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 FY2017-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.

In response to the reconciliation instructions, there was activity in four different House committees—Ways and Means, Energy and Commerce, Budget, and Rules—during the first quarter of 2017. The result of this activity was H.R. 1628, the American Health Care Act (AHCA) of 2017. The version of the AHCA as passed by the House on May 4, 2017 (which incorporated eight amendments referenced in H.Res. 228 and H.Res. 308), is the topic of this report. The bill 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). For example, 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 also would repeal some of the ACA's Medicaid provisions, 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 federal poverty level (FPL).

The AHCA also includes a number of provisions that do not specifically relate to aspects of 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 to states for specified activities intended to improve access to health insurance and health care in the state. The bill would convert Medicaid financing to a per capita cap model (i.e., per enrollee limits on federal payments to states) starting in FY2020, and 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.

This report contains three tables that, together, provide an overview of all 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 the AHCA provision repeals an ACA-related provision). In addition to the three tables, the report includes more detailed summaries of each AHCA provision and two graphics showing the effective dates of AHCA provisions. **Figure 1** covers AHCA provisions related to the private health insurance market, public health, and taxes. **Figure 2** covers AHCA provisions related to the Medicaid program.

The Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation (JCT) issued a cost estimate for the AHCA, as passed by the House on May 4, 2017. According to the estimate, the AHCA would reduce federal deficits by $119 billion over the period FY2017-FY2026. With respect to effects on health insurance coverage, CBO and JCT project that, in

CY2018, 14 million more people would be uninsured under the AHCA than under current law, and in CY2026, 23 million more people would be uninsured than under current law.

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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 FY2017 budget 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 FY2017-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.[1] 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.[2] After debate occurred on the bill, the Speaker pro tempore postponed further consideration of the bill.

On April 6, 2017, the House Rules Committee reported H.Res. 254, which provided that should the House return to consideration of the AHCA, an additional amendment would be automatically agreed to upon adoption of the resolution.[3] H.Res. 254 was subsequently tabled, however, and as a result is no longer available to be considered by the House.[4] On May 3, the House Rules Committee reported H.Res. 308, providing for further debate of the AHCA, as amended by H.Res. 228. H.Res. 308, which was agreed to by the House on May 4, provided for one hour of further debate on the AHCA and automatically amended the AHCA (as amended by H.Res. 228) to incorporate three further amendments (one of which previously had been included in H.Res. 254).[5] The House subsequently passed the AHCA on May 4, 2017, by a vote of 217 to 213. This CRS report includes information on the AHCA as passed by the House (which incorporates each of the eight amendments referenced in H.Res. 228 and H.Res. 308, as noted above).

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[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.

[4] On April 27, 2017, the House agreed to H.Res. 275, a resolution that included a provision laying H.Res. 254 upon the table. This means that H.Res. 254 has been disposed of and is no longer available to be considered. It is likely that the House tabled H.Res. 254 because under House Rule XIII, clause 6(d), if a special rule reported from the House Rules Committee has been on the House calendar for seven legislative days without being called up for consideration, any member of the committee (including a minority-party member) may call it up provided that the Member gives one calendar day of an intention to do so.

[5] The House Rules Committee Amendments # 32, #33, and #34, as posted on the Rules Committee website on May 3, 2017, at https://rules.house.gov/bill/115/hr-1628.

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 effectively would eliminate the ACA's individual and employer mandates.

In addition, the AHCA 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 to states for specified activities intended to improve access to health insurance and health care in the state.

The AHCA also includes a number of changes to the Medicaid program. The bill would repeal some parts of the ACA related to Medicaid, 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 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. The 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 a cost estimate for the AHCA, as passed by the House on May 4, 2017.[6] According to the estimate, the AHCA would reduce federal deficits by $119 billion over the period FY2017-FY2026. With respect to effects on health insurance coverage, CBO and JCT project that, in CY2018, 14 million more people would be uninsured under the AHCA than under current law, and in CY2026, 23 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

[6] Congressional Budget Office (CBO), *Cost Estimate – H.R. 1628, American Health Care Act of 2017*, May 24, 2017, at https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/hr1628aspassed.pdf. CBO issued cost estimates reflecting earlier versions of the AHCA on March 13, 2017, and on March 23, 2017.

to an ACA provision (e.g., whether the AHCA provision repeals an ACA-related provision). In addition to the three tables, the report includes more detailed summaries of each AHCA provision and two graphics showing the effective dates of AHCA provisions. **Figure 1** covers AHCA provisions related to the private health insurance market, public health, and taxes. **Figure 2** covers AHCA provisions related to the Medicaid program.

A table identifying key CRS policy staff appears at the end of the report.

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, authorized 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 specified 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 authorized 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 131	Repeal of Cost-Sharing Subsidy	The ACA authorized subsidies to reduce cost-sharing expenses for eligible individuals enrolled in certain health insurance exchange plans.	Section 131 would repeal the cost-sharing subsidies effective for plan years beginning in 2020.	Yes
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	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	Yes

Sections of the AHCA		Current Law Summary	Explanation of AHCA Provision	Related to the ACA?[a]
		qualified health plans offered through exchanges, established by the ACA under IRC Section 36B, with no sunset date.	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.	
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 individual mandate penalty, retroactively beginning CY2016.	Yes
Section 205	Employer Mandate	The ACA required 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 the firm's 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 for certain plans offered 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). Most plans offered in the individual, small-group, and large-group markets must offer plans on a guaranteed-issue basis. Most private health insurance plans are prohibited from excluding coverage of preexisting conditions.	As described elsewhere, Section 204 would effectively eliminate the annual individual mandate penalty, 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 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	Yes

Sections of the AHCA		Current Law Summary	Explanation of AHCA Provision	Related to the ACA?[a]
			coverage beginning plan year 2019.	
Other Market Reforms				
Section 135	Change in Permissible Age Variation in Health Insurance Premium Rates	Under the ACA, premiums for certain plans offered 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 could 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 would charge 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 required that certain plans offered 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 certain generosity levels.	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 2018 and 2019 and $10 billion in each subsequent year through 2026. Section 132 would provide an additional $15 billion in 2020 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 provide an additional $8 billion for the period 2018-2023 to states with a waiver in effect under proposed AHCA Section 136 relating to allowing issuers to use health status as a factor when developing premiums for certain individuals. Section 132 would 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. Section 132 would appropriate $15 billion for the	No

Sections of the AHCA		Current Law Summary	Explanation of AHCA Provision	Related to the ACA?[a]
			program to be used 2018-2026.	
Section 136	Permitting States to Waive Certain ACA Requirements to Encourage Fair Health Insurance Premiums	Under the ACA, premiums for certain plans offered 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 ACA prohibited most plans offered in the individual and group markets from basing eligibility for coverage on health status-related factors, and it prohibited such plans from requiring an individual to pay a larger premium than any other similarly situated enrollees of the plan on the basis of a health status-related factor of the individual or any of the individual's dependents. The ACA required certain plans offered in the individual and small-group markets to offer a core package of health care services, known as the EHB.	Section 136 would allow states to apply to the HHS Secretary for a waiver for one or more of the following purposes. (1) A state could apply for a waiver to implement an age rating ratio for adults that is higher than the ratio specified in the ACA, as would be amended by AHCA Section 135. This waiver could apply to plan years beginning on or after January 1, 2018. (2) A state could apply for a waiver from the EHB and instead specify its own EHB. This waiver could apply to plan years beginning on or after January 1, 2020. (3) A state could apply to waive the continuous coverage penalty, as would be implemented under AHCA Section 133, and instead allow issuers to use health status as a factor when developing premiums for individuals subject to an enforcement period. This waiver could apply to coverage obtained during special enrollment periods for plan year 2018 and for all coverage beginning plan year 2019.	Yes
Section 137	Constructions	Under current law, private health insurance plans may not vary rates by gender and most plans may not limit access to health insurance coverage for individuals with preexisting conditions.	Section 137 would provide that nothing in the AHCA is to be construed as allowing issuers to vary health insurance rates by gender or as permitting issuers to limit access to coverage for individuals with preexisting conditions.	No
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: Congressional Research Service (CRS) analysis of H.R. 1628, American Health Care Act (AHCA) of 2017, as amended by the amendments referenced in H.Res. 228 and H.Res. 308.

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 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 of the AHCA		Current Law Summary	Explanation of AHCA Provision	Related to the ACA?[a]
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 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).	Yes
Section 112(a)(2)(B)	*Expansion State* Federal Matching Rate	The ACA added the expansion state federal matching rate, which is the federal matching rate available for expansion enrollees without dependent children in expansion states who were eligible for Medicaid on March 23, 2010. In this context, *expansion state* refers to states that already had implemented (or partially implemented) the ACA Medicaid expansion at the time the ACA was enacted.	Section 112(a)(2)(B) would amend 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).	Yes
Section 112(b)	Sunset of Essential Health Benefits Requirement	The ACA amended Medicaid ABP coverage by requiring states to include at least the 10 EHB. 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 may 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 directly 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 above 133% of FPL after December 31, 2017.	Yes
Section 111(1)(A) and (3)	Federal Payments to States: Presumptive Eligibility	The ACA expanded 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 expanded 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. Both changes would be effective January 1, 2020.	Yes
Section 111(1)(B)	Federal Payments to States: Stairstep Children	The ACA expanded the mandatory Medicaid income eligibility level for poverty-related children aged 6 through 18 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, effective October 1, 2017, to permit states to require nondisabled, non-elderly, nonpregnant adults to satisfy a work requirement as a condition for receipt of Medicaid medical	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.	assistance.	

Source: CRS analysis of H.R. 1628, American Health Care Act (AHCA) of 2017, as amended by the amendments referenced in H.Res. 228 and H.Res. 308.

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 also is 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 218	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 218 would provide a circumstance under which HSA withdrawals may be used to pay qualified medical expenses incurred before the HSA was established. Section 218 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 further delay implementation of the tax until 2026.	Yes

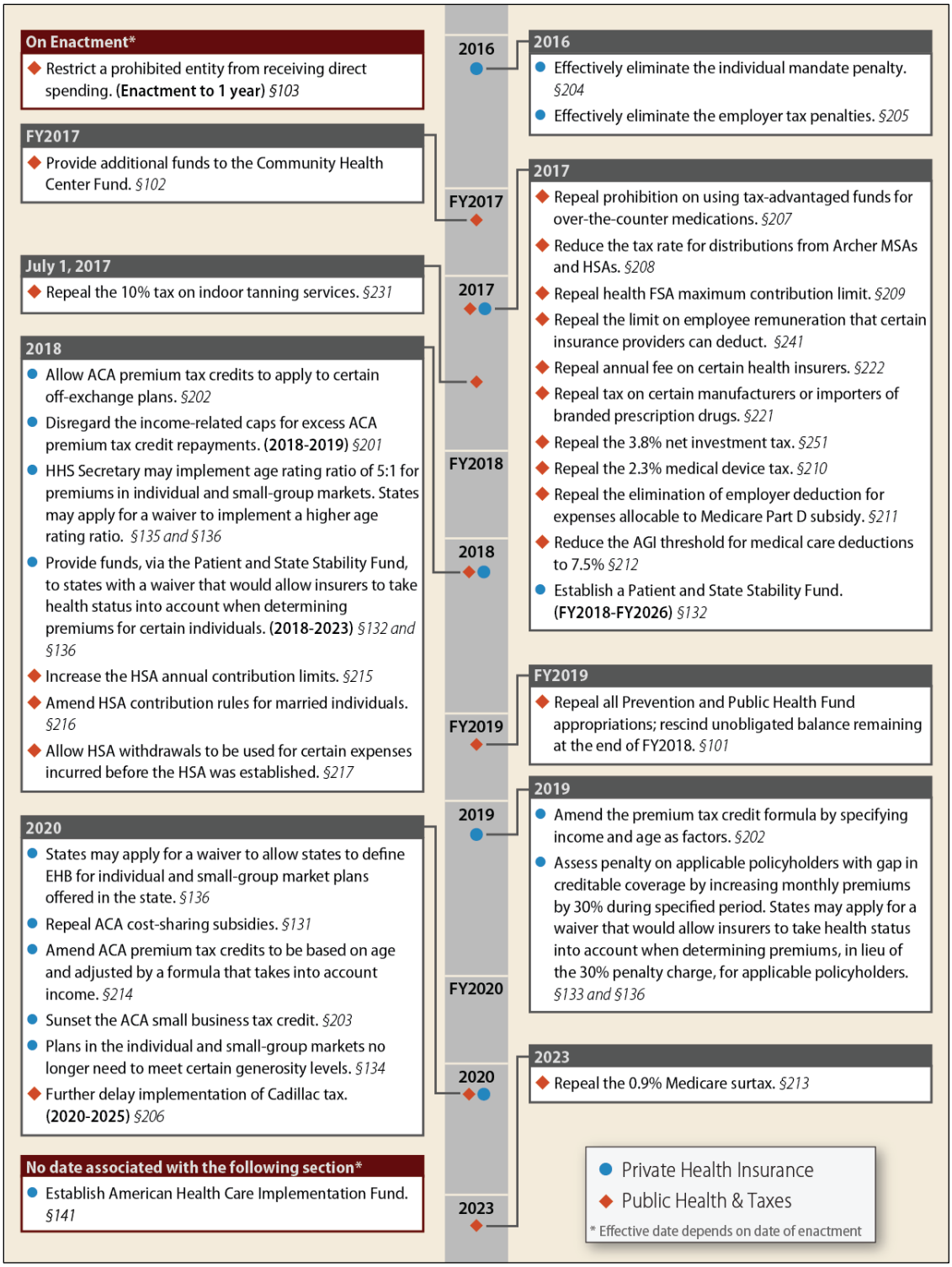
Section of the AHCA		Current Law Summary	Explanation of AHCA Provision	Related to the ACA?[a]
Section 210	Repeal of Medical Device Excise Tax	The ACA established a 2.3% excise tax that is imposed on the sale of certain medical devices. The tax took effect on January 1, 2013, but a subsequent law imposed a two-year moratorium for CY2016-CY2017.	Section 210 would repeal the tax, effective for sales after December 31, 2016.	Yes
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) of 2017, as amended by the amendments referenced in H.Res. 228 and H.Res. 308.

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.

