H.R. 1628: The American Health Care Act (AHCA)

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Summary

In January 2017, the House and Senate adopted a budget resolution for FY2017 (S.Con.Res. 3), which reflects an agreement between the chambers on the budget for FY2017 and sets forth budgetary levels for FY2018-FY2026. S.Con.Res. 3 also includes reconciliation instructions directing specific committees to develop and report legislation that would change laws within their respective jurisdictions to reduce the deficit. These instructions trigger the budget reconciliation process, which may allow certain legislation to be considered under expedited procedures. The reconciliation instructions included in S.Con.Res. 3 direct two committees in each chamber to report legislation within their jurisdictions that would reduce the deficit by $1 billion over the period of FY2017 through FY2026. In the House, the Committee on Ways and Means and the Energy and Commerce Committee are directed to report. In the Senate, the Committee on Finance and the Committee on Health, Education, Labor, and Pensions are directed to report.

On March 6, 2017, the Committee on Ways and Means and the Energy and Commerce Committee independently held markups. Each committee voted to transmit its budget reconciliation legislative recommendations to the House Committee on the Budget. On March 16, 2017, the House Committee on the Budget held a markup and voted to report a reconciliation bill, H.R. 1628, American Health Care Act (AHCA) of 2017. On March 22, the House Rules Committee held a hearing on the AHCA, and on March 24, the Rules Committee reported H.Res. 228, providing for the consideration of the AHCA. H.Res. 228, which was agreed to by the House on March 24, provided for four hours of debate on the AHCA and automatically amended the AHCA to incorporate five "manager's amendments" described as making technical and policy changes to the version of AHCA as reported by the House Budget Committee. After debate occurred on the bill, the Speaker pro tempore postponed further consideration of the bill. On April 6, the House Rules Committee reported H.Res. 254, which provides that should the House return to consideration of the AHCA, an additional amendment would be automatically agreed to, upon adoption of the resolution. This report includes information on the AHCA incorporating each of the six amendments included in H.Res. 228 and H.Res. 254, as noted above.

The AHCA includes a number of provisions that would repeal or modify parts of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) and a number of provisions that do not specifically relate to aspects of the ACA. This report contains three tables that, together, provide an overview of the AHCA provisions. **Table 1** includes provisions that apply to the private health insurance market, **Table 2** includes provisions that affect the Medicaid program, and **Table 3** includes provisions related to public health and taxes. Each table contains a column identifying whether the AHCA provision is related to an ACA provision (e.g., whether it repeals an ACA-related provision).

The Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation (JCT) issued a cost estimate for the AHCA, as amended by four of the five manager's amendments agreed to under H.Res. 228 (4, 5, 24, and 25 but not 31). The estimate does not incorporate the amendment referenced in H.Res. 254. According to the estimate, the AHCA would reduce federal deficits by $150 billion over the period FY2017-FY2026. With respect to effects on health insurance coverage, CBO and JCT project that, in FY2018, 14 million more people would be uninsured under the AHCA than under current law and, in FY2026, 24 million more people would be uninsured.

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The AHCA would repeal or modify several requirements for private health insurance plans established under the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended). The bill would repeal the ACA's cost-sharing subsidies for lower-income individuals who purchase health insurance through the exchanges, and it would substitute the ACA's premium tax credit for a tax credit with different eligibility rules and calculation requirements. The bill would effectively eliminate the ACA's individual and employer mandates. The AHCA also includes new programs and requirements that are not related to the ACA. For example, the bill would establish a late-enrollment penalty for certain individuals who do not maintain health insurance coverage, and it would create a new fund to provide funding for states for specified activities intended to improve access to health insurance and health care in the state.

The AHCA includes a number of changes to the Medicaid program. The bill would repeal some parts of the ACA, such as the changes the ACA made to presumptive eligibility and the state option to provide Medicaid coverage to non-elderly individuals with income above 133% of the

[1] U.S. Congress, House Committee on the Budget, *American Health Care Act of 2017*, 115th Cong., 1st sess., March 20, 2017.

[2] The House Rules Committee Manager's Amendments (Amendment #4 and #24, Technical Changes) and (Amendment #5, #25, and #31, Policy Changes) as posted on the Rules Committee website on March 24, 2017, at https://rules.house.gov/bill/115/hr-1628.

[3] The House Rules Committee Amendment #32 as posted on the Rules Committee website on April 6, 2017, at https://rules.house.gov/bill/115/hr-1628.

federal poverty level (FPL). The bill would amend the enhanced matching rates for the ACA Medicaid expansion and the ACA Medicaid disproportionate share hospital (DSH) allotment reductions.

