

May 2017

Summary of the American Health Care Act

This summary describes key provisions of H.R. 1628, the American Health Care Act, as passed by the House of Representatives on May 4, 2017 as a plan to repeal and replace the Affordable Care Act (ACA) through the Fiscal Year 2017 budget reconciliation process.

	<p style="text-align: center;">American Health Care Act H.R. 1628 (as passed by the House of Representatives on May 4, 2017)</p>
<p>Overall approach</p>	<ul style="list-style-type: none"> • Repeal ACA mandates (2016), standards for health plan actuarial values (2020), and, premium and cost sharing subsidies (2020). • Modify ACA premium tax credits for 2018–2019 to increase amount for younger adults and reduce for older adults, also to apply to coverage sold outside of exchanges and to catastrophic policies. In 2020, replace ACA income-based tax credits with flat tax credits adjusted for age. Eligibility for new tax credits phases out at income levels between \$75,000 and \$115,000 • Retain private market rules, including requirement to guarantee issue coverage, prohibition on pre-existing condition exclusions, requirement to extend dependent coverage to age 26. Modify age rating limit to permit variation of 5:1, unless states adopt different ratios, effective 2018. Retain essential health benefits requirement, with state option to waive. Retain prohibition on health status rating with state option to waive for individual market applicants who have not maintained continuous coverage. • Retain health insurance marketplaces, annual Open Enrollment periods (OE), and special enrollment periods (SEPs). • Impose late enrollment penalty for people who don't stay continuously covered. • Establish State Patient and State Stability Fund with federal funding of \$130 billion over 9 years, and additional funding of \$8 billion over 5 years for states that elect community rating waivers. States may use funds to provide financial help to high-risk individuals, promote access to preventive services, provide cost sharing subsidies, and for other purposes. In 2020, \$15 billion of funds shall be used only for services related to maternity coverage and newborn care, and mental health and substance use disorders. For 2018-2026, \$15 billion is allocated for Federal Invisible Risk Sharing Program (reinsurance) grants to states. In states that don't successfully apply for grants, funds will be used for reinsurance program. For 2018-2023, \$8 billion shall only be used by states electing community rating waivers to provide assistance to reduce premiums or other out of pocket costs for individuals who are subject to higher premiums as a result of the community rating waiver. • Repeal funding for Prevention and Public Health Fund at the end of Fiscal Year 2018 and rescind any unobligated funds remaining at the end of FY2018. Provide supplemental funding for community health centers of \$422 million for FY 2017 • Encourage use of Health Savings Accounts by increasing annual tax free contribution limit and through other changes • Limit enhanced FMAP for Medicaid expansion to states that adopted the expansion as of March 1, 2017, and sunset enhanced FMAP for those states as of January 1, 2020 except for beneficiaries enrolled as of December 31, 2019 who do not have a break in eligibility of more than 1 month.

	<ul style="list-style-type: none"> • Convert federal Medicaid funding to a per capita allotment and limit growth beginning in 2020 using 2016 as a base year with state option to receive block grant for nonexpansion adults and children or only nonexpansion adults • Add state option to require work as a condition of eligibility for nondisabled, nonelderly, nonpregnant Medicaid adults • No change to Medicare benefit enhancements or provider/Medicare Advantage plan payment savings • Repeal Medicare HI tax increase and other ACA revenue provisions • Prohibit federal Medicaid funding for Planned Parenthood clinics
Individual mandate	<ul style="list-style-type: none"> • Tax penalty for not having minimum essential coverage is eliminated effective January 1, 2016 • Late enrollment penalty (30% of otherwise applicable premium) applies for individuals buying non-group coverage who have not maintained continuous creditable coverage. Current law definition of creditable coverage includes group health plan, health insurance coverage (including short-term non-renewable coverage), Medicare, Medicaid, TriCare, Indian Health Service, state high risk pool, FEHBP, other public plan coverage, and coverage for Peace Corps workers. Continuous coverage is assessed during a 12-month look back period prior to the date of enrollment in new coverage. If individual had a lapse in coverage of 63 consecutive days or longer during the look back period, late enrollment penalty applies during the plan year in which the individual enrolls in new non-group coverage. (For SEP, penalty applies for the remainder of the plan year). Late enrollment penalty is effective for special enrollments during the 2018 plan year, for all other enrollments beginning with the 2019 plan year. Private health plans continue to be required by law to provide certificates of creditable coverage; however, no requirement for governmental programs (e.g., Medicaid, CHIP, state high-risk pools) to provide such certificates.
Premium subsidies to individuals	<ul style="list-style-type: none"> • For 2018-2019, modify premium tax credits as follows: <ul style="list-style-type: none"> – Increase credit amounts for young adults with income above 150% FPL and decrease amounts for adults 50 and older above that income level. – For end of year reconciliation of advance credits, the cap on repayment of excess advance payments does not apply. – Tax credits cannot be used for plans that cover abortion. – Premium tax credits can be used to purchase catastrophic plans. – Premium tax credits can be used to purchase qualified health plans (i.e., covering essential health benefits) sold outside of the exchange, but are not advance-payable for such plans. Premium tax credits cannot be used to purchase short term policies or grandfathered or grandmothered individual health insurance policies sold outside of the exchange. • Starting in 2020, replace ACA income-based tax credits with flat tax credit adjusted for age. Credits are payable monthly; annual credit amounts are: <ul style="list-style-type: none"> – \$2,000 per individual up to age 29 – \$2,500 per individual age 30-39 – \$3,000 per individual age 40-49 – \$3,500 per individual age 50-59 – \$4,000 per individual age 60 and older <p>Families can claim credits for up to 5 oldest members, up to limit of \$14,000 per year.</p> <p>Amounts are indexed annually to CPI plus 1 percentage point.</p> <p>U.S. citizens and legal immigrants who are not incarcerated and who are not eligible for coverage through an employer plan, Medicare, Medicaid or CHIP, or TRICARE, are eligible for tax credit. Married couples must file jointly to claim the credit. In addition, eligibility for the tax credit phases out starting at income above \$75,000 (credit is reduced, but not below zero, by 10 cents for every dollar of income above this threshold; tax credit reduced to zero at income of \$95,000 for single individuals</p>