Figure 1. Timeline of Provisions of the American Health Care Act (AHCA) Related to Private Health Insurance, Public Health, and Taxes

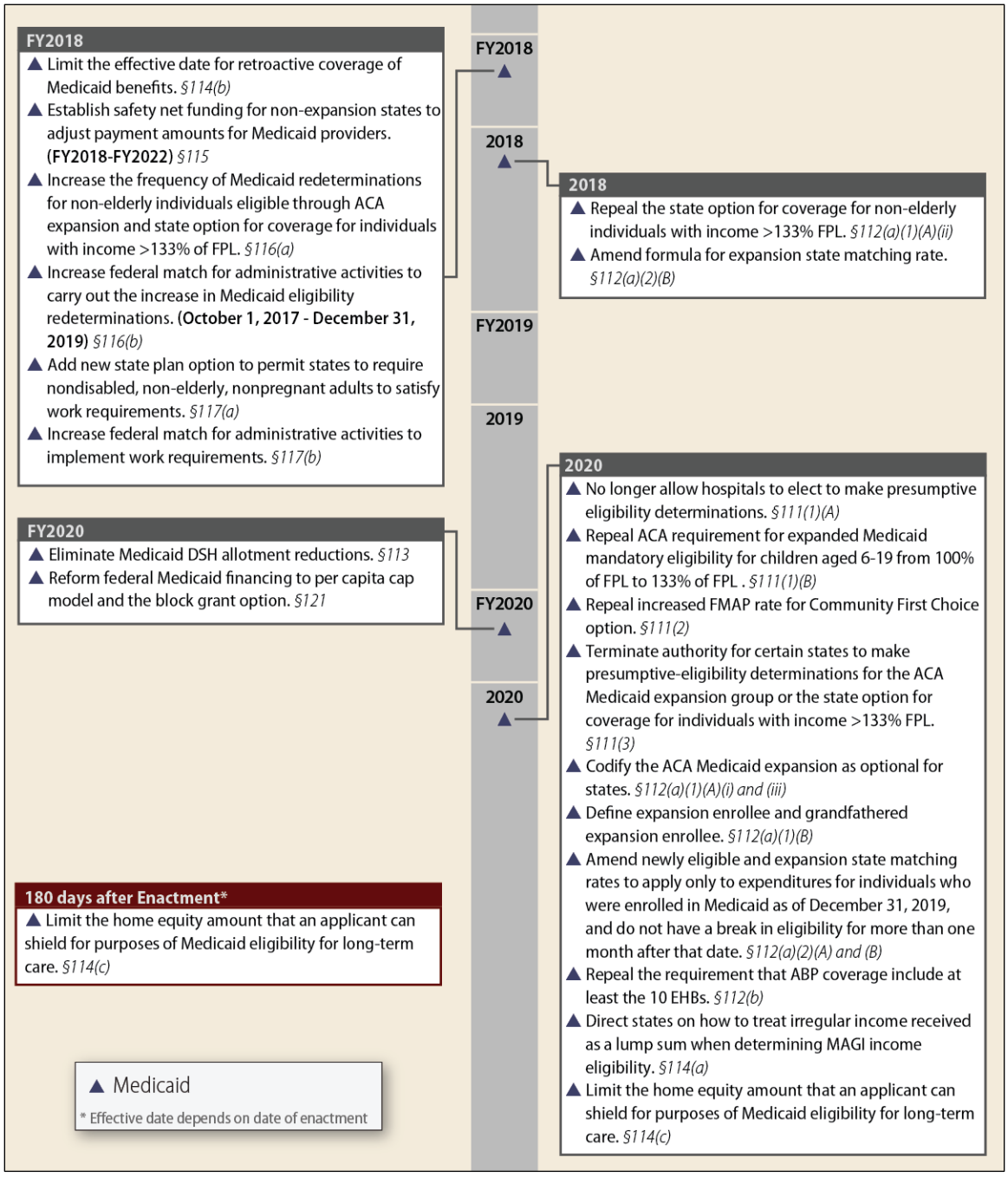


Source: CRS analysis of H.R. 1628, the American Health Care Act (AHCA), as amended by the amendments referenced in H.Res. 228 and H.Res. 308.

Notes: ACA = Patient Protection and Affordable Care Act (P.L. 111-148, as amended); AGI = adjusted gross income; AHCA = American Health Care Act; EHB = essential health benefits; FSA = flexible spending account; FY = fiscal year; HHS = Department of Health and Human Services; HSA = health savings account; MSA = medical savings account.

Provisions that go into effect January 1 of the year, during the calendar year, or during the tax year for a particular year are categorized together. For example, provisions grouped under "2018" may go into effect January 1, 2018, during calendar year 2018, or during tax year 2018. Provisions that go into effect at the start of a fiscal year or during a fiscal year are categorized together. For example, provisions grouped under "FY2018" may go into effect at the start of the fiscal year (October 1, 2017) or during the fiscal year (October 1, 2017-September 31, 2018). Some provision effective dates are dependent on the date of enactment and are indicated as such. Some provision effective dates are not provided in the AHCA and are indicated as such.

Figure 2. Timeline of Provisions of the American Health Care Act Related to Medicaid



Source: CRS analysis of H.R. 1628, the American Health Care Act (AHCA), as amended by the amendments referenced in H.Res. 228 and H.Res. 308.

Notes: ABP = alternative benefit plan; ACA = Patient Protection and Affordable Care Act (P.L. 111-148, as amended); AHCA = American Health Care Act; 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.

Provisions that go into effect January 1 of the year or during the calendar year for a particular year are categorized together. For example, provisions grouped under "2018" may go into effect January 1, 2018, or

during calendar year 2018. Provisions that go into effect at the start of a fiscal year or during a fiscal year are categorized together. For example, provisions grouped under "FY2018" may go into effect at the start of the fiscal year (October 1, 2017) or during the fiscal year (October 1, 2017-September 31, 2018). Some provision effective dates are dependent on the date of enactment and are indicated as such.

Title I Energy and Commerce

Subtitle A—Patient Access to Public Health Programs

Section 101. Prevention and Public Health Fund

Current Law

ACA Section 4002 established the Prevention and Public Health Fund (PPHF), to be administered by the Secretary of the Department of Health and Human Services (HHS), and provided the PPHF with a permanent annual appropriation.[7] Amounts for each fiscal year are available to the HHS Secretary beginning October 1, the start of the respective fiscal year. Congress may explicitly direct the distribution of PPHF funds and did so for FY2014 through FY2017.

Under the ACA, the PPHF's annual appropriation would increase from $500 million for FY2010 to $2 billion for FY2015 and each subsequent fiscal year. Congress has amended the provision two times, using a portion of PPHF funds as an offset for the costs of other activities. Annual appropriations to the PPHF in current law are as follows:

- $500 million for FY2010;
- $1.0 billion for each of FY2012 through FY2017;[8]
- $900 million for each of FY2018 and FY2019;
- $1.0 billion for each of FY2020 and FY2021;
- $1.5 billion for FY2022;
- $1.0 billion for FY2023;
- $1.7 billion for FY2024; and
- $2.0 billion for FY2025 and each fiscal year thereafter.[9]

Explanation of AHCA Provision

Section 101 would amend ACA Section 4002(b) by repealing all PPHF appropriations for FY2019 and subsequent fiscal years. It also would rescind any unobligated PPHF balance remaining at the end of FY2018.

[7] A detailed description of the Prevention and Public Health Fund (PPHF) is provided in CRS Report R44796, *The ACA Prevention and Public Health Fund: In Brief*.

[8] The Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) also appropriated $750 million to the PPHF for FY2011. This line of text was removed from the provision in P.L. 112-96 in 2012, which did not affect the availability of FY2011 funds.

[9] Amounts do not reflect sequestration of funds for FY2013 and subsequent fiscal years.

Section 102. Community Health Center Program

Current Law

ACA Section 10503 created the Community Health Center Fund, which provided mandatory appropriations to the health center program from FY2011 through FY2015.[10] These appropriations provided in subsection (a)(1)—of $3.6 billion annually—subsequently were extended through FY2017 by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA; P.L. 114-10), Section 221(a).

Prior to the ACA, the health center program had received only discretionary appropriations, which made up the entirety of the program's appropriated funds. Since the Community Health Center Fund's creation, the fund has made up an increasing percentage of the health center program's appropriation, ranging from 39% for FY2011 to 71% for FY2016. Under current law, for FY2018, the Community Health Center Fund will not receive a mandatory appropriation.

Explanation of AHCA Provision

Section 102 would provide an additional $422 million for FY2017 to the Community Health Center Fund.

Section 103. Federal Payments to States

Current Law

The Planned Parenthood Federation of America (PPFA) is an umbrella organization supporting 59 independent affiliates that operate approximately 661 health centers across the United States. Government funding—which includes federal, state, and local funds—constitutes the PPFA's largest source of revenue, an estimated 43% in the year ending June 30, 2015.[11] The Congressional Budget Office (CBO) estimates that federal funds accounted for about one-third of PPFA's total revenue in 2013.[12] PPFA receives federal grants (either directly or through another entity, such as a state) and reimbursements for providing services to beneficiaries enrolled in federally funded programs (e.g., Medicaid). It does not receive a direct annual appropriation of any kind.

CBO and the U.S. Government Accountability Office (GAO) found that PPFA's largest source of federal funding is reimbursements for covered services provided to Medicaid beneficiaries. Specifically, CBO estimated that PPFA's federal Medicaid revenue was approximately $390 million in 2013.[13] GAO examined FY2012 PPFA reimbursements and expenditures and found

[10] For more information, see CRS Report R43911, *The Community Health Center Fund: In Brief*.

[11] Planned Parenthood Federation of America, Inc. (PPFA), *2014-2015 Annual Report*, pp. 32-33, at https://www.plannedparenthood.org/files/2114/5089/0863/2014-2015_PPFA_Annual_Report_.pdf. For more information about PPFA and the services it provides, see CRS Report R44295, *Factors Related to the Use of Planned Parenthood Affiliated Health Centers (PPAHCs) and Federally Qualified Health Centers (FQHCs)*.

[12] Letter from CBO to Senator Mike Enzi, Chairman of the Committee on the Budget, August 3, 2015, at https://www.cbo.gov/publication/50700.

[13] Government Accountability Office (GAO), *Health Care Funding: Federal Obligations to and Expenditures by Selected Entities Involved in Health-Related Activities*, 2010–2012, GAO-15-270R, March 20, 2015, at http://www.gao.gov/products/GAO-15-270R. GAO does not provide a grand total for federal funding to PPFA affiliates in FY2012; however, for specific federal funding sources see report Tables 15, 16, 24, 25, and 26 and CBO, *Budgetary Effects of Legislation that Would Permanently Prohibit the Availability of Federal Funds to Planned*
(continued...)

that PPFA had either received reimbursements or expended funds from discretionary programs and from direct spending (as defined in the Balanced Budget and Emergency Deficit Control Act of 1985, 2 U.S.C. 900(c)(8)). *Direct spending* refers to budget authority provided by laws other than through appropriations acts, entitlement authority, and the Supplemental Nutrition Assistance Program (SNAP). PPFA's reimbursements or expenditures from direct spending include reimbursements from Medicaid, Medicare, and the State Children's Health Insurance Program (CHIP) (listed in order of the amount of reimbursements received, according to GAO), as well as certain expenditures from the Social Service Block Grant, the Crime Victims Assistance Program (administered by the Department of Justice), the Personal Responsibility and Education Program, and SNAP (administered by the Department of Agriculture). PPFA also received funds from a number of discretionary programs, either directly or through another entity (e.g., a state). For example, in FY2012, GAO found that PPFA had expended discretionary funds from the Maternal and Child Health Block Grants programs, which are provided to states; some states provided these funds to PPFA entities to provide services.[14]

Under federal law, federal funds generally are not available to pay for abortions, except in cases of rape, incest, or endangerment of a mother's life. This restriction is the result of statutory and legislative provisions such as the Hyde amendment, which has been added to the annual HHS appropriations measure since 1976. Similar provisions exist in the appropriations measures for foreign operations, the District of Columbia, the Department of the Treasury, and the Department of Justice. Other codified restrictions limit the use of funds made available to the Department of Defense and the Indian Health Service.

Explanation of AHCA Provision

Section 103 would prohibit federal funds made available to a state through direct spending from being provided to a prohibited entity (as defined), either directly or through a managed care organization, for a one-year period beginning upon enactment of the AHCA. The provision specifies that this prohibition would be implemented notwithstanding certain programmatic rules (e.g., the Medicaid freedom of choice of provider requirement, which requires enrollees to be able to receive services from any willing Medicaid-participating provider and stipulates that states cannot exclude providers solely on the basis of the range of services they provide).

Section 103 does not explicitly specify that certain federal funds would not be made available to PPFA or its affiliated entities; instead it refers to and defines a *prohibited entity* as an entity that meets the following criteria at enactment: (1) it is designated as a not-for-profit by the Internal Revenue Service (IRS); (2) it is described as an essential community provider that is primarily engaged in family planning services, reproductive health, and related medical care; (3) it is an abortion provider that provides abortion in cases that do not meet the Hyde amendment exception for federal payment; and (4) it received more than $350 million in Medicaid expenditures (both federal and state) in FY2014. When evaluating nearly identical language included in H.R. 3762 during the 114th Congress, CBO determined that the prohibited entity likely would be PPFA because few other health care providers would meet the bill's definition.[15]

(...continued)

Parenthood, September 22, 2015, at https://www.cbo.gov/publication/50833.

[14] GAO, *Health Care Funding: Federal Obligations to and Expenditures by Selected Entities Involved in Health-Related Activities*, 2010–2012, GAO-15-270R, March 20, 2015, at http://www.gao.gov/products/GAO-15-270R.

[15] CBO and Joint Committee on Taxation, H.R. 3762 *Restoring Americans' Healthcare Freedom Reconciliation Act of 2015*, October 20, 2015.

Subtitle B—Medicaid Program Enhancement

Section 111. Repeal of Medicaid Provisions

Section 111(1)(A) and 111(3). Federal Payments to States: Presumptive Eligibility

Current Law

Prior to the enactment of the ACA, states were permitted to enroll certain groups (e.g., children, pregnant women, certain women with breast and cervical cancer, and individuals eligible for family planning services) for a limited period of time before completed Medicaid applications were filed and processed, based on a preliminary determination of likely Medicaid eligibility by certain specified Medicaid providers (i.e., *qualified entities*). Qualified entities had to be certified by the state Medicaid agency as entities that were capable of making presumptive-eligibility determinations. The type of entity that could make presumptive-eligibility determinations depended on the beneficiary's Medicaid eligibility category. For example, certain providers of clinic and outpatient hospital services could determine presumptive eligibility for pregnant women. Agencies that served low-income children under federal programs, such as the Special Supplemental Nutrition Program for Women, Infants, and Children or school lunch programs (under the Richard B. Russell National School Lunch Act) could make presumptive-eligibility determinations for children. Individuals who were determined to be presumptively eligible for Medicaid then had to formally apply for coverage within a given time frame to continue receiving Medicaid benefits.

The ACA expanded the types of entities that are permitted to make Medicaid presumptive-eligibility determinations as well as the groups of individuals for whom presumptive-eligibility determinations may apply. Specifically, the ACA allowed states to permit all hospitals that participate in Medicaid to elect to make presumptive-eligibility determinations for all Medicaid eligibility groups, beginning January 1, 2014.

In addition, states that elected the option to provide a presumptive-eligibility period to children or pregnant women are permitted to provide a presumptive-eligibility period for (1) the ACA Medicaid expansion group, (2) the mandatory coverage group for individuals currently or formerly in foster care who are under the age of 26, (3) low-income families eligible under Section 1931 of the Social Security Act (SSA), or (4) the state option for coverage for individuals with income that exceeds 133% of the federal poverty level (FPL).

Explanation of AHCA Provision

Section 111(1)(A) would no longer allow hospitals that participate in Medicaid to elect to make presumptive-eligibility determinations effective January 1, 2020, and would terminate hospitals' ability to make such an election after that date by modifying SSA Section 1902(a)(47)(B).

On January 1, 2020, Section 111(3) would terminate the authority of certain specified states (i.e., those that elected to provide a presumptive-eligibility period to children or pregnant women) to elect to make presumptive-eligibility determinations for the ACA Medicaid expansion group or the state option for coverage for individuals with income that exceeds 133% of FPL by modifying SSA Section 1920(e). The provision would not modify the authority of such states to elect to make presumptive-eligibility determinations for the mandatory foster care group under the age of

26 or for low-income families eligible under SSA Section 1931 based on a preliminary determination of likely Medicaid eligibility by a specified Medicaid provider.

Section 111(1)(B). Federal Payments to States: Stairstep Children

Current Law

Eligibility for Medicaid is determined by federal and state law. States set individual eligibility criteria within federal standards. Individuals must meet both categorical (e.g., elderly, individuals with disabilities, children, pregnant women, parents, certain non-elderly childless adults) and financial (i.e., income and sometimes asset limits) criteria. In addition, individuals must meet federal and state requirements regarding residency, immigration status, and documentation of U.S. citizenship. Some eligibility groups are mandatory, meaning all states with a Medicaid program must cover them; others are optional. States are permitted to apply to the Centers for Medicare & Medicaid Services (CMS) for a waiver of federal law to expand health coverage beyond the mandatory and optional groups listed in federal statute.

The ACA changed the mandatory Medicaid income eligibility level for poverty-related children aged 6 through 18 from 100% of FPL to 133% of FPL, beginning January 1, 2014. These children sometimes are referred to as *stairstep children*. For the 21 states that transitioned these children from the State Children's Health Insurance Program (CHIP) to Medicaid due to the ACA, coverage continues to be financed with states' CHIP annual allotment funding (i.e., state-specific annual limits) at the higher enhanced federal medical assistance percentage (E-FMAP), which is the CHIP federal matching rate.