In addition, the AHCA includes a number of new Medicaid provisions that are not specific to aspects of the ACA. The most significant new provision would convert Medicaid financing to a per capita cap model (i.e., per enrollee limits on federal payments to states) starting in FY2020. One provision under the per capita cap would reduce the target amount for New York if certain local contributions to the state share are required. Also, states would have the option to receive block grant funding (i.e., a predetermined fixed amount of federal funding) instead of per capita cap funding for non-elderly, nondisabled, non-expansion adults and children starting in FY2020. AHCA includes a provision that would permit states to require nondisabled, non-elderly, nonpregnant adults to satisfy a work requirement to receive Medicaid coverage.

The AHCA could restrict federal funding for the Planned Parenthood Federation of America (PPFA) and its affiliated clinics for a period of one year, and it would appropriate an additional $422 million for FY2017 to the Community Health Center Fund. The bill also would repeal all funding for the ACA-established Prevention and Public Health Fund (PPHF). The AHCA would repeal many of the new taxes and fees established under the ACA, and it includes several provisions that would modify the rules governing health savings accounts (HSAs).

The Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation (JCT) issued an estimate of the AHCA, as amended by four of the five manager's amendments agreed to under H.Res. 228. The estimate incorporates manager's amendments 4, 5, 24, and 25, but not 31, and does not include the amendment referenced in H.Res. 254. (See the text box for information about the substantive policy changes in manager's amendment 31 and in the amendment referenced in H.Res. 254.) According to their estimate, the AHCA would reduce federal deficits by $150 billion over the period FY2017-FY2026.[4] With respect to effects on health insurance coverage, CBO and JCT project that, in FY2018, 14 million more people would be uninsured under the AHCA than under current law and, in FY2026, 24 million more people would be uninsured than under current law.

This report contains three tables that, together, provide an overview of the AHCA provisions, as amended by the five manager's amendments and the amendment referenced in H.Res. 254. **Table 1** includes provisions that apply to the private health insurance market, **Table 2** includes provisions that affect the Medicaid program, and **Table 3** includes provisions related to public health and taxes. Each table contains a column identifying whether the AHCA provision is related to an ACA provision (e.g., whether it repeals an ACA-related provision). A table identifying key CRS policy staff appears at the end of the report.

[4] Congressional Budget Office (CBO), Cost estimate for H.R. 1628, the American Health Care Act, incorporating manager's amendments 4, 5, 24, and 25, March 23, 2017, at https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/hr1628.pdf.

Manager's Amendment 31 and H.Res. 254

The changes to the AHCA made by manager's amendment 31 and the amendment referenced in H.Res. 254 are reflected in the tables in this report; however, CBO's and JCT's cost estimate does not reflect these changes. The substantive changes made by these amendments are as follows.

Manager's amendment 31 would

- amend Section 132 to expand how states could use funds received from the Patient and State Stability Fund and to increase the appropriation for the fund by $15 billion for FY2020;
- create a new Section 136 that provides that each state would define the essential health benefits (EHB) for plans offered in the state for purposes of the premium tax credit for plan years and taxable years beginning on or after January 1, 2018; and
- amend Section 213 to delay repeal of the 0.9% Medicare surtax from tax year 2018 to tax year 2023.

The amendment referenced in H.Res. 254 would

- amend Section 132 to establish a Federal Invisible Risk Sharing Program to provide payments to health insurance issuers that offer individual market coverage to help with high-cost medical claims of certain individuals; $15 billion would be appropriated for the program to be used CY2018-CY2026.

Private Health Insurance

Table 1. Provisions of the American Health Care Act (AHCA) Related to Private Health Insurance

Sections of the AHCA		Current Law Summary	Explanation of AHCA Provision	Related to the ACA?[a]
Health Insurance Tax Credit and Cost-Sharing Subsidies				
Section 202	Additional Modifications to Premium Tax Credit	The ACA, under IRC Section 36B, authorizes premium tax credits to help eligible individuals pay for certain health plans offered through individual exchanges only. Eligible individuals may receive the credit in advance (i.e., during the year). It also specifies the tax credit calculation formula, which includes income as a factor.	Section 202 would amend the ACA premium tax credits to allow the credits to apply to certain off-exchange plans, beginning tax year 2018. It would amend the tax credit calculation formula by specifying income and age as factors. These changes would go into effect beginning tax year 2019. (Section 214 would amend IRC Section 36B with respect to a refundable, advanceable tax credit, effective beginning tax year 2020.)	Yes
Section 201	Recapture Excess Advance Payments of Premium Tax Credits	The ACA authorizes premium tax credits to help eligible individuals pay for certain health plans offered through individual exchanges only. Individuals may receive the credit during the year; such payments are later reconciled when individuals file income-tax returns. Individuals who receive excess credits must pay back those amounts; amounts are capped for those with incomes under 400% of FPL.	Section 201 would disregard the income-related caps applicable to excess credit repayments for 2018 and 2019. In other words, any individual who was overpaid in tax credits would have to repay the entire excess amount during those two years, regardless of income.	Yes
Section	Repeal of Cost-	The ACA authorizes subsidies to reduce cost-sharing expenses for	Section 131 would repeal the cost-sharing subsidies effective for plan	Yes

