017 before combining them into a larger package that is being called the "American Health Care Act."

As we explained in our letter to House leadership in response to their request for input on healthcare recommendations, NACo is most concerned about structural changes to the nation's healthcare system, particularly to Medicaid, that could unintentionally shift federal and state costs to counties. Such changes could create an even more challenging dynamic at the local level as 42 states impose some limitation on counties' ability to raise property tax rates and property assessments, typically the primary source of revenue for counties. Additionally, our counties are just coming back from the Great Recession, with our smaller counties—mainly in Southern states—having yet to reach pre-recession levels.

At this point, the American Health Care Act (AHCA) does not have a Congressional Budget Office score or coverage estimates, and therefore it is difficult to accurately determine how the proposed legislation would fully impact counties in their multi-faceted roles as payers, providers and administrators of health services and stewards of local taxpayer dollars. However, in our initial analysis of the policy provisions, there are several ways that counties would likely be impacted by the proposed legislation:

1. **The proposed legislation would fundamentally alter the important federal-state-local partnership for Medicaid and reduce Medicaid coverage levels.**

Since 1965, the Medicaid program has been crucial to helping counties meet their often state-mandated obligations to provide healthcare to low-income populations. Counties help some states administer the program and contribute to the non-federal share of Medicaid in 26 states. The AHCA would fundamentally transform the nature of the Medicaid program, changing it from an open-ended entitlement program to one in which states would get a capped amount for each person enrolled in Medicaid. The per capita caps would go into effect in 2020 and set different funding levels for populations enrolled in Medicaid such as the elderly, the blind and disabled, children not enrolled in the Children's Health Insurance Program (CHIP) and adults. The baseline rate would be based off Fiscal Year (FY) 2016 enrollment and spending and rise annually based off the medical care component of the Consumer Price Index. NACo opposes any efforts to cap federal spending to Medicaid, as it would shift costs to states and eventually counties.

In addition to changing the structure of the Medicaid program as it existed before the ACA, the proposed legislation would also impact ACA's Medicaid expansion that has been adopted by 31 states and the District of Columbia. Under AHCA, enhanced federal funding for low-income individuals in Medicaid expansion would only remain through 2019 for those who are already enrolled and maintain continuous coverage. Medicaid expansion states could continue to enroll the adult group beginning in 2020 and beyond, but would only receive the regular federal matching rate which by then would be subject to the per capita caps. NACo opposes efforts to repeal the Medicaid expansion and supports maintaining the current eligibility and coverage standards.

For states that did not expand Medicaid, AHCA would offer some additional support through a series of complicated funding changes including providing $10 billion in safety net funding over five years and the restoration of Disproportionate Share Hospital (DSH) payments in 2018. These federal payments, which have been reduced under the ACA, would be reinstated for expansion states in 2020. NACo supports the full restoration of DSH payments to hospitals that serve a disproportionate share of Medicaid and uninsured individuals, including many county-supported hospitals.

2. The proposed legislation could have indirect and direct impacts on county health systems, including county public health departments.

Although each state is different, county governments play an integral role in paying for and providing health services. Counties invest $83 billion annually—or about one of every five dollars of county budgets—in community health systems. Counties are major Medicaid providers, helping to support 961 hospitals, 883 skilled nursing facilities, 750 behavioral health authorities and 1,943 public health departments –all of whom typically serve a disproportionate share of low-income populations and would be greatly impacted by federal reductions in Medicaid spending. Medicaid helps reduce the frequency of uncompensated care provided by county hospitals and provides patient revenue that helps retain health professionals, especially in rural areas. Medicaid is also currently the largest single funder for mental health services and substance abuse treatment.

In addition to its indirect effects, AHCA would also directly impact the nation's 2,800 local public health departments, two-thirds of which are county-based, by eventually eliminating the Prevention and Public Health Fund after cutting it by $100 million in FY 2018. Created in 2010 by the ACA, the Fund provided $932 million for public health programs in 2016, including $324 million for immunization programs and $160 million in preventive services block grants—one of the few funding mechanisms that state and local health departments receive from the Centers for Disease Control and Prevention (CDC) that allow them to adapt to their unique needs. The overall cut would be approximately 12 percent of CDC's budget.

Federal investments, mainly from the CDC, are responsible for approximately 23 percent of local health departments' revenue. Since 2008, local health departments have lost 43,000 jobs, a decrease of 23 percent, and budget cuts continue to affect one in four local health departments. Dedicated funding sources such as the Prevention and Public Health Fund (PPHF) are critical to helping counties support core local public health programs. NACo opposes cuts to core local public health and prevention funding like the Prevention and Public Health Fund.

3. The proposed legislation retains the 40 percent excise tax on employer health benefits included in the ACA.

Counties employ 3.6 million people and spend approximately $25 billion annually to provide quality health benefits to their workforce. The proposed legislation only delays—rather than permanently repeals—the 40 percent tax on certain employer health benefits instituted under the ACA, or the so-called "Cadillac Tax." Under AHCA, the Cadillac Tax would be retained as a revenue mechanism, though its implementation is delayed from 2020 through 2024. County governments are generally not able to compete with private sector wages and salaries, so healthcare coverage is the primary benefit used to attract and maintain a quality workforce. The Cadillac Tax may negatively impact counties by forcing them to raise insurance deductibles or significantly reduce healthcare benefits for employees, removing this crucial employment tool. While earlier drafts of the legislation would have placed a cap on the tax exclusion for employer-sponsored coverage, AHCA does not contain such a provision.

In addition to these highlighted provisions, AHCA would fundamentally change the nation's health care system through other mechanisms. AHCA would repeal ACA's employer and individual mandate, and instead allow insurers to charge a 30 percent surcharge if consumers did not keep continuous coverage. The income-based subsidies made available through the ACA would be replaced with age-based tax credits ranging in age from $2,000 to $4,000 to help people pay for coverage. Other provisions through the ACA such as allowing children to stay on their parent's insurance plans until age 26 and the requirement that insurers accept everyone regardless of pre-existing conditions remain intact. Except for the Cadillac Tax, most of the other taxes included in the ACA are repealed beginning in 2018, such as the medical device tax, the tanning tax, taxes on high earners and taxes on investments.

NACo will continue to analyze potential impacts of the "American Health Care Act" and other legislative proposals while working with Congress to ensure our counties remain healthy, vibrant and safe.

Contact: For more information, please contact NACo Associate Legislative Director for Health Brian Bowden at bbowden@naco.org or 202.942.4275.

NACo Resources:
Presentation on Medicaid and the role of counties
Fact Sheet on Medicaid
Fact Sheet on the Prevention and Public Health Fund (PPHF)
Fact Sheet on Health Services for Justice Involved Individuals
Fact Sheet on SAMHSA
Fact Sheet on repeal of the 40% excise tax on employer-sponsored health care