Explanation of AHCA Provision

Section 111(1)(B) would repeal the stairstep children provision by amending SSA Section 1902(l)(2)(C) to specify the end date to the requirement to cover children up to 133% of FPL effective December 31, 2019. After that date, states would still be required to cover children in this group with household incomes of up to 100% of FPL.

Section 111(2). Federal Medicaid Matching Rate for Community First Choice Option

Current Law

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 *federal medical assistance percentage* (FMAP) rate, which varies by state and is designed so that the federal government pays a larger portion of Medicaid costs in states with lower per capita incomes relative to the national average (and vice versa for states with higher per capita incomes).[16] Exceptions to the regular FMAP rate have been made for certain states, situations, populations, providers, and services.

The ACA Section 2401 established the Community First Choice option under SSA Section 1915(k), which allows states to offer community-based attendant services and supports as an

[16] For more information about the federal medical assistance percentage (FMAP) rate, see CRS Report R43847, *Medicaid's Federal Medical Assistance Percentage (FMAP)*.

optional Medicaid state plan benefit and receive a six-percentage-point increase to the FMAP rate for covered services. The Community First Choice option provides community-based attendant services and supports to assist eligible aged and disabled Medicaid beneficiaries in accomplishing activities of daily living, instrumental activities of daily living, and health-related tasks. In addition, states may provide transition expenses when a beneficiary moves from a nursing facility to a community-based setting or other services that increase independence. According to CMS, eight states have received approval for this option (California, Connecticut, Maryland, Montana, New York, Oregon, Texas, and Washington) as of January 2017. CMS also is providing technical assistance to states that are considering offering the Community First Choice option.[17]

Explanation of AHCA Provision

Section 111(2) would repeal the increased FMAP rate for the Community First Choice option on January 1, 2020, by modifying SSA Section 1915(k)(2).

Section 112. Repeal of Medicaid Expansion

Section 112(a)(1)(A)(i) and (iii). ACA Medicaid Expansion

Current Law

Eligibility for Medicaid is determined by federal and state law. States set individual eligibility criteria within federal standards. Individuals must meet both categorical (e.g., elderly, individuals with disabilities, children, pregnant women, parents, certain non-elderly childless adults) and financial (i.e., income and sometimes asset limits) criteria. In addition, individuals must meet federal and state requirements regarding residency, immigration status, and documentation of U.S. citizenship. Some eligibility groups are mandatory, meaning all states with a Medicaid program must cover them; others are optional. States are permitted to apply to the CMS for a waiver of federal law to expand health coverage beyond the mandatory and optional groups listed in federal statute.

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*, finding that the enforcement mechanism for the ACA Medicaid expansion violated the Constitution, which effectively made the ACA Medicaid expansion optional for states. On January 1, 2014, 24 states and the District of Columbia implemented the ACA Medicaid expansion. Since then, seven additional states have decided to implement the expansion.[18]

Explanation of AHCA Provision

Section 112(a)(1)(A)(i) and (iii) would codify the ACA Medicaid expansion as optional for states after December 31, 2019, by specifying the end date of the ACA Medicaid expansion (at SSA

[17] Centers for Medicare & Medicaid Services (CMS), Medicaid & CHIP, *Strengthening Coverage, Improving Health, January 2017*, p. 24, at https://www.medicaid.gov/medicaid/program-information/downloads/accomplishments-report.pdf.

[18] For more information about the ACA Medicaid expansion, see CRS In Focus IF10399, *Overview of the ACA Medicaid Expansion*.

Section 1902(a)(10)(A)(i)(VIII)) as December 31, 2019, and adding a new Medicaid optional eligibility group (at SSA Section 1902(a)(10)(a)(ii)(XXIII)) beginning January 1, 2020.

Section 112(a)(1)(A)(ii). State Option for Coverage for Non-elderly Individuals with Income That Exceeds 133% of FPL

Current Law

In addition to the ACA Medicaid expansion, 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 (or waiver), effective January 1, 2014. As of January 2017, the District of Columbia is the only state that has implemented this option.

Explanation of AHCA Provision

Section 112(a)(1)(A)(ii) would repeal the state option to extend coverage to non-elderly individuals above 133% of FPL (SSA Section 1902(a)(10)(A)(ii)(XX)) by specifying an end date of December 31, 2017.

Section 112(a)(1)(B). Existing ACA Definition of Expansion Enrollees and New Definition for Grandfathered Expansion Enrollees

Current Law

Under the ACA, an *expansion enrollee* is defined as an individual who is a non-elderly, nonpregnant adult with annual income at or below 133% of FPL and who is not entitled to or enrolled for benefits in Medicare Part A or enrolled for benefits under Medicare Part B.

Explanation of AHCA Provision

Section 112(a)(1)(B) would incorporate the existing ACA expansion enrollee definition for the purposes of the new optional Medicaid eligibility group for expansion enrollees. It also 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 (i.e., SSA Section 1902(a)(10)(A)(i)(VIII)), including provisions related to payments to states, medical assistance, alternative benefit plan coverage, presumptive eligibility, and so on.

Section 112(a)(2)(A). *Newly Eligible* Federal Matching Rate

Current Law

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). The newly eligible individuals are defined as expansion enrollees who would not have been eligible for Medicaid in the state as of December 1, 2009 (or were eligible under a waiver but were not enrolled because of limits or caps on waiver enrollment). States received 100% federal matching rate (i.e., full federal financing) for the cost of providing Medicaid

coverage to newly eligible individuals, from CY2014 through CY2016. The rate for newly eligible individuals phases down to 95% in CY2017, 94% in CY2018, 93% in CY2019, and 90% for CY2020 and subsequent years.[19]

Explanation of AHCA Provision

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, after December 31, 2019, 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).

Section 112(a)(2)(B). *Expansion State* Federal Matching Rate

Current Law

The ACA added a few FMAP exceptions, including the *expansion state* federal matching rate, which is the federal matching rate available for expansion enrollees without dependent children in expansion states who were eligible for Medicaid on March 23, 2010.[20]

The expansion state federal matching rate varies from state to state. The formula used to calculate the expansion state federal matching rates is based on each state's regular FMAP rate and annual transition percentages set in statute.[21] The annual transition percentages for the expansion state matching rate formula are 50% in CY2014, 60% in CY2015, 70% in CY2016, 80% in CY2017, 90% in CY2018, and 100% for CY2019 and subsequent years.

Table 4 shows the range for the expansion state matching rate. From CY2014 through CY2018, the expansion state federal matching rate is lower than the newly eligible federal matching rate and higher than each state's regular FMAP rate. The expansion state federal matching rate phases up until CY2019, when the expansion state federal matching rate will match the newly eligible federal matching rate for CY2019 and subsequent years.

[19] For more information about the newly eligible matching rate, CRS In Focus IF10399, *Overview of the ACA Medicaid Expansion*.

[20] This definition of expansion state was established prior to the Supreme Court decision making the ACA Medicaid expansion optional for states. In this context, *expansion state* refers to states that already had implemented (or partially implemented) the ACA Medicaid expansion at the time the ACA was enacted. Specifically, expansion states are defined as those that, as of March 23, 2010 (the ACA's date of enactment), had provided health benefits coverage meeting certain criteria statewide to parents with dependent children and adults without dependent children up to at least 100% of the federal poverty level (FPL).

[21] Expansion state FMAP formula = [regular FMAP + (newly eligible FMAP – regular FMAP) × transition percentage equal to 50% in CY2014, 60% in CY2015, 70% in CY2016, 80% in CY2017, 90% in CY2018, and 100% in CY2019 and subsequent years].

Table 4. Range of Expansion State Matching Rate

	2014	2015	2016	2017	2018	2019	2020+
Certain Individuals in Expansion States	75%-92%	80%-93%	85%-95%	86%-93%	90%-93%	93%	90%

Source: Prepared by CRS.

Notes: For the calculation of the expansion state matching rates, the lower bound is for a state with a regular federal medical assistance percentage (FMAP) rate of 50% (which is the statutory minimum) and the upper bound is for a state with a regular FMAP rate of 83% (which is the statutory maximum).

Explanation of AHCA Provision

Section 112(a)(2)(B) would amend SSA Section 1905(z)(2) by amending the formula for the expansion state matching rate so that the matching rate would stop phasing up after CY2017 and the transition percentage would remain at the CY2017 level for each subsequent year. In addition, after December 31, 2019, 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

Current Law

As an alternative to providing all the mandatory and selected optional benefits under traditional Medicaid, the Deficit Reduction Act of 2005 (DRA; P.L. 109-171) gave states the option to enroll state-specified groups (with exceptions for selected special-needs subgroups) in what previously was referred to as benchmark or benchmark-equivalent coverage but currently is called *alternative benefit plans* (ABPs). States that choose to implement the ACA Medicaid expansion are required to provide ABP coverage (with exceptions for selected special-needs subgroups), rather than traditional Medicaid, to the individuals eligible for Medicaid through the ACA Medicaid expansion. In addition, states have the option to provide ABP coverage to other subgroups.

The ACA made significant changes to both ABP design and ABP requirements. Among these changes, the ACA required such packages to provide at least the 10 essential health benefits (EHB), which are (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.

Explanation of AHCA Provision

Section 112(b) would specify that SSA Section 1937(b)(5) would not apply after December 31, 2019. This means that Medicaid ABP coverage would no longer be required to include the EHB after that date.

Section 113. Elimination of Disproportionate Share Hospital Cuts

Current Law

SSA Section 1923 requires states to make Medicaid disproportionate share hospital (DSH) payments to hospitals treating large numbers of low-income patients.[22] This provision is intended to recognize the disadvantaged financial situation of those hospitals because low-income patients are more likely to be uninsured or Medicaid enrollees. Hospitals often do not receive payment for services rendered to uninsured patients, and Medicaid provider payment rates generally are lower than the rates paid by Medicare and private insurance.

Whereas most federal Medicaid funding is provided on an open-ended basis, federal Medicaid DSH funding is capped. Each state receives an annual DSH allotment, which is the maximum amount of federal matching funds that each state is permitted to claim for Medicaid DSH payments.

The ACA reduced the number of uninsured individuals in the United States through its health insurance coverage provisions. Built on the premise that with fewer uninsured individuals there should be less need for Medicaid DSH payments, the ACA included a provision directing the HHS Secretary to make aggregate reductions in Medicaid DSH allotments for FY2014 through FY2020. However, multiple subsequent laws have amended these reductions. Under current law, the aggregate reductions to the Medicaid DSH allotments are to impact FY2018 through FY2025. After FY2025, allotments will be calculated as though the reductions never occurred, which means the allotments will include the inflation adjustments for the years during the reductions.[23]

Explanation of AHCA Provision

Section 113 would amend SSA Section 1923(f) by eliminating the Medicaid DSH allotment reductions after FY2019. This would mean that the aggregate reductions to the Medicaid DSH allotments would impact FY2018 and FY2019. Under Section 113, after FY2019, allotments would be calculated as though the reductions never occurred, which means the allotments would include the inflation adjustments for the years during the reductions.

In addition, non-expansion states would be exempt from the ACA Medicaid DSH allotment reductions. For this provision, *expansion state* would be defined as a state that provides eligibility under the ACA Medicaid expansion or the state option for coverage for individuals with incomes that exceed 133% of FPL as of July 1 of the previous fiscal year. A *non-expansion state* would be defined as a state that is not an expansion state.

[22] For more information about Medicaid disproportionate share hospital (DSH) payments, see CRS Report R42865, *Medicaid Disproportionate Share Hospital Payments*.

[23] For more information about the ACA Medicaid DSH reductions, see CRS In Focus IF10422, *Medicaid Disproportionate Share Hospital (DSH) Reductions*.

Section 114. Reducing State Medicaid Costs

Section 114(a). Letting States Disenroll High-Dollar Lottery Winners

Current Law

Internal Revenue Code (IRC) Section 36B, as established under the ACA, provides premium assistance tax credits for individuals to purchase coverage through the health insurance exchanges, among other purposes. IRC Section 36B includes a definition of household income, based on modified adjusted gross income (MAGI), which is used to determine eligibility for various federal health programs, including Medicaid. As of January 1, 2014, MAGI rules are used in determining eligibility for most of Medicaid's non-elderly populations,[24] including the ACA Medicaid expansion.

Medicaid's MAGI income-counting rule is set forth in law and regulation. Under the Medicaid MAGI counting rule, the state looks at each individual's MAGI, deducts 5%, which the law provides as a standard disregard for individuals at the highest income limit for coverage, and compares that income to the income standards set by the state in coordination with CMS.

For Medicaid, MAGI is defined as the IRC's adjusted gross income (AGI, which reflects a number of deductions, including trade and business deductions, losses from sale of property, and alimony payments) increased by certain types of income (e.g., tax-exempt interest income received or accrued during the taxable year and the nontaxable portion of Social Security benefits). In addition, under Medicaid regulations certain types of income are subtracted (e.g., certain scholarships and fellowships) to arrive at MAGI. Also under Medicaid regulations, irregular income received as a lump sum (e.g., state income tax refund, lottery or gambling winnings, one-time gifts or inheritances) is counted as income only in the month received. In addition to specifying the types of household income that must be considered during eligibility determinations, the regulations also define *household*. The income of any person defined as a part of an individual's household must be counted when determining that individual's income level for purposes of a Medicaid eligibility determination.

Medicaid program regulations make a distinction with regard to the budget period when determining income eligibility for applicants and new enrollees as compared to eligibility redeterminations for current enrollees. Specifically, income eligibility for applicants and new enrollees is based on current monthly household income. When *redetermining* eligibility for current Medicaid enrollees, states are permitted to use current monthly income and family size or projected annual income and family size for the remaining months of the calendar year. For states that choose the latter measure when redetermining eligibility, Medicaid requires the applicant to predict income and household size for the remaining months of the calendar year.

[24] Under the ACA, certain groups are exempt from income eligibility determinations for Medicaid based on modified adjusted gross income (MAGI). Prior law's income determination rules under Medicaid will continue to be used for determining eligibility for the following groups: (1) individuals who are eligible for Medicaid through another federal or state assistance program (e.g., foster care children and individuals receiving Supplemental Security Income [SSI]), (2) the elderly, (3) certain disabled individuals who qualify for Medicaid on the basis of being blind or disabled without regard to whether the individual is eligible for SSI, (4) the medically needy, and (5) enrollees in a Medicare Savings Program (e.g., qualified Medicare beneficiaries for whom Medicaid pays the Medicare premiums or coinsurance and deductibles). In addition, MAGI does not affect eligibility determinations through Express Lane enrollment (to determine whether a child has met Medicaid or Children's Health Insurance Program [CHIP] eligibility requirements), for Medicare prescription drug low-income subsidies, or for determinations of eligibility for Medicaid long-term services and supports (LTSS).

Explanation of AHCA Provision

Section 114(a) would amend SSA Section 1902(a)(17) to require states to consider "qualified lottery winnings" and/or "qualified lump sum income" received by an individual on or after January 1, 2020, when determining eligibility for Medicaid based on MAGI for each such individual. Such income would *not* be counted as household income when determining Medicaid eligibility for other members (aside from the individual's spouse) of the individual's household.

Winnings and/or income in an amount less than $80,000 would be considered in the month that such winnings and/or income are received. Amounts greater than or equal to $80,000 but less than $90,000 would be prorated over a period of two months. Amounts greater than or equal to $90,000 but less than $100,000 would be prorated over a period of three months. For purpose of prorating winnings and/or income in amounts greater than or equal to $100,000, one additional month would be added for each increment of $10,000 received, not to exceed 120 months (or 10 years) for winnings and/or income of $1,260,000 or more.

The provision would establish a state option for a hardship exemption for individuals for whom the denial of Medicaid eligibility based on such income would cause an undue medical or financial hardship as determined by criteria established by the HHS Secretary. In addition, it would require states to inform individuals in advance of their loss of Medicaid eligibility, as well as the date that such individual would be permitted to reapply.