Sections of the AHCA		Current Law Summary	Explanation of AHCA Provision	Related to the ACA?[a]
131	Sharing Subsidy	eligible individuals enrolled in certain health insurance exchange plans.	years beginning in 2020.	
Section 214	Refundable Tax Credit for Health Insurance Coverage	The federal tax code currently allows two credits to help eligible individuals pay for health insurance that meets specified standards: (1) the Health Coverage Tax Credit, with a sunset date of January 1, 2020, and (2) the premium tax credit for eligible individuals enrolled in qualified health plans offered through exchanges, established by the ACA under IRC Section 36B, with no sunset date.	Section 214 would amend IRC Section 36B with respect to a refundable, advanceable tax credit, effective beginning tax year 2020. The credits would be allowed for citizens, nationals, and qualified aliens enrolled in qualified health plans (individual insurance that meets requirements specified in the section) who are not eligible for other sources of coverage. The credit amounts would be based on age and adjusted by a formula that takes into account income. Credits would be capped according to a maximum dollar amount and family size.	Yes
Section 203	Small Business Tax Credit	The ACA established a small business health insurance tax credit.	Section 203 would sunset the small business tax credit beginning tax year 2020.	Yes
Repeal Mandates				
Section 204	Individual Mandate	The ACA created an individual mandate, a requirement for most individuals to maintain health insurance coverage or pay a penalty for noncompliance.	Section 204 would effectively eliminate the annual penalty, retroactively beginning CY2016.	Yes
Section 205	Employer Mandate	The ACA requires employers to either provide health coverage or face potential employer tax penalties. The penalties are imposed on firms with at least 50 full-time equivalent employees if one or more of their full-time employees obtain a premium tax credit through a health insurance exchange.	Section 205 would effectively eliminate the employer tax penalties retroactively beginning CY2016.	Yes
Continuous Coverage				
Section 133	Continuous Health Insurance Coverage Incentive	The ACA created an individual mandate, a requirement for most individuals to maintain health insurance coverage or pay a penalty for noncompliance. Under the ACA, premiums in the individual and small-group markets may vary only by self-only or family enrollment, geographic rating area, tobacco use (limited to a ratio of 1.5:1), and age (limited to a ratio of 3:1 for adults). Health insurance issuers offering health plans in the individual, small-group, and large-group markets must offer	Section 204 would effectively repeal the individual mandate, retroactively beginning CY2016. Section 133 would require issuers offering plans in the individual market to assess a penalty (or, in essence, vary premiums) on policyholders who (1) had a gap in creditable coverage that exceeded 63 days in the prior 12 months or (2) aged out of their dependent coverage (i.e., young adults up to the age of 26) and did not enroll in coverage during the next open enrollment period. The	Yes

Sections of the AHCA		Current Law Summary	Explanation of AHCA Provision	Related to the ACA?[a]
		plans on a guaranteed-issue basis. Issuers and sponsors of health plans (e.g., employers) are prohibited from excluding coverage of preexisting conditions.	penalty would be a 30% increase in monthly premiums during the enforcement period, which is either a 12-month period or the remainder of the plan year (if a person enrolls in coverage outside the open enrollment period). The provision would be effective for coverage obtained during special enrollment periods for plan year 2018 and for all coverage beginning plan year 2019.	
Other Market Reforms				
Section 135	Change in Permissible Age Variation in Health Insurance Premium Rates	Under the ACA, premiums in the individual and small-group markets may vary only by self-only or family enrollment, geographic rating area, tobacco use (limited to a ratio of 1.5:1), and age (limited to a ratio of 3:1 for adults). The age rating ratio means that a plan may not charge an older individual more than three times the premium that the plan charges a 21-year-old individual.	Under Section 135, the HHS Secretary may implement an age rating ratio of 5:1 for adults for premiums in the individual and small-group markets for plan years beginning on or after January 1, 2018. That is, a plan would not be able to charge an older individual more than five times the premium that the plan charges a 21-year-old individual. States would have the option to implement a different ratio for adults.	Yes
Section 134	Increasing Coverage Options	The ACA requires that nongrandfathered plans offered by health insurance issuers in the individual and small-group markets must (1) cover certain benefits (i.e., the 10 EHB); (2) comply with specific cost-sharing limitations; and (3) meet a certain generosity level (i.e., actuarial value)—bronze (60% AV), silver (70% AV), gold (80% AV), or platinum (90% AV).	Under Section 134, plans offered after December 31, 2019, would no longer need to meet a certain generosity level.	Yes
Section 132	Patient and State Stability Fund	NA	Section 132 would establish a Patient and State Stability Fund to provide funding to states for specified activities in the amounts of $15 billion in each of FY2018 and FY2019 and $10 billion in each subsequent year through FY2026. Section 132 would provide an additional $15 billion in FY2020 that states could use for two of the specified activities: (1) maternity coverage and newborn care and (2) prevention, treatment, or recovery support services for mental or substance use disorders. Section 132 also would establish a Federal Invisible Risk Sharing Program to provide payments to health insurance issuers that offer individual	No