The provision would define *qualified lottery winnings* as winnings (including amounts awarded as a lump-sum payment) from a state-conducted sweepstakes, lottery, or pool, or from a lottery operated by a multistate or multi-jurisdictional lottery association. The bill would define *qualified lump-sum* income as income received as a lump sum (1) from monetary winnings from gambling (as defined by the HHS Secretary and including monetary winnings from gambling activities described in Section 1955(b)(4) of Title 18 of the *United States Code*) or (2) as liquid assets from the estate of a deceased individual (as defined in Section 1917(b)(4) of SSA). The bill would specify that states may recover lottery winnings awarded to the individual to pay for Medicaid medical assistance furnished to the individual.

Section 114(b). Repeal of Retroactive Eligibility

Current Law

Eligibility for Medicaid is determined by federal and state law. States set individual eligibility criteria within federal standards. Once an individual is determined eligible for Medicaid, coverage is effective either on the date of application or the first day of the month of application. Benefits must be covered retroactively for services provided in or after the third month 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 (or had someone applied for him or her), regardless of whether the individual is alive when application for Medicaid is made. Coverage generally stops at the end of the month in which a person no longer meets the requirements for eligibility.

Explanation of AHCA Provision

Section 114(b) would amend SSA Sections 1902(a)(34) and 1905(a) to limit the effective date for retroactive coverage of Medicaid benefits to the month in which the applicant applied. This provision would apply to Medicaid applications made (or deemed to be made) on or after October 1, 2017.

Section 114(c). Updating Allowable Home-Equity Limits in Medicaid

Current Law

DRA established SSA Section 1917(f), which required limitations on the amount of home equity that an applicant could shield from asset limits that otherwise would disqualify the applicant from Medicaid eligibility for nursing facility services or other Medicaid-covered long-term services and supports (LTSS). Prior to enactment of the DRA, Medicaid deferred to asset-counting rules under the Supplemental Security Income (SSI) program and excluded the entire value of an applicant's home for the purposes of Medicaid LTSS eligibility. Under current law, Medicaid bars eligibility if the applicant's equity interest in the home exceeds a statutorily determined limit, which is annually adjusted. Initially, the minimum and maximum home-equity dollar limits specified in statute were $500,000 and $750,000, respectively. Beginning in 2011, these dollar amounts were updated annually to reflect the percentage increase in the Consumer Price Index for All Urban Consumers (CPI-U), rounded to the nearest $1,000. In 2017, the minimum home-equity limit is $560,000. However, a state may elect to substitute an amount that exceeds $560,000 but does not exceed $840,000 in 2017. In doing so, states may choose to apply a higher home-equity limit to specific geographic areas within a state. Individuals who have a spouse, child under the age of 21, or child who is blind or disabled (under SSI or as defined by SSA Section 1614) and lawfully residing in the individual's home are able to exempt the home as a countable asset. Also, states can choose not to apply this rule if the state determines that doing so would cause an undue hardship in a given case. In addition to the District of Columbia, the following 10 states choose a home-equity limit that is above the minimum amount: California, Connecticut, Hawaii, Idaho, Maine, Massachusetts, New Jersey, New Mexico, New York, and Wisconsin.[25]

Explanation of AHCA Provision

Section 114(c) would repeal the authority for states to elect to substitute a higher home-equity limit amount that is above the statutory minimum amount (SSA Section 1917(f)(1)(B)). It would apply to Medicaid eligibility determinations that are made more than 180 days after enactment. In situations where the HHS Secretary determines that state legislation would be required to amend the state plan, then states would have additional time to comply with these requirements.

Section 115. Safety-Net Funding for Non-expansion States

Current Law

On January 1, 2014, when the ACA Medicaid expansion went into effect, 24 states and the District of Columbia included the expansion as part of their Medicaid programs. Since then, seven additional states have implemented the expansion at different times: Michigan (April 1, 2014), New Hampshire (July 1, 2014), Pennsylvania (January 1, 2015), Indiana (February 1, 2015), Alaska (September 1, 2015), Montana (January 1, 2016), and Louisiana (July 1, 2016). For the most part, states establish their own payment rates for Medicaid providers. Federal statute requires that these rates are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that covered benefits will be available to Medicaid

[25] For information on state home-equity limits, see Appendix Table 7 in M. O'Malley Watts et al., *Medicaid Financial Eligibility for Seniors and People with Disabilities in 2015*, Kaiser Family Foundation, March 1, 2016, at http://kff.org/report-section/medicaid-financial-eligibility-for-seniors-and-people-with-disabilities-in-2015-appendix/.

enrollees at least to the same extent they are available to the general population in the same geographic area. In some cases, states make supplemental payments to Medicaid providers that are separate from, and in addition to, the standard payment rates for services rendered to Medicaid enrollees. Medicaid DSH payments are one type of supplemental payment, and federal statute requires that states make Medicaid DSH payments to hospitals treating large numbers of low-income patients.

Explanation of AHCA Provision

Section 115 would add a new Section 1923A to the SSA to establish safety-net funding for non-expansion states. For FY2018 through FY2022, each state (defined as the 50 states and the District of Columbia) that has not implemented the ACA Medicaid expansion (through the state plan or a waiver) as of July 1 of the preceding year may receive safety-net funding to adjust payment amounts for Medicaid providers. For these payment adjustments using the safety-net funding, non-expansion states would receive an increased matching rate of 100% for FY2018 through FY2021 and 95% for FY2022. The maximum amount of safety-net funding for all non-expansion states would be $2.0 billion for each year, for a total of $10 billion from FY2018 through FY2022. Each non-expansion state's allotment for each year would be determined according to the number of individuals in the state with income below 138% of FPL in 2015 relative to the total number of individuals with income below 138% of FPL for all the non-expansion states in 2015. The 2015 American Community Survey one-year estimates as published by the Bureau of the Census would be used to determine the portion of each state's population that is below 138% of FPL.

The payment adjustments to providers may not exceed the provider's costs incurred to furnish health care services for Medicaid enrollees or the uninsured. The provider's costs would be determined by the Secretary, and the costs would be net of other Medicaid payments and payments from uninsured patients. If a non-expansion state implements the ACA Medicaid expansion, the state would no longer be treated as a non-expansion state for safety-net funding for subsequent years.

Section 116. Providing Incentives for Increased Frequency of Eligibility Redeterminations

Section 116(a). Frequency of Eligibility Redeterminations

Current Law

As of January 1, 2014, SSA Section 1902(e)(14) requires states to determine income eligibility based on MAGI for most of Medicaid's non-elderly populations, including the ACA Medicaid expansion and the state option for coverage for individuals with income that exceeds 133% of FPL. 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.

Explanation of AHCA Provision

Beginning October 1, 2017, Section 116(a) would amend SSA Section 1902(e)(14) to require states to redetermine Medicaid eligibility at least every six months (or sooner in the case where the Medicaid agency receives information about a change in a beneficiary's circumstances that

may affect eligibility) for individuals eligible for Medicaid through (1) the ACA Medicaid expansion or (2) the state option for coverage for individuals with income that exceeds 133% of FPL.

Section 116(b). Increased Administrative Matching Percentage for Eligibility Redeterminations

Current Law

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, which varies by state and is designed so that the federal government pays a larger portion of Medicaid costs in states with lower per capita incomes relative to the national average (and vice versa for states with higher per capita incomes). 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.

Explanation of AHCA Provision

Section 116(b) would increase the federal match for the administrative activities attributable to carrying out the increased frequency of Medicaid eligibility redeterminations required under Section 116(a) by five percentage points. This increased federal match would be available from October 1, 2017, through December 31, 2019.

Section 117. Permitting States to Apply a Work Requirement for Nondisabled, Non-elderly, Nonpregnant Adults Under Medicaid

Section 117(a). State Option for Work Requirements

Current Law

Medicaid is a program that pays for certain medical services furnished to low-income individuals. It is jointly financed by the federal government and participating states. Generally, participating states must have a state medical assistance plan that complies with SSA Section 1902.[26] Among other things, Section 1902(a)(10)(A)(i) identifies specific categories of beneficiaries that must be covered under a state plan, as well as a requirement in Section 1902(a)(10)(B) that medical assistance offered to any individual in such a mandatory eligibility group may not be less in amount, duration, or scope than assistance made available to any other person under the state plan.

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 1931 authorizes states to terminate Temporary Assistance for Needy Families (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.

[26] SSA §1902 sets forth the requirements for state plans for medical assistance.

Explanation of AHCA Provision

Section 117(a) would modify SSA Section 1902 by adding a new Section at 1902(oo) to permit states, effective October 1, 2017, to require nondisabled, non-elderly, nonpregnant adults to satisfy a work requirement as a condition for receipt of Medicaid medical assistance. The provision would define *work requirements* as an individual's participation in work activities for a specified period of time as administered by the state. The provision would incorporate, by reference, the definition of work activities as they appear in SSA Section 407(d) under Part A of Title IV (Block Grants to States for TANF), and would include

- unsubsidized employment;
- subsidized private-sector employment;
- subsidized public-sector employment;
- work experience (including work associated with the refurbishing of publicly assisted housing) if sufficient private-sector employment is not available;
- on-the-job training;
- job search and job readiness assistance;
- community service programs;
- vocational educational training (not to exceed 12 months with respect to any individual);
- job skills training directly related to employment;
- education directly related to employment, in the case of a recipient who has not received a high school diploma or a certificate of high school equivalency;
- satisfactory attendance at secondary school or a course of study leading to a certificate of general equivalence, in the case of a recipient who has not completed secondary school or received such a certificate; and
- the provision of child-care services to an individual who is participating in a community service program.

Participating states would be required to exempt the following groups from participation in the work requirement: (1) pregnant women (for the duration of the pregnancy and through the end of the month in which the 60-day postpartum period ends); (2) individuals under 19 years of age; (3) an individual who is the sole parent or caretaker relative in the family of (a) a child who is under the age of 6 or (b) a child with disabilities; or (4) an individual who is less than 20 years of age, who is married or a head of household and who (a) maintains satisfactory attendance at secondary school or the equivalent or (b) participates in education directly related to employment.

Section 117(b). Increase in Matching Rate for Implementation of Work Requirement

Current Law

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, which varies by state and is designed so that the federal government pays a larger portion of Medicaid costs in states with lower per capita incomes relative to the national average (and vice versa for states with higher per capita incomes). 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.

Explanation of AHCA Provision

Section 117(b) would increase the federal match for administrative activities to implement the work requirement under Section 117(a) by five percentage points in addition to any other increase to such federal matching rate.

Subtitle C—Per Capita Allotment for Medical Assistance

Section 121. Per Capita Allotment for Medical Assistance

Current Law

Medicaid is a means-tested entitlement program that finances the delivery of primary and acute medical services as well as long-term services and supports. Medicaid is a federal and state partnership. The states are responsible for administering their Medicaid programs, and Medicaid is jointly financed by the federal government and the states. In FY2015, Medicaid is estimated to have provided health care services to 70 million individuals at a total cost of $552 billion (including federal and state expenditures).[27] Participation in Medicaid is voluntary, though all states, the District of Columbia, and the territories choose to participate. The federal government sets some basic requirements for Medicaid, and states have the flexibility to design their own version of Medicaid within the federal government's basic framework. In addition, there are several waiver and demonstration authorities that allow states to operate their Medicaid programs outside of federal rules.

States incur Medicaid costs by making payments to service providers (e.g., for beneficiaries' doctor visits) and performing administrative activities (e.g., making eligibility determinations). The federal government reimburses states for a share of each dollar spent in accordance with their federally approved Medicaid state plans. The federal government's share of most Medicaid expenditures is called the FMAP. Generally determined annually, the FMAP formula is designed so that the federal government pays a larger portion of Medicaid costs in states with lower per capita incomes relative to the national average (and vice versa for states with higher per capita incomes). Exceptions to the regular FMAP rate have been made for certain states, situations, populations, providers, and services.

After a state has made Medicaid expenditures, it can draw down federal matching funds. CMS makes quarterly grant awards to states to cover the federal share of Medicaid expenditures based on the quarterly estimates states submit to CMS on the Form CMS-37. Each state must submit a Form CMS-64 no later than 30 days after the end of each quarter with the state's accounting of actual recorded expenditures. CMS then reviews the expenditures reported on the Form CMS-64 to reconcile the states' estimates from the CMS-37 with the actual documented expenditures to ensure that the reported expenditures are allowable under the Medicaid statute and the Medicaid state plan.

[27] Christopher J. Truffer, Christian J. Wolfe, and Kathryn E. Rennie, *2015 Actuarial Report on the Financial Outlook for Medicaid*, Office of the Actuary, CMS, U.S. Department of Health & Human Services (HHS), 2016.

Medicaid is an entitlement for both states and individuals. The Medicaid entitlement to states ensures that, so long as states operate their programs within the federal requirements, states are entitled to federal Medicaid matching funds. Medicaid is also an individual entitlement, which means that anyone eligible for Medicaid under his or her state's eligibility standards is guaranteed Medicaid coverage. Federal Medicaid funding to states is open-ended.[28]

Explanation of AHCA Provision

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 amounts 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. States would elect this option for a 10-year period.

Section 121(1) would add references to the new SSA Section 1903A (explained below) in SSA Section 1903, which is the section of statute that lays out how the federal government makes payments to states for the Medicaid program.

Section 121(2) would add a new SSA Section 1903A. The following provides a description of what would be the new SSA Section 1903A.

Section (a). Application of Per Capita Cap on Payments for Medical Assistance Expenditures

Under Section (a) of the new SSA Section 1903A, beginning in FY2020, if a state has excess aggregate medical assistance expenditures for a fiscal year, the state's quarterly Medicaid payments from the federal government for the following fiscal year would be reduced by one-quarter of the excess aggregate medical assistance payments for the previous fiscal year. This section would be applicable to the 50 states and the District of Columbia.

Excess aggregate medical assistance expenditures for the state and fiscal year would be the amount by which the adjusted total medical assistance expenditures (defined under Section (b) of the new SSA Section 1903A) exceeds the amount of target total medical assistance expenditures (defined under Section (c) of the new SSA Section 1903A).

Excess aggregate medical assistance payments would be the product of the excess aggregate medical assistance expenditures and the federal average medical assistance matching percentage.

The *federal average medical assistance matching percentage* for each state and fiscal year would be the ratio of (1) the amount of federal payments made to the state under SSA Section 1903(a)(1) for medical assistance expenditures in the fiscal year prior to any potential reduction applied

[28] For more information about Medicaid financing and expenditures, see CRS Report R42640, *Medicaid Financing and Expenditures*.

under this section to (2) the amount of the state's total medical assistance expenditures for the fiscal year (including both federal and state expenditures).

Section (b). Adjusted Total Medical Assistance Expenditures

Under Section (b), there would be two formulas for *adjusted total medical assistance expenditures*: one formula for FY2016 and another formula for FY2019 and subsequent years. Both formulas for adjusted total medical assistance expenditures would exclude expenditures for Medicaid DSH payments under SSA Section 1923, Medicare cost-sharing payments under SSA Section 1905(p)(3), and safety-net provider payment adjustments in non-expansion states.[29]

The FY2016 formula for adjusted total medical assistance expenditures would be the product of (1) the amount of medical assistance expenditures for a state reduced by the amount of any excluded expenditures in FY2016 and (2) the *1903A FY2016 population percentage*, which is the HHS Secretary's calculation of the percentage of actual medical assistance expenditures attributable to 1903A enrollees in a state in FY2016 (discussed below, under Section (e)).

The FY2019 or subsequent fiscal years formula for adjusted total medical assistance expenditures for a state and fiscal year would be the amount of medical assistance expenditures attributable to 1903A enrollees reduced by any excluded expenditures.

Medical assistance expenditures would be defined as medical assistance payments as reported under the medical services category on the Form CMS-64 quarterly expense report (or successor to such form) for which payment is made pursuant to SSA Section 1903(a)(1).

The language specifies that the medical assistance expenditures for FY2019 and subsequent years would include non-DSH supplemental payments (including certain waiver expenditures for delivery system reform incentive pools, uncompensated care pools, and designated state health programs). The medical assistance expenditures for FY2019 and subsequent years would not include expenditures for the Vaccines for Children program.

Section (c). Target Total Medical Assistance Expenditures

Under Section (c) of the new SSA Section 1903A, *target total medical assistance expenditures* for a state and fiscal year would be the sum of the following formula for each 1903A enrollee category (defined under Section (e) of the new SSA Section 1903A): (1) target per capita medical assistance expenditures for the enrollee category times (2) the number of 1903A enrollees for such 1903A enrollee category.

For FY2020, the *target per capita medical assistance expenditures* for each 1903A enrollee category would be the provisional FY2019 target per capita amount (defined in Section (d) of the new SSA Section 1903A) for such enrollee category for the state increased by the applicable annual inflation factor. For subsequent years, the target per capita medical assistance expenditures for each 1903A enrollee category would be the target per capita medical assistance expenditures for the previous year for such enrollee category for the state increased by the applicable annual inflation factor.

The applicable inflation factor would vary by 1903A enrollee category. For the children; expansion enrollee; and other non-elderly, nondisabled, non-expansion adult categories, the applicable inflation factor would be the percentage increase in the medical care component of the CPI-U from September of the previous fiscal year to September of the fiscal year involved. For the elderly and disabled categories, the applicable inflation factor would be the percentage

[29] AHCA §115 would add a new §1923A to the SSA to establish safety-net funding for non-expansion states.

increase in the medical care component of the CPI-U from September of the previous fiscal year to September of the fiscal year involved plus one percentage point.

Beginning in FY2020, there would be a decrease in the target total medical assistance expenditures for states that (1) have a Medicaid DSH allotment in FY2016 that was more than six times the national average and (2) require political subdivisions within the state to contribute funds toward medical assistance or other expenditures under Medicaid (including under a waiver) for the fiscal year involved. The decrease would be the amount that political subdivisions in the state are required to contribute under Medicaid without reimbursement from the state other than the following required contributions: (1) from political subdivisions with a population of more than 5 million that impose local income tax upon their residents and (2) for certain administrative expenses required to be paid by the political subdivision as of January 1, 2017.[30]

Section (d). Calculation of FY2019 Provisional Target Amount for Each 1903A Enrollee Category

The HHS Secretary would calculate for each state the provisional FY2019 per capita target amounts for each 1903A enrollee category. The formula for the *provisional FY2019 per capita target amounts* would be the average per capita medical assistance expenditures for the state for FY2019 for such enrollee category multiplied by the ratio of (1) the product of the FY2019 average per capita amount for the state and the number of 1903A enrollees for the state in FY2019 to (2) the amount of FY2019 adjusted total medical assistance expenditures for the state. This calculation would be subject to treatment of states expanding coverage after FY2016 (discussed in Section (f) of the new SSA Section 1903A).

The *average per capita medical assistance expenditures* for FY2019 for each 1903A enrollee category would be the FY2019 adjusted total medical assistance expenditures for the state divided by the number of 1903A enrollees for the state in FY2019. The FY2019 adjusted total medical assistance expenditures would exclude non-DSH supplemental expenditures (including certain waiver expenditures for delivery system reform incentive pools, uncompensated care pools, and designated state health programs) for FY2019 and would be increased by the *non-DSH supplemental payment percentage* for FY2016, which is the ratio of

- the total amount of non-DSH supplemental payments for FY2016 to
- adjusted total medical assistance expenditures for FY2016.

For each state, the FY2019 *average per capita amount* would be the FY2016 average per capita medical assistance expenditures increased by the percentage increase in the medical care component of the CPI-U from September 2016 to September 2019. The *FY2016 average per capita medical assistance expenditures* would be the amount of the FY2016 adjusted total medical assistance expenditures (discussed in Section (b)) divided by the number of 1903A enrollees for the state in FY2016.

Section (e). 1903A Enrollee; 1903A Enrollee Category

This section would define *1903A enrollees* as Medicaid enrollees (i.e., individuals eligible for medical assistance under Medicaid and enrolled under the Medicaid state plan or waiver) for the month in a state that is not covered under the block grant option and does not fall into one of the following categories:

[30] This provision would impact only New York because New York is the only state with a Medicaid DSH allotment in FY2016 that was more than six times the national average and New York requires political subdivisions to contribute to Medicaid.

- individuals covered under a CHIP Medicaid expansion program (SSA Section 2101(a)(2)),
- individuals who receive medical assistance through an Indian Health Service facility (the third sentence under SSA Section 1905(b)),
- individuals entitled to medical assistance coverage of breast and cervical cancer treatment due to screening under the Breast and Cervical Cancer Early Detection Program (SSA Section 1902(a)(10)(A)(ii)(XVIII)), or
- the following partial-benefit enrollees:
  - unauthorized (illegally present) aliens eligible for Medicaid emergency medical care (SSA Section 1903(v)(2)),
  - individuals eligible for Medicaid family planning options (SSA Section 1902(a)(10)(A)(ii)(XXI)),
  - individuals infected with tuberculosis (SSA Section 1902(a)(10)(A)(ii)(XII)),
  - dual-eligible individuals eligible for coverage of Medicare cost sharing (SSA Section 1905(p)(3)(A)(i) or (ii)), or
  - individuals eligible for premium assistance (SSA Section 1906 or 1906A).

The enrollment count would be based on the average monthly amount reported through the Form CMS-64 as required under Section (h).

The *1903A enrollee categories* would be (1) elderly; (2) blind and disabled; (3) children; (4) expansion enrollees; and (5) other non-elderly, nondisabled, non-expansion adults.

Section (f). Special Payment Rules

Section (f) of the new SSA Section 1903A would provide special payment rules for (1) payments made under Section 1115 waivers or Section 1915 waivers, (2) states that did not have ACA Medicaid expansion in FY2016 and later implement the expansion, and (3) states that fail to satisfactorily submit data in accordance with Section (h)(1) of the new SSA Section 1903A.

Section (g). Recalculation of Certain Amounts for Data Errors

Section (g) of the new SSA Section 1903A would allow for the recalculation of certain amounts for data errors. Any adjustment under this section would not result in an increase of the target total medical assistance expenditures exceeding 2%.

Section (h). Required Reporting and Auditing of CMS-64 Data; Transitional Increase in Federal Matching Percentage for Certain Administrative Expenses

In addition to the required reporting for ACA Medicaid expansion on the Form CMS-64 report as of January 1, 2017, Section (h) of the new SSA Section 1903A would impose additional reporting requirements on states starting October 1, 2018. The additional reporting requirements would include data on medical assistance expenditures within categories of services and categories of enrollees (including each 1903A enrollee category and the enrollment categories excluded from the definition of 1903A enrollees). In addition, Section (h) would require reporting of the number of enrollees within each enrollee category. The HHS Secretary would determine the specific reporting requirements. The HHS Secretary also would conduct audits of each state's enrollment and expenditures reported on the Form CMS-64 for FY2016, FY2019, and subsequent years. These audits may be conducted on a representative sample, as determined by the HHS Secretary.

This section would provide a temporary increase to the federal matching percentage for the administrative activities related to improving data reporting systems. The temporary increases would impact expenditures on or after October 1, 2017, and before October 1, 2019.

Section (i). Flexible Block Grant Option for States

Section (i) would provide states with an option to receive block grant funding instead of per capita cap funding for a portion of their Medicaid program starting in FY2020.[31] States would elect this option for a 10-year period.

When a state uses the block grant option, the enrollees covered under the block grant would not be counted as 1903A enrollees for the per capita limitations. If the block grant option were not extended after the 10-year period, then the per capita limitations would apply as if the block grant option had never taken place.

The block grant funds could be used only to provide coverage of the health care assistance specified in the block grant state plan, and the coverage provided to the enrollees under the block grant option would be instead of other Medicaid coverage.

No payment would be made through the block grant option unless the state has an approved block grant state plan. A block grant state plan would be deemed approved by the HHS Secretary unless within 30 days of receipt the Secretary finds the plan incomplete or actuarially unsound. For the block grant state plan, some statutory requirements would not apply. These requirements are as follows:

- statewide operation, which requires a state pan to be in effect throughout the state, with certain exceptions (SSA Section 1902(a)(1));
- comparability, which means services available to the various population groups must be equal in amount, duration, and scope within a state (SSA Section 1902(a)(10)(B));
- reasonable standards for income and resources, meaning states must use eligibility standards and methodologies that are reasonable and consistent with the objectives of Medicaid, with certain exceptions (SSA Section 1902(a)(17)); and
- freedom of choice, which means enrollees must be able to obtain services from any qualified Medicaid provider that undertakes to provide services to them, with certain exceptions (SSA Section 1902(a)(23)).

The block grant state plan would be required to specify who is covered under the block grant, the conditions of eligibility for the block grant, and the services covered under the block grant. Under their block grant, states could cover either

- children[32] and other non-elderly, nondisabled, non-expansion adults[33] or
- only other non-elderly, nondisabled, non-expansion adults.

Under the block grant option, states would be able to specify the conditions of eligibility.[34] However, states would be required to provide coverage to pregnant women that are currently

[31] Block grants are a predetermined fixed amount of federal funding that does not adjust as enrollment increases or decreases.

[32] As defined in SSA §1903A (e)(2)(C) from AHCA §121.

[33] As defined in SSA §1903A (e)(2)(E) from AHCA §121.

required to be covered by Medicaid programs under SSA Section 1902(a)(10)(A)(i). If children are included in a state's block grant, the state would be required to provide coverage to children that are currently required to be covered by Medicaid programs under SSA Section 1902(a)(10)(A)(i) and SSA Section 1902(e)(4). This would include the poverty-related populations of pregnant women with income up to 133% of FPL, children aged 0 through 5 with income up to 133% of FPL, and children aged 6 through 18 with income up to 100% of FPL.[35] In addition, this would include deemed newborns, foster care children, and former foster care children up to the age of 26, among others.

States using the block grant option would be able to determine the types of items and services covered under the block grant (with the exception of some required services) in addition to the amount, duration, and scope for those services. Also, states would be able to specify the cost-sharing and delivery model for the block grant. This coverage could differ from the Medicaid coverage provided outside of the block grant, but states would be required to provide coverage of the following services under the block grant: 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 the age of 18.

The block grant funding for the initial fiscal year in the 10-year period would be equal to the sum of the following formula for each block grant category (i.e., children or other, non-elderly, nondisabled, non-expansion adults). The formula for each block grant category would be (1) the target per capita medical assistance expenditures for such state and fiscal year times (2) the number of 1903A enrollees for the state for FY2019 times (3) the federal average medical assistance percentage for the state for FY2019.[36] For subsequent fiscal years within the 10-year period, the block grant amount would be equal to the previous year's block grant amount increased by the annual increase in the CPI-U for the fiscal year involved.

Block grant funds for a fiscal year would remain available to a state in the succeeding fiscal year as long as the state is still using the block grant option in the succeeding fiscal year.

The federal payment to states under the block grant option would be made from the block grant amount. Quarterly payments would be made to states using the enhanced FMAP (E-FMAP) rate used for CHIP as the matching rate for block grant expenditures.[37] The state would be responsible for the balance of the funds necessary to carry out the block grant state plan.

As a condition of receiving funds under the block grant option, a state would be required to contract with an independent entity to conduct annual audits of its expenditures made with respect to the activities under the block grant to ensure that the block grant funds are used consistent with the block grant requirements. The audits would need to be made available to the HHS Secretary upon request.

(...continued)

[34] There is no statutory definition of *conditions of eligibility*, but in regulations, conditions of eligibility include, for example, income requirements, immigration status, and residency.

[35] AHCA §111(1)(B) would roll back the required income level for children aged 6 through 18 from 133% of FPL to 100% of FPL.

[36] *Target per capita medical assistance expenditures* as defined in SSA §1903A (c)(2) from AHCA §121.

[37] The enhanced federal medical assistance percentage (E-FMAP) rate is based on the FMAP rate, and the E-FMAP rate is calculated by reducing the state share under the regular FMAP rate by 30.0%. Statutorily, the E-FMAP can range from 65.0% to 85.0%. For more information about the E-FMAP, see CRS Report R43949, *Federal Financing for the State Children's Health Insurance Program (CHIP)*.

Subtitle D—Patient Relief and Health Insurance Market Stability

Section 131. Repeal of Cost-Sharing Subsidy

Current Law

ACA Section 1402 authorized subsidies to eligible individuals to reduce the cost-sharing expenses for health insurance plans offered in the individual market through health insurance exchanges.[38] Cost-sharing assistance is provided in two forms. The first form of assistance reduces the out-of-pocket limit applicable for a given exchange plan; the second reduces actual cost-sharing requirements (e.g., lowers the deductible or reduces a co-payment) applicable to a given exchange plan. Both types of assistance provide greater subsidy amounts to individuals with lower household incomes. Individuals who meet applicable eligibility requirements may receive both types of cost-sharing subsidies.

Explanation of AHCA Provision

Section 131 would repeal ACA Section 1402, terminating the cost-sharing subsidies (and payments to issuers for such reductions), effective for plan years beginning in 2020.

Section 132. Patient and State Stability Fund

Current Law

Over the years, Congress has taken different actions intended to provide financial assistance for individuals with high-cost medical needs. For example, Congress made appropriations available to fund high-risk pools (HRPs) through legislation enacted prior to the ACA. Prior to the ACA, 35 states established HRPs to provide health insurance options to individuals who sought coverage in the individual market; many such individuals were denied coverage, offered coverage with premiums that exceeded those found in the HRPs, or offered coverage that excluded services to treat preexisting health conditions. The coverage provided through state HRPs generally reflected coverage available in the private individual insurance market in those states. Congress first authorized and provided appropriations for state grants, for the purpose of funding HRPs, during the 107th Congress. Additional appropriations were made available during the 109th, 110th, and 111th Congresses.

Congress also made appropriations available for HRPs under the ACA. The ACA required the HHS Secretary to establish a temporary HRP, known as the Pre-Existing Condition Insurance Plan (PCIP). The intent of the PCIP was to provide transitional coverage for uninsured individuals with preexisting conditions until January 1, 2014, when most private health insurance plans would be prohibited from having preexisting condition exclusions.[39] The ACA provided appropriations, beginning in 2010, to fund the PCIP program, which terminated at the end of 2013.

[38] For more information, see CRS Report R44425, *Health Insurance Premium Tax Credits and Cost-Sharing Subsidies: In Brief*.

[39] The prohibition on preexisting condition exclusions applies to non-grandfathered health plans offered in the individual market, all plans offered in the small- and large-group markets, and all self-insured plans.

In another example, Congress established a transitional reinsurance program under the ACA, which was designed to provide payment to non-grandfathered individual market plans that enrolled high-risk enrollees for 2014 through 2016. Under the program, the HHS Secretary collected reinsurance contributions from health insurance issuers and from third-party administrators on behalf of group health plans. The HHS Secretary then used those contributions to make reinsurance payments to issuers who enrolled high-cost enrollees in their non-grandfathered individual market plans both inside and outside of the exchanges. (Statutes required the HHS Secretary to determine how high-risk enrollees are identified, and the HHS Secretary in turn defined high-risk enrollees as high-cost enrollees.) The program covers a portion of the claims costs for these enrollees based on payment parameters set by the HHS Secretary.