Sections of the AHCA		Current Law Summary	Explanation of AHCA Provision	Related to the ACA?[a]
			market coverage to help with high-cost medical claims of certain individuals. Section 132 would appropriate $15 billion for the program to be used CY2018-CY2026.	
Section 136	Essential Health Benefits Defined by the States	The ACA requires that nongrandfathered plans offered by health insurance issuers in the individual and small-group markets must cover the EHB. The ACA does not define the EHB. Instead, it lists 10 categories from which benefits and services must be included and requires the HHS Secretary to further define the EHB.	Under Section 136, each state would define the EHB for plans offered in the state for purposes of the premium tax credit for plan years and taxable years beginning on or after January 1, 2018.	Yes
Implementation Funding				
Section 141	American Health Care Implementation Fund	NA	Section 141 would establish an American Health Care Implementation Fund within HHS to be used to implement the following AHCA provisions: per capita allotment for medical assistance; patient and state stability fund; additional modifications to the premium tax credit; and refundable tax credit for health insurance coverage. Section 141 would appropriate $1 billion to the fund.	No

Sources: CRS analysis of H.R. 1628, American Health Care Act (AHCA), as amended by the amendments agreed to under H.Res. 228 and referenced in H.Res. 254.

Notes: ACA = Patient Protection and Affordable Care Act (P.L. 111-148, as amended); AHCA = American Health Care Act; AV = actuarial value; CY = calendar year; EHB = essential health benefits; FPL = federal poverty level; FY = fiscal year; HHS = Department of Health and Human Services; IRC=Internal Revenue Code; NA = not applicable.

a. Yes = Proposed provision would repeal or amend (1) provision(s) newly established in the ACA or (2) modifications made by the ACA to previously established provisions.
No = Proposed provision would not repeal or amend any provisions described above.

Medicaid

Table 2. Provisions of the American Health Care Act (AHCA) Related to Medicaid

Section of the AHCA		Current Law Summary	Explanation of AHCA Provision	Related to the ACA?[a]
ACA Medicaid Expansion				
Section 112(a)(1)(A)(i) and (iii)	ACA Medicaid Expansion	The ACA established 133% of FPL as the new mandatory minimum Medicaid income-eligibility level for most non-elderly adults beginning January 1, 2014. On June 28, 2012, the U.S. Supreme Court issued its decision in *National Federation of Independent Business v. Sebelius*, which effectively made the ACA Medicaid expansion optional for states.	Section 112(a)(1)(A)(i) and (iii) would codify the ACA Medicaid expansion as optional for states after December 31, 2019.	Yes
Section 112(a)(1)(B)	Existing ACA Definition of Expansion Enrollees and New Definition for Grandfathered Expansion Enrollees	The ACA defined an expansion enrollee as an individual who is a non-elderly, nonpregnant adult with annual income at or below 133% of FPL based on MAGI and who is not entitled to or enrolled for benefits in Medicare Part A or enrolled for benefits under Medicare Part B.	Section 112(a)(1)(B) would incorporate the existing ACA definition of expansion enrollees and add a definition of grandfathered expansion enrollees for the purposes of the new optional Medicaid eligibility group. The provision would define a grandfathered expansion enrollee as an expansion enrollee who was enrolled in Medicaid (under the state plan or a waiver) as of December 31, 2019, and does not have a break in eligibility for more than one month after that date. The provision also would apply these definitions to existing provisions in Medicaid statute that currently reference the ACA Medicaid expansion group.	Yes
Section 112(a)(2)(A)	"Newly Eligible" Federal Matching Rate	Medicaid is jointly financed by the federal government and the states. The federal government's share of a state's expenditures for most Medicaid services is called the FMAP rate. Exceptions to the regular FMAP rate have been made for certain states, situations, populations, providers, and services. The ACA added a few FMAP exceptions, including the newly eligible federal matching rate (i.e., the matching rate for individuals who are newly eligible for Medicaid due to the ACA Medicaid expansion).	Section 112(a)(2)(A) would maintain the current structure of the newly eligible matching rate for expenditures before January 1, 2020, for states that covered newly eligible individuals as of March 1, 2017. However, on or after January 1, 2020, the newly eligible matching rate would apply only to expenditures for newly eligible individuals who are enrolled in Medicaid as of December 31, 2019, and do not have a break in eligibility for more than one month after that date (i.e., grandfathered expansion enrollees).	Yes
Section	"Expansion State"	The ACA added the expansion	Section 112(a)(2)(B) would amend	Yes