Explanation of AHCA Provision

Section 132 would add a new Title XXII to the SSA. Section 2201 of the new title would establish the Patient and State Stability Fund, which is to be administered by the CMS Administrator. The fund's purpose is to provide funding to the 50 states and the District of Columbia from January 1, 2018, to December 31, 2026. Per Section 2202(a) of the new title, states may use payments allocated from the Patient and State Stability Fund for any of the following activities:

- a new or existing mechanism that provides financial assistance to certain high-risk individuals who do not have access to employer-sponsored insurance to enroll in the individual market;
- providing incentives to entities to enter into arrangements with the state for the purpose of stabilizing premiums in the individual market;
- reducing health insurance costs in the individual and small-group markets for individuals who have or are projected to have high health care utilization (as measured by cost) and individuals who face high costs of health insurance coverage due to low population density in the state;
- promoting health insurance issuer participation and increasing insurance options in the individual and small-group markets;
- promoting access to preventive, dental, or vision services, or any combination of such services;
- maternity coverage and newborn care;
- prevention, treatment, or recovery services for individuals with mental or substance abuse disorders that focus on inpatient or outpatient clinical care of treatment of addiction and mental illness and early identification and intervention for children and young adults with mental illness;
- providing payments, directly or indirectly, to health care providers for the provision of services specified by the CMS Administrator; and
- providing assistance to reduce out-of-pocket costs (including premiums) for individuals with health insurance coverage in the state.

Section 2203 of the new title would specify the application process for states to become eligible to receive payments from the Patient and State Stability Fund. The application would include a description of how payments would be used for allowed activities; a certification that states would make required contributions for allowed activities; and other information as required by the CMS Administrator. A state would need to apply only once to be treated as providing applications for subsequent years.

Section 2204(b)(2)(A) of the new title would specify a formula for allocations to states for 2018 and 2019 for one or more of the allowed activities. The formula relies on the medical claims incurred by health insurance issuers in the state, the number of uninsured individuals in the state whose income is below 100% of FPL, and the number of issuers offering coverage through the state's exchange. For 2020 through 2026, Section 2204(b)(2)(B) of the new title would authorize the CMS Administrator to develop a method by which Patient and State Stability Fund payments would be allocated among the states, requiring that the Administrator take into account medical claims incurred by issuers in the state, the number of uninsured individuals in the state whose income is below 100% of FPL, and the number of issuers participating in the state's insurance market. The CMS Administrator would be required to consult with various stakeholders (e.g., health care consumers, issuers, state insurance commissioners) prior to establishing the allocation method for 2020-2026, and the method is to reflect the goals of improving the health insurance risk pool, promoting competition, and increasing choice for health care consumers.

Section 2203(b) would provide that if a state does not have an approved application for the allowed activities for a year, the CMS Administrator, in consultation with the state insurance commissioner, is to use the state's allocation for the year for market stabilization payments to issuers offering coverage in the individual and small-group markets in the state. These payments would be paid to such issuers for claims that exceed $50,000 but do not exceed $350,000 in 2018 and in 2019, in an amount equal to 75% of the claims. The dollar thresholds and the payment percentage are to be specified by the CMS Administrator for years 2020 through 2026.

Section 2204(c) would provide for the reallocation of unused funds to states. Section 2204(e) would require states, as a condition of receipt of Patient and State Stability Fund allocations, to make contributions toward the activities or programs for which the application was approved. The state contributions would equal a certain percentage of the fund allocation. For those states carrying out allowed activities, the contributions begin at 7% in 2020 and increase annually to 50% in 2026. For those states with market-stabilization programs, state contributions begin at 10% in 2020, increase to 50% by 2024, and remain at 50% through 2026.

Section 2204(a) would authorize appropriations for the Patient and State Stability Fund and provide specific appropriation amounts. For 2018 and 2019, the appropriation would be $15 billion each year, and states would be able to use appropriated funds for any of the allowed activities. For 2020-2026, the appropriation would be $10 billion each year for any allowed activities. Amounts appropriated and allocated to states are to remain available for expenditure through December 31, 2027.

Section 2204(a) also would provide for two additional appropriations for specified activities. For 2020, there would be an additional $15 billion appropriated that states could use only for maternity coverage and newborn care and prevention, treatment, or recovery services for individuals with mental or substance abuse disorders. For 2018-2023, there would be an additional $8 billion that could be allocated to certain states. The only states that could receive funds from the $8 billion would be those with a waiver in effect under new Public Health Service Act (PHSA) Section 2701(b)(1)(C), as would be established by AHCA Section 136. The new PHSA Section 2701(b)(1)(C) would allow states to waive the continuous coverage penalty, as would be implemented under AHCA Section 133, and instead allow issuers to use health status as a factor when developing premiums for individuals subject to an enforcement period. The additional $8 billion would be allocated to states with these waivers in effect according to a methodology specified by the HHS Secretary. States would be required to use the allocations to provide assistance in reducing premiums or out-of-pocket costs for individuals in the state subject to an increase in premiums as a result of the state's waiver.

Section 2204(e)(3) would prohibit the CMS Administrator from making an allocation to a state if the state were to use the allocation for purposes not permitted under SSA Section 2105(c)(7), related to abortion.

Section 2205 of the new title would establish a Federal Invisible Risk Sharing Program within the Patient and State Stability Fund. Like the fund, the program is to be administered by the CMS Administrator. The purpose of the Federal Invisible Risk Sharing Program would be to provide payments to health insurance issuers to help them offset the medical claims costs of high-cost enrollees (referred to as *eligible individuals*). The CMS Administrator would be required to establish the parameters for the Federal Invisible Risk Sharing Program, including

- defining *eligible individuals*;
- developing and using health status statements for eligible individuals;
- identifying health conditions that would automatically qualify individuals as eligible individuals at the time they apply for health insurance;
- creating a process health insurance issuers could use to voluntarily qualify enrollees who do not automatically qualify as eligible individuals;
- determining a percentage of an enrollee's paid premiums that would be collected for the program's use; and
- determining the program's attachment point—the dollar amount of claims for an eligible individual after which the program would make payments to the issuer—and determining the portion of such claims the program would pay.

The CMS Administrator must establish the parameters of the Federal Invisible Risk Sharing Program for plan year 2018 no later than 60 days after enactment, and the CMS Administrator must establish a process for state operation of the program beginning in plan year 2020.

Section 2205 of the new title would appropriate $15 billion to be used for the Federal Invisible Risk Sharing Program from January 1, 2018, to December 31, 2026.

Section 133. Continuous Health Insurance Coverage Incentive

Current Law

IRC Section 5000A, as added by ACA Section 1501, created an individual mandate, a requirement for most individuals to maintain health insurance coverage or pay a penalty for noncompliance. To comply with the mandate, most individuals need to maintain *minimum essential coverage*, which includes most types of private (e.g., employer-sponsored) coverage and public coverage (e.g., Medicare and Medicaid). Certain individuals are exempt from the mandate and its associated penalty.

Section 2701 of the PHSA, as amended by ACA Section 1201, provided that premiums for certain plans offered 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).[40] 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.

[40] The rating restrictions apply to all non-grandfathered health plans offered in the individual and small-group markets, and they do not apply to self-insured plans.

PHSA Section 2702, as amended by ACA Section 1201, provides that most plans offered in the individual, small-group, and large-group markets must be offered on a guaranteed-issue basis.[41] In general, guaranteed issue in health insurance is the requirement that a plan accept every applicant for health coverage, as long as the applicant agrees to the terms and conditions of the insurance offer (e.g., the premium).

PHSA Section 2704(a), as amended by ACA Section 1201, prohibits most private health insurance plans from excluding coverage of preexisting health conditions.[42] Plans cannot exclude benefits based on health conditions for any individual. A preexisting health condition is a medical condition that was present before the date of enrollment for health coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.

Explanation of AHCA Provision

As described elsewhere in this report, Section 204 would effectively eliminate the annual penalty associated with IRC Section 5000A, the individual mandate, retroactively beginning CY2016.

Section 133 would add a new Section 2710A to the PHSA. Under the new section, issuers offering plans in the individual market are to assess a penalty on applicable policyholders by increasing monthly premiums by 30% during an enforcement period. (In essence, the penalty is a variation in premiums.) The requirement would apply to enrollments beginning in plan year 2019, and it also would apply to enrollments that occur in special enrollment periods in plan year 2018. Applicable policyholders are (1) individuals who had a gap in creditable coverage, as currently defined in PHSA Section 2704(c), that exceeded 63 days in the 12 months prior to enrolling in current coverage and (2) individuals who aged out of their dependent coverage (i.e., young adults up to the age of 26) and did not enroll in coverage during the first open enrollment period following the date they aged out of their coverage. The enforcement period, with respect to enrollment beginning plan year 2019, is a 12-month period beginning the first day an individual enrolls in a plan. The enforcement period, with respect to enrollments during a special enrollment period in 2018, is the first month the individual is enrolled in coverage and ends in the last month of the plan year.

Section 134. Increasing Coverage Options

Current Law

ACA Section 1302 required certain plans offered in the individual and small-group markets to meet a generosity level.[43] The generosity level (i.e., actuarial value, or AV) is a summary measure of a plan's generosity of coverage. It is expressed as the percentage a given health insurance plan will pay for covered medical expenses, for a standard population. Plans must meet one of the following AV levels: bronze (60% AV), silver (70% AV), gold (80% AV), or platinum (90% AV). On average, as AV increases, consumer cost sharing decreases. For example, for a silver-level plan, on average, a plan pays for 70% of covered services and a consumer pays for 30% of covered services out-of-pocket.

[41] The requirement applies to non-grandfathered plans offered in the individual, small-group, and large-group markets. It does not apply to self-insured plans.

[42] The prohibition on preexisting condition exclusions applies to all non-grandfathered health plans offered in the individual market, all plans offered in the small- and large-group markets, and self-insured plans.

[43] The requirement applies to non-grandfathered plans offered in the individual and small-group markets. It does not apply to self-insured plans.

Explanation of AHCA Provisions

Section 134 would amend ACA Sections 1302(a)(3) and 1302(d) to provide that plans offered after December 31, 2019, no longer need to meet a certain generosity level.

Section 135. Change in Permissible Age Variation in Health Insurance Premium Rates

Current Law

PHSA Section 2701(a)(1), as amended by ACA Section 1201, provided that premiums for certain plans offered 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).[44] 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. PHSA Section 2701(a)(5), as amended by ACA Section 10103, provides that if a state permits large-group coverage to be sold through the state's health insurance exchange, then the rating restrictions apply to all fully insured plans offered in the state's large-group market.

Explanation of AHCA Provision

Section 135 would amend PHSA Section 2701(a)(1)(A)(iii) and establish that for plan years beginning on or after January 1, 2018, the HHS Secretary may implement, through rulemaking, an age rating ratio of 5:1 for adults. That is, a plan would not be able to charge an older individual more than five times the premium that the plan would charge a 21-year-old individual. States would have the option to implement a ratio for adults that is different from the 5:1 ratio.

Section 136. Permitting States to Waive Certain ACA Requirements to Encourage Fair Health Insurance Premiums

Section 137. Constructions

Current Law

Current federal law includes a number of restrictions related to the factors that can be used for determining an individual's eligibility for private health insurance coverage and the premium for such coverage. As described earlier, PHSA Section 2701(a)(1), as amended by ACA Section 1201, provided that premiums for certain plans offered 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).[45] Premiums for such plans cannot vary for any other factors, such as gender or health status.

PHSA Section 2704(a), as amended by ACA Section 1201, prohibited most private health insurance plans from excluding coverage of preexisting health conditions.[46] Plans cannot exclude

[44] The rating restrictions apply to all non-grandfathered health plans offered in the individual and small-group markets, and they do not apply to self-insured plans.

[45] The rating restrictions apply to all non-grandfathered health plans offered in the individual and small-group markets, and they do not apply to self-insured plans.

[46] The prohibition on preexisting condition exclusions applies to non-grandfathered health plans offered in the (continued...)

benefits based on health conditions for any individual or group. A preexisting health condition is a medical condition that was present before the date of enrollment for health coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.

PHSA Section 2705(a), as amended by ACA Section 1201, prohibited most private health insurance plans from basing eligibility for coverage on health status-related factors.[47] Such factors include health status, medical condition (including both physical and mental illness), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), disability, and any other health status-related factor determined appropriate by the HHS Secretary.

PHSA Section 2705(b)(1) prohibited private health insurance plans from requiring an individual to pay a larger premium than any other similarly situated enrollees of the plan on the basis of a health status-related factor of the individual or any of the individual's dependents.[48] PHSA Section 2705(b)(2) provided that such plans may offer premium discounts or rewards based on enrollee participation in wellness programs. PHSA Section 2705(b)(3) prohibited all group plans from adjusting premiums for the covered group on the basis of genetic information.[49]

ACA Section 1302 required certain plans offered in the individual and small-group markets to offer a core package of health care services, known as the EHB.[50] The ACA did not specifically define this core package. Instead, ACA Section 1302(b) listed 10 categories from which benefits and services must be included and required the HHS Secretary to further define the EHB. The 10 categories are ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory service; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

ACA Section 1252 required all standards and requirements adopted by a state pursuant to Title I of the ACA, or any amendments to Title I, to apply uniformly within applicable health insurance markets in the state. ACA Section 1324(a) provides that private health insurance issuers are not subject to federal or state laws (specified under ACA Section 1324(b)) if the laws do not apply to qualified health plans offered under ACA Section 1322 (Consumer-Operated and Oriented Plan [CO-OP] Program) or ACA Section 1334 (Multistate Plan [MSP] Program).

Explanation of New Provisions

Section 136 would amend PHSA Section 2701 by adding a new subsection (b) that would allow states to apply for waivers from certain federal health insurance requirements. The new

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(...continued)

individual market, all plans offered in the small- and large-group markets, and all self-insured plans.

[47] The prohibition applies to all non-grandfathered health plans offered in the individual, small-group, and large-group markets, including non-grandfathered, self-insured plans.

[48] The prohibition applies to all non-grandfathered health plans offered in the individual market and all plans offered in the small-group and large-group markets, including self-insured plans.

[49] The prohibition applies to all health plans offered in the group market and to self-insured plans.

[50] The requirement applies to all non-grandfathered health plans offered in the individual and small-group markets, and it does not apply to self-insured plans.

subsection (b)(1) would allow states to apply for a waiver for one or more of the following purposes.

- States could apply for a waiver to implement an age rating ratio for individuals aged 21 and older for plans purchased in the individual and small-group markets that is higher than the ratio specified in PHSA Section 2701(a)(1)(A)(iii), as would be amended by AHCA Section 135.[51] This waiver could apply to plan years beginning on or after January 1, 2018.
- States could apply for a waiver from the EHB as specified in ACA Section 1302(b), and instead the state could specify its own EHB for plans purchased in the individual and small-group markets. This waiver could apply to plan years beginning on or after January 1, 2020.
- States could apply for a waiver of the continuous coverage penalty, as would be implemented under AHCA Section 133. The continuous coverage penalty would require issuers offering coverage in the individual market to assess a penalty on individuals who have a gap in health insurance coverage (i.e., are subject to an enforcement period). A state could apply to waive the application of the penalty and instead allow issuers to use health status as a factor when developing premiums for individuals subject to an enforcement period. Specifically, the new subsection (b)(1)(C)(ii) would provide that PHSA Section 2701(a) would be applied as if health status were included as a factor and PHSA Section 2705(b) would not apply. To obtain this type of waiver, a state must have a program in effect that carries out at least one of the purposes described in (1) or (2) of SSA Section 2202(a) (as would be added under AHCA Section 132) or the state must participate in the Federal Invisible Risk Sharing Program established under SSA Section 2205 (as would be added under AHCA Section 132). This waiver could apply to coverage obtained during special enrollment periods for plan year 2018 and for all coverage beginning plan year 2019.

The new subsection (b)(3) would specify the waiver application requirements. The HHS Secretary would determine the timing and manner for submitting waiver applications. A state's application would be required to explain how approval of the application would provide for one or more of the following outcomes in the state:

- reducing average premiums for health insurance,
- increasing enrollment in health insurance,
- stabilizing the health insurance market,
- stabilizing premiums for individuals with preexisting conditions, or
- increasing the choice of health plans.

The application also would have to include information about what the state would put in place of the waived provision. For example, if the state applied for a waiver to define the EHB, the application would have to specify the EHB that would be put in place in the state under the waiver.