Section of the AHCA		Current Law Summary	Explanation of AHCA Provision	Related to the ACA?[a]
112(a)(2)(B)	Federal Matching Rate	state federal matching rate, which is the federal matching rate available for nonpregnant, childless adults in expansion states that have implemented the ACA Medicaid expansion who were eligible for Medicaid on March 23, 2010, and are in the eligibility group for the ACA Medicaid expansion.	the formula for the expansion state matching rate after CY2017. In addition, after January 1, 2020, the expansion state matching rate would apply only to expenditures for eligible individuals who were enrolled in Medicaid as of December 31, 2019, and do not have a break in eligibility for more than one month after that date (i.e., grandfathered expansion enrollees).	
Section 112(b)	Sunset of Essential Health Benefits Requirement	The ACA amends Medicaid Alternative Benefit Plan coverage by requiring states to include at least the 10 essential health benefits. The 10 EHB include (1) ambulatory patient services, (2) emergency services, (3) hospitalization, (4) maternity and newborn care, (5) mental health and substance use disorder services (including behavioral health treatment), (6) prescription drugs, (7) rehabilitative and habilitative services and devices, (8) laboratory services, (9) preventive and wellness services and chronic disease management, and (10) pediatric services, including oral and vision care.	Section 112(b) would repeal the requirement that ABP coverage include at least the 10 EHB after December 31, 2019	Yes

Section of the AHCA		Current Law Summary	Explanation of AHCA Provision	Related to the ACA?[a]
Medicaid Financing				
Section 121	Per Capita Allotment for Medical Assistance	The federal government reimburses states for a portion (i.e., the federal share) of each state's Medicaid program costs. Because federal Medicaid funding is an open-ended entitlement to states, there is no upper limit or cap on the amount of federal Medicaid funds a state may receive. The federal government provides broad guidelines to states regarding allowable funding sources for the state share of Medicaid expenditures. States can use state general funds (i.e., personal-income, sales, corporate-income taxes) and "other state funds" (i.e., provider taxes, local government funds, tobacco settlement funds, etc.) to finance the state share of Medicaid. Federal statute allows as much as 60% of the state share to come from local government funding.	Section 121 would reform federal Medicaid financing to a per capita cap model (i.e., per enrollee limits on federal payments to states) starting in FY2020. Specifically, each state's spending in FY2016 would be the base to set targeted spending for each enrollee category in FY2019 and subsequent years for that state. Each state's targeted spending amount would increase annually by the applicable annual inflation factor, which varies by enrollee category. Starting in FY2020, any state with spending higher than its specified targeted aggregate amount would receive reductions to its Medicaid funding for the following fiscal year. One provision would reduce the target amount for New York if certain local government contributions to the state share are required. States would have the option to receive block grant funding (i.e., a predetermined fixed amount of federal funding) instead of per capita cap funding for non-elderly, nondisabled, non-expansion adults and children starting in FY2020. Some statutory requirements would not apply under the block grant option.	No
Section 113	Elimination of DSH Cuts	The ACA required aggregate reductions in Medicaid DSH allotments for FY2014 through FY2020. Subsequent laws amended these reductions. Under current law, the aggregate reductions to the Medicaid DSH allotments are to impact FY2018 through FY2025.	Section 113 would eliminate the Medicaid DSH allotment reductions after FY2019. In addition, non-expansion states would be exempt from the ACA Medicaid DSH allotment reductions.	Yes
Section 115	Safety Net Funding for Non-expansion States	NA	Section 115 would establish safety net funding for non-expansion states to adjust payment amounts for Medicaid providers. The fund would provide $2 billion each year starting in FY2018 through FY2022. Non-expansion states would receive an increased matching rate of 100% for FY2018 through FY2021 and 95% for FY2022 for the provider payment adjustments.	No

Section of the AHCA		Current Law Summary	Explanation of AHCA Provision	Related to the ACA?[a]
Section 111(2)	Federal Medicaid Matching Rate for Community First Choice Option	The ACA established the Community First Choice Option, which allows states to offer community-based attendant services and supports as an optional Medicaid state plan benefit and to receive an FMAP increase of 6 percentage points for doing so.	Section 111(2) would repeal the increased FMAP rate for the Community First Choice Option on January 1, 2020.	Yes
Section 116(b)	Increased Administrative Matching Percentage for Eligibility Redeterminations	The federal government's share of a state's expenditures for most Medicaid services is called the FMAP rate. Exceptions to the regular FMAP rate have been made for certain states, situations, populations, providers, and services. Most administrative activities receive a 50% federal matching rate.	Section 116(b) would increase the federal match for administrative activities to carry out the increase in Medicaid eligibility redeterminations under Section 116(a) by 5 percentage points. This increased federal match would be available from October 1, 2017, through December 31, 2019.	No
Section 117(b)	Increase in Matching Rate for Implementation of Work Requirement	Same as above.	Section 117(b) would increase the federal match for administrative activities to implement the work requirement under Section 117(a) by 5 percentage points in addition to any other increase to such federal matching rate.	No
Medicaid Eligibility and Enrollment				
Section 112(a)(1)(A)(ii)	State Option for Coverage for Non-elderly Individuals with Income That Exceeds 133% of FPL	The ACA created an optional Medicaid eligibility category for all non-elderly individuals with income above 133% of FPL up to a maximum level specified in the Medicaid state plan.	Section 112(a)(1)(A)(ii) would repeal the state option to extend coverage to non-elderly individuals with income above133% of FPL after December 31, 2017.	Yes
Section 111(1)(A) and (3)	Federal Payments to States: Presumptive Eligibility	The ACA expands the types of entities (i.e., all hospitals) that are permitted to make presumptive-eligibility determinations to enroll certain groups in Medicaid for a limited time until a formal Medicaid eligibility determination is made. The ACA also expands the groups of individuals for whom presumptive-eligibility determinations may apply.	Section 111(1)(A) would no longer allow hospitals to elect to make presumptive-eligibility determinations. Section 111(3) would terminate the authority for certain states to make presumptive-eligibility determinations for the ACA Medicaid expansion group or the state option for coverage for non-elderly individuals with income that exceeds 133% of FPL. The repeal would be effective January 1, 2020.	Yes
Section 111(1)(B)	Federal Payments to States: Stairstep Children	The ACA expands the mandatory Medicaid income eligibility level for poverty-related children aged 6 to 19 from 100% of FPL to 133% of FPL.	Section 111(1)(B) would repeal the ACA requirement, specifying the end date of the ACA requirement as December 31, 2019.	Yes

Section of the AHCA		Current Law Summary	Explanation of AHCA Provision	Related to the ACA?[a]
Section 114(a)	Letting States Disenroll High-Dollar Lottery Winners	The ACA created a definition of household income based on MAGI to determine income eligibility for various Medicaid eligibility groups. Under Medicaid regulations, states are directed to include certain types of irregular income received as a lump sum (e.g., state income tax refund, lottery or gambling winnings) when determining income eligibility based on MAGI, but only in the month the irregular income is received.	Section 114(a) would direct states on how to treat irregular income received as a lump sum when determining MAGI income eligibility on or after January 1, 2020.	Yes
Section 114(b)	Repeal of Retroactive Eligibility	States are required to cover Medicaid benefits retroactively for three months before the month of application for individuals who are subsequently determined eligible, if the individual would have been eligible during that period had he or she applied.	Section 114(b) would limit the effective date for retroactive coverage of Medicaid benefits to the month in which the applicant applied for Medicaid applications on or after October 1, 2017.	No
Section 114(c)	Updating Allowable Home Equity Limits in Medicaid	There is a limit on the amount of home equity a Medicaid applicant can shield from aggregate asset limits that otherwise would disqualify the applicant from Medicaid eligibility for nursing-facility services or other long-term care. In 2017, the federal minimum home-equity limit is $560,000; a state may elect a higher amount, not to exceed $840,000.	Section 114(c) would repeal the authority for states to elect a home equity limit amount above the federal minimum, effective after 180 days from enactment.	No
Section 116(a)	Frequency of Eligibility Determinations	The ACA requires states to determine income eligibility based on MAGI for most of Medicaid's non-elderly populations. For such individuals, states are required to redetermine Medicaid eligibility once every 12 months, except in the case where the Medicaid agency receives information about a change in a beneficiary's circumstances that may affect eligibility. In this case, the Medicaid agency must redetermine Medicaid eligibility at the appropriate time based on such changes.	Section 116(a) would increase the frequency of redeterminations from every 12 months to every 6 months for individuals eligible for Medicaid through (1) the ACA Medicaid expansion or (2) the state option for coverage for non-elderly individuals with income that exceeds 133% of FPL for eligibility determinations beginning October 1, 2017.	Yes
Section 117(a)	State Option for Work Requirements	The Medicaid statute does not appear to expressly address whether a state plan may permissibly impose work requirements as a condition of receiving benefits for most beneficiaries. However, SSA Section	Section 117(a) would add a new state plan option to permit states to require nondisabled, non-elderly, nonpregnant adults to satisfy a work requirement as a condition for receipt of Medicaid medical assistance.	No

Section of the AHCA	Current Law Summary	Explanation of AHCA Provision	Related to the ACA?[a]
	1931 authorizes states to terminate TANF recipients' eligibility for medical assistance under Medicaid if the individuals' TANF benefits are denied for failing to comply with work requirements imposed under the TANF program.		

Source: CRS analysis of H.R. 1628, American Health Care Act (AHCA), as amended by the amendments agreed to under H.Res. 228 and referenced in H.Res. 254.

Notes: ABP = Alternative Benefit Plan; ACA = Patient Protection and Affordable Care Act (P.L. 111-148, as amended); AHCA = American Health Care Act; CHIP = State Children's Health Insurance Program; CY = calendar year; DSH = disproportionate share hospital; EHB = essential health benefits; FMAP = federal medical assistance percentage; FPL = federal poverty level; FY = fiscal year; MAGI = modified adjusted gross income; NA = not applicable; SSA = Social Security Act; TANF = Temporary Assistance for Needy Families.

a. Yes = Proposed provision would repeal or amend (1) provision(s) newly established in the ACA or (2) modifications made by the ACA to previously established provisions.
No = Proposed provision would not repeal or amend any provisions described above.