[51] AHCA §135 would establish that for plan years beginning on or after January 1, 2018, the HHS Secretary may implement, through rulemaking, an age rating ratio of 5:1 for adults. States would have the option to implement a ratio for adults that is different from the 5:1 ratio.

Per new subsection (b)(2), a state's application for a waiver would be approved unless the HHS Secretary notifies the state that the waiver has been denied (and provides the reason for denial) no later than 60 days after the application is submitted. New subsection (b)(4)(A) would provide that a state's waiver cannot extend longer than 10 years unless a state requests continuation. If a state requests continuation, such a request would be granted unless the HHS Secretary denies the request or asks the state for additional information within 90 days of the state's submission of a continuation request.

New subsection (b)(5)(A) would provide that the waivers allowed under the new PHSA Section 2701(b) cannot apply to the following ACA sections:

- 1301, regarding requirements for qualified health plans (QHPs), to the extent it applies to QHPs offered under ACA Section 1322 (CO-OP program) or ACA Section 1334 (MSP program);
- 1312(d)(3)(D), regarding health insurance coverage for Members of Congress;[52]
- 1331, regarding the Basic Health Program;
- 1332, regarding state innovation waivers;[53]
- 1333, regarding health care choice compacts; and
- 1334, regarding the MSP program.

New subsection (b)(5)(B) would provide that any standards and requirements a state adopts pursuant to an approved waiver would be deemed compliant with ACA Sections 1252 and 1324(a).

Section 137 would provide that nothing in the AHCA is to be construed as allowing issuers to vary health insurance rates by gender or as permitting issuers to limit access to coverage for individuals with preexisting conditions.

Subtitle E—Implementation Funding

Section 141. American Health Care Implementation Fund

Current Law

Section 1005 of the Health Care and Education Reconciliation Act of 2010 (HCERA; P.L. 111-152) established the Health Insurance Reform Implementation Fund (HIRIF) within HHS and appropriated $1 billion to the HIRIF to help cover the federal administrative costs of implementing the ACA. Through the end of FY2016, a total of $994.9 million had been obligated from the HIRIF. The obligated amounts, by agency, are as follows: IRS, $542.8 million; HHS, $440.9 million; Office of Personnel Management, $6.1 million; Department of Labor, $4.5 million; and Social Security Administration, $0.6 million.

[52] On May 3, 2017, the House Rules Committee reported H.Res. 308, a resolution providing for House consideration of H.R. 2192, a bill to amend the Public Health Service Act to eliminate the non-application of certain state waiver provisions to Members of Congress and their staff. On May 4, 2017, the House agreed to H.Res. 308 and subsequently passed H.R. 2192. H.R. 2192 would amend proposed AHCA §136 to remove ACA §1312(d)(3)(D) from the list of provisions to which proposed AHCA §136 does not apply.

[53] For more information about state innovation waivers, see CRS Report R44760, *State Innovation Waivers: Frequently Asked Questions*.

Explanation of New Provision

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 (Section 121); Patient and State Stability Fund (Section 132); additional modifications to the premium tax credit (Section 202); and refundable tax credit for health insurance coverage (Section 214). Section 141 would appropriate $1 billion to the American Health Care Implementation Fund.

Title II—Committee on Ways and Means

Subtitle A—Repeal and Replace of Health-Related Tax Policy

Section 201. Recapture Excess Advance Payments of Premium Tax Credits

Section 202. Additional Modifications to Premium Tax Credit

Current Law

IRC Section 36B, as added by ACA Section 1401, and related amendments authorized premium tax credits to help eligible individuals pay for health insurance.[54] The tax credits apply toward premiums for qualified health plans (QHPs) offered in the individual market through health insurance exchanges.[55] QHPs are allowed to be offered outside of exchanges (off-exchange plans), but the premium credits may not be used toward the purchase of such plans. The premium credit is refundable, so individuals may claim the full credit amount when filing their taxes, even if they have little or no federal income tax liability. The credit also is advanceable, so individuals may choose to receive the credit on a monthly basis to coincide with the payment of insurance premiums.

ACA Section 1411 generally makes the premium tax credit available to those who do not have access to subsidized public coverage (e.g., Medicaid) or employer-sponsored coverage that meets certain standards. The amount of the premium tax credit varies from individual to individual. The ACA specifies formulas for calculation of the premium tax credit amount and the amount that the individual (or family) must contribute toward the premium. That latter amount—the required premium contribution—is calculated according to a formula that incorporates a certain percentage (*applicable percentage*) of a given individual's (or family's) household income (MAGI) and the premium for the standard plan (i.e., the second-lowest-cost silver plan) in that individual's (or family's) local area.[56] The required premium contribution is capped according to MAGI, with such income measured relative to FPL. A smaller cap applies to lower-income individuals—

[54] CRS Report R44425, *Health Insurance Premium Tax Credits and Cost-Sharing Subsidies: In Brief*.

[55] For more information, see CRS Report R44425, *Health Insurance Premium Tax Credits and Cost-Sharing Subsidies: In Brief*.

[56] Most health plans sold through exchanges established under the ACA are required to meet actuarial value (AV) standards, among other requirements. AV is a summary measure of a plan's generosity, expressed as the percentage of medical expenses estimated to be paid by the insurer for a standard population and set of allowed charges. An exchange plan that is subject to the AV standards is given a precious metal designation: platinum (AV of 90%), gold (80%), silver (70%), or bronze (60%).

compared to the cap applicable to higher-income persons—meaning such individuals generally receive greater tax assistance.

ACA Section 1412 establishes an advance payment program, for making the credits available during the year. The advanced amounts are reconciled when individuals file income-tax returns for the actual year in which they receive the credits. If a tax filing unit's income decreases during the tax year, and the filer should have received a larger credit, this additional credit amount will be included in the tax refund for the year. By contrast, any excess amount that was overpaid in credits to the filer will have to be repaid to the federal government as a tax payment. IRC Section 36B(f)(2)(B) imposes limits on the excess amounts to be repaid under certain conditions. For households with incomes below 400% of FPL, the specific limits apply to single and joint filers separately.

ACA Section 1414 authorizes the disclosure of taxpayer information by amending IRC Section 6103(l). IRC Section 6055, as added by ACA Section 1502, requires every entity (including employers, insurers, and government programs) that provides *minimum essential coverage* (including QHPs) to an individual to report that information to the IRS and provide a statement to the covered individual.

Explanation of AHCA Provisions

Section 201 would not apply IRC Section 36B(f)(2)(B), relating to limits on the excess amounts to be repaid with respect to the ACA premium tax credits, to taxable years beginning after December 31, 2017, and before January 1, 2020. In other words, for tax years 2018 and 2019, any individual who was overpaid in premium tax credits would have to repay the entire excess amount, regardless of income.

Section 202 would disregard certification, plan choice, and regulatory compliance requirements applicable to QHPs and the requirement for QHPs to be offered through an exchange for ACA premium tax credit purposes. Advance payments of the credit, however, would not be allowed for plans offered outside of exchanges. Section 202 would allow the ACA credits to be applied toward the purchase of catastrophic plans but not grandfathered plans, grandmothered plans, or abortion coverage (except if necessary to save the life of the mother or if the pregnancy is the result of rape or incest). The section would allow an individual to purchase abortion-only coverage or a plan that includes abortion coverage, and would allow a health insurer to offer such coverage or plan, but would prohibit ACA premium tax credits to be used to pay for either. Section 202 would amend IRC Section 6055, relating to the reporting of minimum essential coverage, to require an entity that offers an off-exchange QHP to report certain specified information.

With respect to the formula for calculating required premium contributions, Section 202 would specify age and income-adjusted applicable percentages for tax year 2019. The applicable percentages would range from 2% for those in the lowest income band to 11.5% for those in the highest income band and the oldest age band, which generally would provide greater tax assistance to lower-income individuals. Beginning in tax year 2019, the applicable percentages would be adjusted to take into account premium growth in comparison with other specified economic measures.[57]

Section 202 would go into effect beginning tax year 2018, unless otherwise specified.

[57] §202(c)(4) indicates that the new applicable percentages would go into effect beginning in 2019. However, §202(b) includes an "indexing" provision for annual adjustment of such percentages, also beginning in 2019.

Section 203. Small Business Tax Credit

Current Law

Section 45R of the IRC, as added by ACA Section 1421, provided for a small business health insurance tax credit. The credit is intended to help make the premiums for small-group health insurance coverage more affordable for certain small employers. The credit generally is available to nonprofit and for-profit employers with fewer than 25 full-time-equivalent employees with average annual wages that fall under a statutorily specified cap. To qualify for the credit, employers must cover at least 50% of the cost of each of their employees' self-only health insurance coverage.

As of 2014, small employers must obtain insurance through a Small Business Health Options Program (SHOP) exchange to receive the credit, and the credit is available for two consecutive tax years only. The two-year period begins with the first year an employer obtains coverage through a SHOP exchange. For example, if an employer first obtains coverage through a SHOP exchange in 2017, the credit will be available to the employer only in 2017 and 2018.

Explanation of AHCA Provision

Beginning in tax year 2018, Section 203 would amend IRC Section 45R to indicate that the small business health insurance tax credit amount is to be determined based on QHPs that do not include coverage for abortion, except abortions necessary to save the life of the mother or abortions for pregnancies that are a result of rape or incest. The provision further states that an employer would not be prohibited from purchasing for its employees separate coverage for abortion, so long as no tax credit under IRC Section 45R is allowed with respect to employer contributions for such coverage.

Section 203 would provide that the small business health insurance tax credit would not be available beginning tax year 2020.

Section 204. Individual Mandate

Current Law

IRC Section 5000A, as added by ACA Section 1501, created an individual mandate, a requirement for most individuals to maintain health insurance coverage or pay a penalty for noncompliance.[58] To comply with the mandate, most individuals need to obtain *minimum essential coverage*, which includes most types of private (e.g., employer-sponsored) coverage and public coverage (e.g., Medicare and Medicaid). Certain individuals are exempt from the mandate and its associated penalty.

The individual mandate went into effect in 2014. Individuals who are not exempt from the mandate are required to pay a penalty for each month of noncompliance. The annual penalty is the *greater* of a percentage of income or a flat dollar amount (but not more than the national average premium of a specified health plan). The percentage of income increased from 1.0% in 2014 to 2.5% in 2016 and beyond. The flat dollar amount increased from $95 in 2014 to $695 in 2016 and is adjusted for inflation thereafter.

[58] CRS Report R44438, *The Individual Mandate for Health Insurance Coverage: In Brief*.

Explanation of AHCA Provision

Section 204 would effectively eliminate the annual penalty associated with IRC Section 5000A, the individual mandate, by reducing the percentage of income to 0% and the flat dollar amount to $0, retroactively beginning CY2016.

Section 205. Employer Mandate

Current Law

IRC Section 4980H, as added by ACA Section 1513, required that employers either provide health coverage or face potential employer tax penalties.[59] The potential employer penalties apply to all common-law employers, including government entities (such as federal, state, local, or Indian tribal government entities) and nonprofit organizations that are exempt from federal income taxes. 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. The total penalty for any applicable large employer is based on the employer's number of full-time employees (averaging 30 hours or more per week) and whether the employer offers affordable health coverage that provides minimum value.

Explanation of AHCA Provision

Section 205 would modify the tax penalty associated with IRC Section 4980H, effectively eliminating it by reducing the penalty to $0 retroactively beginning in CY2016.

Section 206. Repeal of the Tax on Employee Health Insurance Premiums and Health Plan Benefits

Current Law

IRC Section 4980I, as added by ACA Section 9001, created a new excise tax on high-cost employer-sponsored coverage (the so-called Cadillac tax).[60] Under the ACA, the tax was scheduled to take effect in 2018; however, the Consolidated Appropriations Act, 2016 (P.L. 114-113) delayed implementation of the tax until 2020. When it is implemented, the tax is to be imposed at a 40% rate on the aggregate cost of employer-sponsored health coverage that exceeds a specified dollar limit. If a tax is owed, it is levied on the entity providing the coverage (e.g., the health insurance issuer or the employer).

Explanation of AHCA Provision

Section 206 would delay implementation of IRC Section 4980I (the so-called Cadillac tax) until taxable periods beginning January 1, 2026.

[59] CRS Report R43981, *The Affordable Care Act's (ACA) Employer Shared Responsibility Determination and the Potential Employer Penalty*.

[60] CRS Report R44147, *Excise Tax on High-Cost Employer-Sponsored Health Coverage: In Brief*.

Section 207. Repeal of Tax on Over-the-Counter Medications

Current Law

Under the IRC, taxpayers may use several different types of tax-advantaged health accounts to pay or be reimbursed for qualified medical expenses: health flexible spending accounts (health FSAs), health reimbursement accounts (HRAs), Archer Medical Savings Accounts (MSAs), and health savings accounts (HSAs). ACA Section 9003 amended the relevant IRC provisions (IRC Sections 106, 220, and 223) to provide that, for each of these accounts, amounts paid for medicine or drugs are qualified expenses only in the case of prescribed drugs and insulin.

Explanation of AHCA Provision

Section 207 would repeal the language in IRC Sections 106, 220, and 223 stipulating that a medicine or drug must be a prescribed drug or insulin to be considered a qualified expense in terms of spending from a tax-advantaged health account. The provision would be generally effective beginning tax year 2017.

Section 208. Repeal of Increase of Tax on Health Savings Accounts

Current Law

ACA Section 9004 imposed a 20% tax on distributions from Archer MSAs and HSAs that are used for purposes other than paying for qualified medical expenses. Prior to the ACA, IRC Section 220 applied a 15% rate on such distributions if made from an Archer MSA and IRC Section 223 applied a 10% rate on such distributions if made from an HSA.

Explanation of AHCA Provision

Section 208 would amend IRC Sections 220 and 223 to reduce the applicable rate to 15% and 10% for Archer MSAs and HSAs, respectively. The lower rates would apply to distributions made after December 31, 2016.

Section 209. Repeal of Limitations on Contributions to Flexible Spending Accounts

Current Law

IRC Section 125 allowed employers to establish *cafeteria plans*, benefit plans under which employees may choose between receiving cash (typically additional take-home pay) and certain normally nontaxable benefits (such as employer-paid health insurance) without being taxed on the value of the benefits if they select the latter. (A general rule of taxation is that when given a choice between taxable and nontaxable benefits, taxpayers will be taxed on whichever they choose because they are deemed to be in constructive receipt of the cash.)

ACA Section 9005 amended IRC Section 125(i) to provide that a health FSA cannot be a nontaxable benefit under a cafeteria plan unless the cafeteria plan provides that an employee may not elect for any taxable year to have a salary reduction contribution in excess of $2,500 made to such arrangement. Also, the $2,500 limit is indexed for cost-of-living adjustments for plan years beginning after December 31, 2013.

Explanation of AHCA Provision

Section 209 would repeal IRC Section 125(i), the contribution limit for health FSAs, effective beginning tax year 2017.

Section 210. Repeal of Medical Device Excise Tax

Current Law

Section 1405 of the HCERA created a new excise tax that is imposed on the sale of certain medical devices.[61] The tax is codified in IRC Section 4191. The tax is equal to 2.3% of the device's sales price and generally is imposed on the manufacturer or importer of the device. The tax took effect on January 1, 2013. The Consolidated Appropriations Act, 2016 (P.L. 114-113) provided a two-year moratorium on the tax. The tax does not apply to sales in the period beginning January 1, 2016, and ending December 31, 2017.

Explanation of AHCA Provision

Section 210 would provide that the medical device excise tax does not apply to sales after December 31, 2016.

Section 211. Repeal of Elimination of Deduction for Expenses Allocable to Medicare Part D Subsidy

Current Law

Employers that provide Medicare-eligible retirees with prescription drug coverage that meets or exceeds set federal standards are eligible for federal subsidy payments. The subsidies are equal to 28% of plans' actual spending for prescription drug costs in excess of $400 and not to exceed $8,250 (for 2017).[62] The subsidies were created as part of the Medicare Part D prescription drug program (Medicare Modernization Act of 2003; P.L. 108-173) to provide employers with an incentive to maintain drug coverage for their retirees.

Employers are allowed to exclude qualified retiree prescription drug plan subsidies from gross income for the purposes of corporate income tax. Prior to implementation of the ACA, employers also 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. ACA Section 9012 amended IRC Section 139A, beginning in 2013, to require employers to coordinate the subsidy and the deduction for retiree prescription drug coverage. The amount allowable as a deduction for retiree prescription drug coverage is reduced by the amount of the federal subsidy received.

[61] CRS Report R43342, *The Medical Device Excise Tax: Economic Analysis*.

[62] CMS, "Announcement of Calendar Year (CY) 2017 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter," April 4, 2016, p. 69, at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2017.pdf.

Explanation of AHCA Provision

Section 211 would repeal the ACA change to IRC Section 139A 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.

Section 212. Reduction of Income Threshold for Determining Medical Care Deduction

Current Law

Under IRC Section 213, taxpayers who itemize their deductions may deduct qualifying medical expenses. The medical-expense deduction may be claimed only for expenses that exceed 10% of the taxpayer's adjusted gross income (AGI), which was reduced for taxable years ending before January 1, 2017, to 7.5% if the taxpayer or spouse was aged 65 or older. The 10% threshold was imposed by ACA Section 9013. Prior to the ACA, the AGI threshold was 7.5% for all taxpayers.

Explanation of AHCA Provision

Section 212 would amend IRC Section 213(a) to reduce the AGI threshold to 5.8% for all taxpayers, effective tax year 2017.

Section 213. Repeal of Medicare Tax Increase

Current Law

ACA Sections 9015 and 10906 imposed a Medicare Hospital Insurance (HI) surtax at a rate equal to 0.9% of an employee's wages or a self-employed individual's self-employment income. The surtax, which is found in IRC Sections 1401 and 3101, 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. The tax is in addition to the regular Federal Insurance Contributions Act and Self-Employment Contributions Act taxes that generally apply (i.e., Social Security and Medicare taxes).

Explanation of AHCA Provision

Section 213 would amend IRC Sections 1401(b) and 3101(b) to repeal the 0.9% Medicare surtax, effective for remuneration received and taxable years beginning after December 31, 2022.

Section 214. Refundable Tax Credit for Health Insurance Coverage

Current Law

The federal tax code currently allows two credits to help eligible individuals and dependents pay for health insurance that meets specified standards. The Health Coverage Tax Credit, codified in IRC Section 35, was reauthorized under the Trade Preferences Extension Act of 2015 with a

sunset date of January 1, 2020.[63] In addition, the ACA authorized a premium tax credit for eligible individuals enrolled in exchange coverage, codified in IRC Section 36B, with no sunset date.[64]

Explanation of AHCA Provision

Section 214 would amend IRC Section 36B by replacing the text with completely new language, effective beginning tax year 2020. It would establish a refundable, advanceable tax credit for health insurance purposes. To be eligible for the tax credit, an individual would be required to be covered under a state-certified QHP; to not be eligible for private or public coverage as specified in the section; to be a citizen, national, or qualified alien of the United States; and to not be incarcerated (except incarceration pending disposition of charges). For tax credit purposes, a QHP would be any coverage offered in the individual health insurance market; such coverage would *exclude* grandfathered plans, grandmothered plans, abortion coverage (except if necessary to save the life of the mother or if the pregnancy is the result of rape or incest), and coverage that consists substantially of either excepted benefits or short-term limited-duration insurance (as defined under current law).

Qualifying family members would include only the individual's spouse, any dependent of the individual, and any child (aged 26 or younger) of the individual who is enrolled in the same QHP as the individual (or other parent). A qualifying spouse must file a joint tax return with the eligible individual if married to that individual at the end of the tax year (with exceptions). A credit would be allowed for a dependent only by the individual who claims such a dependent for income-tax purposes.

The credit amount would be the lesser of flat credit amounts adjusted by age for an eligible individual and that individual's qualifying family members or the amounts equal to the premiums paid by an eligible individual and that individual's qualifying family members for a QHP.[65] The age-adjusted credit amounts for 2020 would be

- $2,000 for eligible individuals under the age of 30;
- $2,500 for those between 30 and 39 years of age;
- $3,000 for those between 40 and 49 years of age;
- $3,500 for those between 50 and 59 years of age; and
- $4,000 for those who aged 60 and older.

The calculation of a given family's credit would take into account the age-adjusted credit amounts applicable to the five oldest individuals only. The total credit amount would be reduced (but not below zero) by 10% of any amount that MAGI (as defined in the section) exceeds $75,000, or $150,000 for a joint tax return (MAGI limitation). The maximum tax credit amount allowed for an eligible individual and qualifying family members for a given tax year (*aggregate dollar limitation*) would be $14,000. Beginning in 2021, the age-adjusted credit amounts, the dollar amounts under the MAGI limitation, and the aggregate dollar limitation would be adjusted annually by the CPI-U, as specified.

[63] CRS Report R44392, *The Health Coverage Tax Credit (HCTC): In Brief*.

[64] The ACA tax credit is described in more detail in this memorandum in the current law summary for §§201 and 202.

[65] This section would allow premiums paid for a qualified health plan that exceed the age-adjusted credit amounts to be included in determination of the medical-expense deduction under IRC §213.

If an eligible individual or qualifying family member has a *qualified small-employer health-reimbursement arrangement*,[66] the age-adjusted credit amount would be reduced (but not below zero) by the permitted benefit provided under such an arrangement. For any month in which an individual elects to receive the Health Coverage Tax Credit, authorized under IRC Section 35, such an individual would not be eligible to receive the tax credit authorized under IRC Section 36B. The current deduction allowed for health insurance premiums paid by self-employed individuals for coverage for such individuals (and their families), authorized under IRC Section 162(l), would be reduced (not below zero) by the new tax credit amounts (including advance payments) provided to such individuals.

An individual who makes an erroneous claim for an excessive tax credit amount would be liable for a penalty equal to 25% of the excessive amount. Section 214 would amend ACA Section 1412, relating to the advance payment program, to require the HHS Secretary and the Treasury Secretary to promulgate regulations that they deem necessary relating to protection of taxpayer information, verification of eligibility, proper and timely payments, and program integrity.

Section 214 would go into effect beginning tax year 2020.

Section 215. Maximum Contribution Limit to Health Savings Account Increased to Amount of Deductible and Out-of-Pocket Limitation

Current Law

IRC Section 223 provided for HSAs, which are tax-exempt trusts or custodial accounts established for paying the health-related expenses of an account beneficiary. HSAs are established and owned by individuals. Eligible individuals can establish and fund HSAs when they have a qualifying high-deductible health plan (HDHP) and no other health plan, with some exceptions. To be HSA-qualified, the HDHP must have a minimum deductible, it must limit out-of-pocket expenditures for covered benefits to no more than a certain maximum level, and only preventive care services can be covered prior to the deductible being met. The minimum deductible amounts and out-of-pocket limits are set by statute and adjusted for inflation. For 2017, the minimum deductible is $1,300 for single coverage and $2,600 for family coverage. The out-of-pocket limit is $6,550 for single coverage and $13,100 for family coverage.

Contributions to HSAs 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. HSA contributions are either deductible as an above-the-line deduction or excluded from an account holder's gross income.

Explanation of AHCA Provision

Section 215 would increase the HSA annual contribution limits for self-only and family coverage to match the out-of-pocket limits for HSA-qualified HDHPs for self-only and family coverage. The change would go into effect beginning in tax year 2018.

[66] For more information, see Section 18001 of CRS Report R44730, *Increasing Choice, Access, and Quality in Health Care for Americans Act (Division C of P.L. 114-255)*.

Section 216. Allow Both Spouses to Make Catch-Up Contributions to the Same Health Savings Account

Current Law

IRC Section 223 established HSAs, which are tax-exempt trusts or custodial accounts established for paying the health-related expenses of the account beneficiary. Eligible individuals can establish and contribute to HSAs when they have a qualifying HDHP and no other health plan, with some exceptions.

Contributions to HSAs may be made by eligible individuals, as well as by other individuals or entities on their behalf. Thus, individuals may contribute to accounts of eligible family members, and employers may contribute to accounts of eligible employees. HSA contributions are deductible as an above-the-line deduction if made by individuals. Contributions made by employers, including through salary-reduction agreements, are excluded from income, Social Security, and Medicare taxes.

The aggregate contributions to HSAs are subject to an annual limit, which is adjusted for inflation each year. In 2017, the contribution limit is $3,400 for self-only coverage and $6,750 for family coverage. Individuals aged 55 and older who are not yet eligible for Medicare are allowed to contribute an additional $1,000 each year. This "catch-up" contribution is not adjusted for inflation.

IRC Section 223(b)(5) established contribution rules for married couples. 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. In other words, the spouses' aggregate contributions to their respective HSAs cannot be more than the annual contribution limit for family coverage. Their annual 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.

Explanation of AHCA Provision

Section 216 would amend IRC Section 223(b)(5) to provide that, with respect to the contribution limit to an HSA, married persons do not have to take into account whether their spouse is also covered by an HSA-qualified HDHP. In other words, spouses' aggregate contributions to their respective HSAs could be more than the annual contribution limit for family coverage. Their annual contribution limit would be reduced by any amount paid to Archer MSAs of either spouse for the taxable year, and then the remaining contribution amount would be divided equally between the spouses unless they agreed on a different division. If both spouses are eligible to make catch-up contributions before the close of the taxable year, then each spouse's catch-up contribution is included when dividing up the contribution amounts between the spouses. This provision would effectively allow both spouses to make catch-up contributions to one HSA and would apply to taxable years beginning in 2018.

Section 218. Special Rule for Certain Medical Expenses Incurred Before Establishment of Health Savings Account

Current Law

In general, withdrawals from HSAs are exempt from federal income taxes if used for qualified medical expenses described in IRC Section 213(d), 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.

Explanation of AHCA Provision

Section 217 would amend IRC Section 223(d)(2) to provide a circumstance under which HSA withdrawals can be used to pay qualified medical expenses incurred before the HSA was established. If an HSA were established within 60 days of when an individual's coverage under an HSA-qualified plan begins, then the HSA would be treated as having been established on the date the coverage begins for purposes of determining whether an HSA withdrawal is used for a qualified medical expense. Section 217 would apply to coverage beginning after December 31, 2017.

Subtitle B—Repeal of Certain Consumer Taxes

Section 221. Repeal of Tax on Prescription Medications

Current Law

ACA Section 9008 imposed an annual tax on covered entities engaged in the business of manufacturing or importing branded prescription drugs. In general, the tax is imposed on covered manufacturers and importers with aggregated branded prescription drug sales of more than $5 million to specified government programs or pursuant to coverage under these programs.

Explanation of AHCA Provision

Section 221 would amend ACA Section 9008 to provide that the tax would not be imposed effective calendar year 2017.

Section 222. Repeal of Health Insurance Tax

Current Law

ACA Section 9010 imposed an annual fee on certain health insurers beginning in 2014. The ACA fee is based on net health care premiums written by covered issuers during the year prior to the year that payment is due. The aggregate ACA fee is set at $8.0 billion in 2014, $11.3 billion in 2015 and in 2016, $13.9 billion in 2017, and $14.3 billion in 2018. After 2018, the fee is indexed to the annual rate of U.S. health insurance premium growth. Each year, the IRS apportions the fee among affected insurers based on (1) their net premiums written in the previous calendar year as a share of total net premiums written by all covered insurers and (2) their dollar value of business. Covered insurers are not subject to the fee on their first $25 million of net premiums written. The fee is imposed on 50% of net premiums above $25 million and up to $50 million, and it is imposed on 100% of net premiums in excess of $50 million.

Certain types of health insurers or insurance arrangements are not subject to the fee, including self-insured plans; voluntary employees' beneficiary associations; and federal, state, or other governmental entities, including Indian tribal governments and nonprofit entities incorporated under state law that receive more than 80% of their gross revenues from government programs that target low-income, elderly, or disabled populations. In addition, only 50% of net premiums written by tax-exempt entities are included in determining an entity's market share.

ACA Section 9010(j) made these provisions effective for calendar years beginning after December 31, 2013. The Consolidated Appropriations Act, 2016 (P.L. 114-113) provides a one-year moratorium on the tax for calendar year 2017.

Explanation of AHCA Provision

Section 222 would amend ACA Section 9010 to provide that the annual fee would not be imposed effective calendar year 2017.

Subtitle C—Repeal of Tanning Tax

Section 231. Repeal of Tanning Tax

Current Law

ACA Section 10907 created a new excise tax on indoor tanning services. The tax is equal to 10% of the amount paid for such services. The provision is codified in Chapter 49 of the IRC.

Explanation of AHCA Provision

Section 231 would repeal the tax on indoor tanning services (IRC Chapter 49), effective for services performed after June 30, 2017.

Subtitle D—Remuneration from Certain Insurers

Section 241. Remuneration from Certain Insurers

Current Law

Generally, employers may deduct the remuneration paid to employees as "ordinary and necessary" business expenses under IRC Section 162, subject to any statutory limitations. ACA Section 9014(b) added a statutory limitation for certain health insurance providers. Under the provision, which is codified at IRC Section 162(m)(6), covered health insurance providers may not deduct the remuneration paid to an officer, director, or employee in excess of $500,000.

Explanation of AHCA Provision

Section 241 would terminate IRC Section 162(m)(6), effective beginning tax year 2017.

Subtitle E—Repeal of Net Investment Income Tax

Section 251. Repeal of Net Investment Income Tax

Current Law

HCERA Section 1402 imposed a net investment tax on high-income taxpayers. The tax, which is codified in Chapter 2A of Subtitle A of the IRC, applies at a rate of 3.8% to certain net investment income of individuals, estates, and trusts with income above amounts specified in the statute.

Explanation of AHCA Provision

Section 251 would repeal the net investment tax (Chapter 2A of IRC Subtitle A), effective beginning tax year 2017.

Appendix. List of Abbreviations

ABPs: Alternative benefit plans

ACA: Patient Protection and Affordable Care Act (P.L. 111-148, as amended)

AGI: Adjusted gross income

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

AV: Actuarial value

CBO: Congressional Budget Office

CHIP: State Children's Health Insurance Program

CMS: Centers for Medicare & Medicaid Services

CO-OP: Consumer Operated and Oriented Plan

CPI-U: Consumer Price Index for All Urban Consumers

CY: Calendar year

DSH: Disproportionate share hospital

E-FMAP: Enhanced federal medical assistance percentage

EHB: Essential health benefits

FMAP: Federal medical assistance percentage

FPL: Federal poverty level

FQHCs: Federally Qualified Health Centers

FY: Fiscal year

GAO: U.S. Government Accountability Office

HCERA: Health Care and Education Reconciliation Act of 2010 (P.L. 111-152)

HDHP: High-deductible health plan

Health FSAs: Health flexible spending accounts

HHS: Health and Human Services

HI: Hospital Insurance

HIRIF: Health Insurance Reform Implementation Fund

HRAs: Health reimbursement accounts

HRPs: High-risk pools

HSA: Health savings account

IRC: Internal Revenue Code

IRS: Internal Revenue Service

JCT: Joint Committee on Taxation

LTSS: Long-term services and supports

MACRA: The Medicare Access and CHIP Reauthorization Act of 2015 (P.L. 114-10)

MAGI: Modified adjusted gross income

MSAs: Medical savings accounts

MSP: Multistate plan

PCIP: Pre-Existing Condition Insurance Plan

PHSA: Public Health Service Act

PPFA: Planned Parenthood Federation of America

PPHF: Prevention and Public Health Fund

QHPs: Qualified health plans

SHOP: Small Business Health Options Program

SNAP: Supplemental Nutrition Assistance Program

SSA: The Social Security Act

SSI: Supplemental Security Income

TANF: Temporary Assistance for Needy Families

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