Public Health and Taxes

Table 3. Public Health and Tax-Related Provisions of the American Health Care Act (AHCA)

Section of the AHCA		Current Law Summary	Explanation of AHCA Provision	Related to the ACA?[a]
Public Health				
Section 101	Prevention and Public Health Fund	The ACA established the Prevention and Public Health Fund and provided a permanent annual appropriation for prevention and public health programs. Annual appropriation amounts were subsequently reduced.	Section 101 would repeal all Prevention and Public Health Fund appropriations starting in FY2019 and rescind any unobligated balance remaining at the end of FY2018.	Yes
Section 102	Community Health Center Program	The ACA created the Community Health Center Fund and directly appropriated $3.6 billion annually to support the health center program for FY2011-FY2015. The annual appropriation was subsequently extended for FY2016-FY2017.	Section 102 would provide an additional $422 million to the Community Health Center Fund in FY2017.	Yes
Section 103	Federal Payments to States	Planned Parenthood Federation of America-affiliated health centers receive reimbursements, including from Medicaid and other federal programs, for family planning and other services provided to beneficiaries. Planned Parenthood Federation of America and its affiliates may receive federal grants. Some facilities provide abortions using nonfederal revenue sources because	Section 103 would restrict a prohibited entity, for a period of one year effective at enactment, from receiving direct spending (e.g., Medicaid reimbursements). A prohibited entity is (1) a nonprofit organization; (2) an essential community provider that provides family planning, reproductive health, and any other related services; (3) an	No

Section of the AHCA		Current Law Summary	Explanation of AHCA Provision	Related to the ACA?[a]
		federal funds are available for abortions only in cases of rape, incest, or endangerment of a mother's life.	organization that provides abortions in instances when the pregnancy is not the result of rape, incest, or likely to endanger the mother's life; and (4) an organization that received federal and state Medicaid reimbursements in FY2014 that exceeded $350 million. The Congressional Budget Office expects that this prohibited entity would be the Planned Parenthood Federation of America.	
Tax Advantaged Accounts				
Section 207	Repeal of Tax on Over-the-Counter Medications	Taxpayers may use several different types of tax-advantaged health accounts to pay or be reimbursed for qualified medical expenses. However, the ACA imposed the requirement that amounts paid for medicine or drugs are qualified expenses only in the case of prescribed drugs and insulin and not in the case of over-the-counter medications.	Section 207 would repeal the requirement, effective beginning tax year 2017.	Yes
Section 208	Repeal of Increase of Tax on Health Savings Accounts	Distributions from Archer MSAs and HSAs that are used for purposes other than paying for qualified medical expenses are taxed at 20%. Prior to the ACA, the tax rate on such distributions was 15% and 10% for Archer MSAs and HSAs, respectively.	Section 208 would reduce the applicable tax rate to 15% and 10% for Archer MSAs and HSAs, respectively, for distributions made after December 31, 2016.	Yes
Section 209	Repeal of Limitations on Contributions to Flexible Spending Account	Under the ACA, an employee may contribute a maximum of $2,500 to a health FSA established under a cafeteria plan.	Section 209 would repeal this limit, effective beginning tax year 2017.	Yes
Section 215	Maximum Contribution Limit to Health Savings Account Increased to Amount of Deductible and Out-of-Pocket Limitation	HSA contributions are subject to an annual limit, which is adjusted for inflation. In 2017, the contribution limit is $3,400 for account holders enrolled in self-only coverage and $6,750 for account holders enrolled in family coverage.	Section 215 would increase the HSA annual contribution limits to match the out-of-pocket limits for HSA-qualified high-deductible health plans for self-only and family coverage, effective beginning in tax year 2018.	No
Section 216	Allow Both Spouses to Make Catch-Up Contributions to the Same Health Savings Account	HSA contributions are subject to limits. In the case of a married couple, if either spouse has HSA-qualified family coverage and both spouses have their own HSAs, then both spouses are treated as if they have only one family plan for purposes of the HSA contribution limit. Their annual	Under Section 216, with respect to the contribution limit to an HSA, married individuals would not have to take into account whether their spouse is also covered by an HSA-qualified high-deductible health plan. The section also would effectively	No

Section of the AHCA		Current Law Summary	Explanation of AHCA Provision	Related to the ACA?[a]
		contribution limit is first reduced by any amount paid to Archer MSAs of either spouse for the taxable year, and then the remaining contribution amount is divided equally between the spouses unless they agree on a different division. Each spouse is allowed to make catch-up contributions to his or her respective HSA, provided each spouse is eligible to do so.	allow both spouses to make catch-up contributions to one HSA. The section would apply to taxable years beginning in 2018.	
Section 217	Special Rule for Certain Medical Expenses Incurred Before Establishment of Health Savings Account	In general, withdrawals from HSAs are exempt from federal income taxes if used for qualified medical expenses, except for health insurance. However, withdrawals from HSAs are not exempt from federal income taxes if used to pay qualified medical expenses incurred before the HSA was established.	Section 217 would provide a circumstance under which HSA withdrawals may be used to pay qualified medical expenses incurred before the HSA was established. Section 217 would apply to coverage beginning after December 31, 2017.	No
Tax Provisions				
Section 241	Remuneration from Certain Insurers	Generally, employers may deduct the remuneration paid to employees as "ordinary and necessary" business expenses, subject to any statutory limitations. However, under the ACA, certain health insurance providers cannot deduct the remuneration paid to an officer, director, or employee in excess of $500,000.	Section 241 would repeal this limit, effective beginning tax year 2017.	Yes
Section 231	Repeal of Tanning Tax	The ACA imposes an excise tax on indoor tanning services equal to 10% of the amount paid.	Section 231 would repeal the tax, effective after June 30, 2017.	Yes
Section 221	Repeal of Tax on Prescription Medications	The ACA imposes an annual tax on certain manufacturers or importers of branded prescription drugs.	Section 221 would repeal the tax, effective CY2017.	Yes
Section 222	Repeal of Health Insurance Tax	The ACA imposes an annual fee on certain health insurers. The fee has been suspended for CY2017 but is to apply again beginning in CY2018.	Section 222 would repeal the fee, effective CY2017.	Yes
Section 251	Repeal of Net Investment Income Tax	The ACA applies a 3.8% tax to certain net investment income of individuals, estates, and trusts with income above specified amounts.	Section 251 would repeal the net investment tax, effective beginning tax year 2017.	Yes
Section 206	Repeal of the Tax on Employee Health Insurance Premiums and Health Plan Benefits	The ACA established a 40% excise tax on high-cost employer-sponsored coverage (the so-called Cadillac tax) effective in 2018; however, a subsequent law delayed implementation until 2020.	Section 206 would delay implementation of the tax until 2026.	Yes
Section	Repeal of Medical	The ACA established a 2.3% excise	Section 210 would repeal the tax,	Yes

Section of the AHCA		Current Law Summary	Explanation of AHCA Provision	Related to the ACA?[a]
210	Device Excise Tax	tax that is imposed on the sale of certain medical devices. The tax took effect on January 1, 2013, but a subsequent law imposed a two-year moratorium for CY2016-CY2017.	effective for sales after December 31, 2016.	
Section 211	Repeal of Elimination of Deduction for Expenses Allocable to Medicare Part D Subsidy	Employers that provide Medicare-eligible retirees with qualified prescription drug coverage are eligible for federal subsidy payments. Prior to implementation of the ACA, employers were allowed to claim a business deduction for their qualified retiree prescription drug expenses, even though they also received the federal subsidy to cover a portion of those expenses. Under the ACA, beginning in 2013, the amount allowable as a deduction is reduced by the amount of the federal subsidy received.	Section 211 would repeal the ACA change and reinstate business-expense deductions for retiree prescription drug costs without reduction by the amount of any federal subsidy. The change would be effective for taxable years beginning after December 31, 2016.	Yes
Section 212	Reduction of Income Threshold for Determining Medical Care Deduction	Under the ACA, taxpayers who itemize their deductions may deduct qualifying medical expenses if the expenses exceed 10% of the taxpayer's adjusted gross income. Prior to the ACA, the AGI threshold was 7.5% for all taxpayers.	Section 212 would reduce the AGI threshold to 5.8% for all taxpayers, effective beginning tax year 2017.	Yes
Section 213	Repeal of Medicare Tax Increase	Under the ACA, a Medicare Hospital Insurance surtax is imposed at a rate equal to 0.9% of an employee's wages or a self-employed individual's self-employment income. The surtax applies only to taxpayers with taxable income in excess of $250,000 if married filing jointly; $125,000 if married filing separately; and $200,000 for all other taxpayers.	Section 213 would repeal the 0.9% Medicare surtax, with respect to remuneration received after, and taxable years beginning after, December 31, 2022.	Yes

Sources: CRS analysis of H.R. 1628, American Health Care Act (AHCA), as amended by the amendments agreed to under H.Res. 228 and referenced in H.Res. 254.

Notes: ACA = Patient Protection and Affordable Care Act (P.L. 111-148, as amended); AGI = adjusted gross income; AHCA = American Health Care Act; CY = calendar year; FFP = federal financial participation; FSA = flexible spending account; FY = fiscal year; HSA = health savings account; MSA = medical savings account.

a. Yes = Proposed provision would repeal or amend (1) provision(s) newly established in the ACA or (2) modifications made by the ACA to previously established provisions.
No = Proposed provision does not repeal or amend any provisions described above.

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