up to age 29, \$115,000 for individuals age 60 and older. For joint filers, credits begin to phase out at income of \$150,000; tax credit reduced to zero at income of \$190,000 for couples up to age 29; tax credit reduced to zero at income \$230,000 for couples age 60 or older; tax credit reduced to zero at income of \$290,000 for couples claiming the maximum family credit amount.)

Taxpayers who are also enrolled in qualified small employer health reimbursement arrangements (HRA) that apply to non-group coverage will have tax credit reduced, but not below zero, by the amount of the HRA benefit.

- Premium tax credit can be applied to any eligible individual health insurance policy (but not grandfathered or grandmothers policies or short term policies) sold on or off the exchange. In addition, credit can be applied to unsubsidized COBRA premiums. Eligible policies do not include those for which substantially all coverage is for excepted benefits; policies that cover abortion (with Hyde exceptions) are not eligible policies. States shall certify plans eligible for the credit; employer group health plan sponsors shall certify COBRA coverage eligible for the credit. The federal government must establish a program for making advance payment of tax credits no later than January 1, 2020; to the greatest extent practicable the program will use methods and procedures used for the ACA advance payable premium tax credit.

Cost sharing subsidies to individuals	<ul style="list-style-type: none"> ▪ ACA cost sharing subsidies are repealed effective January 1, 2020.
Individual health insurance market rules	<ul style="list-style-type: none"> • Require guaranteed issue of all non-group health plans during annual open enrollment. Insurers also must offer 60-day special enrollment periods (SEP) for individuals after qualifying events. Short-term non-renewable policies can continue to be sold using medical underwriting. • Continue ACA rating rules, except age rating of 5:1 is permitted starting January 1, 2018, unless states adopt a different ratio. However, states that use Patient Stability Fund grants for high risk pools or reinsurance, or that participate in the Federal Invisible Risk Sharing Program, can apply to waive community rating (instead permitting health status as a rating factor) for individual market participants who do not maintain continuous coverage. Short-term non-renewable policies can continue to set premiums based on health status. • Prohibition on pre-existing condition exclusion periods is not changed. Short term non-renewable policies can continue to exclude pre-existing conditions
Benefit design	<ul style="list-style-type: none"> • ACA requirement to cover 10 essential health benefit categories is not changed, however starting in 2020, states may apply for waivers to re-define essential health benefits for health insurance coverage offered in the individual or small group market. ACA requirement for maximum out of pocket limit on cost sharing is not changed. ACA requirement for plans to be offered at specified actuarial values/metal levels sunsets on 12/31/2019. • Prohibition on lifetime and annual dollar limits is not changed; however, the prohibition applies to limits on essential health benefits, which can be changed under state waiver authority • Requirement for individual and group plans to cover preventive benefits with no cost sharing is not changed. • Requirement for all plans to apply in-network level of cost sharing for out-of-network emergency services is not changed • Prohibit abortion coverage from being required. Federal premium tax credits cannot be applied to plans that cover abortion services, beyond those for saving the life of the woman or in cases of rape or incest (Hyde amendment). Nothing prevents an insurer from offering or an individual from buying separate policies to cover abortion as long as no premium tax credits are applied.
Women's health	<ul style="list-style-type: none"> • ACA essential health benefit requirement for individual and small group health insurance policies is not changed, including requirement to cover maternity care as an essential health benefit; however, EHB can be changed under state waiver authority. • Requirement for individual and group plans to cover preventive benefits, such as contraception and cancer screenings, with no cost sharing is not changed.

	<ul style="list-style-type: none"> • Prohibition on gender rating is not changed • Prohibition on pre-existing conditions exclusions, including for pregnancy, prior C-section, and history of domestic violence, is not changed. • Prohibit federal Medicaid funding for Planned Parenthood clinics for one year, effective upon date of enactment. Specifies that federal funds to states including those used by managed care organizations under state contract are prohibited from going to such entity. • In states electing Medicaid block grant, family planning would no longer be a mandatory covered service. • Redefine qualified health plan to exclude any plan that covers abortion services, beyond those for saving the life of the woman or in cases of rape or incest (Hyde amendment), effective in 2018 • Prohibit federal premium tax credits from being applied to plans that cover abortion services, beyond Hyde limitations. Disqualify small employers from receiving tax credits if their plans include abortion coverage beyond Hyde limitations, effective in 2018. Does not prevent an insurer from offering or an individual from buying separate policies to cover abortion as long as no tax credits are applied.
Health Savings Accounts (HSAs)	<ul style="list-style-type: none"> • Modify certain rules for HSAs, changes take effect January 1, 2018: <ul style="list-style-type: none"> – Increase annual tax free contribution limit to equal the limit on out-of-pocket cost sharing under qualified high deductible health plans (\$6,550 for self only coverage, \$13,100 for family coverage in 2017, indexed for inflation). – Additional catch up contribution of up to \$1,000 may be made by persons over age 55. Both spouses can make catch up contributions to the same HSA. – Amounts withdrawn for qualified medical expenses are not subject to income tax. Qualified medical expense definition expanded to include over-the-counter medications and expenses incurred up to 60 days prior to date HSA was established – Tax penalty for HSA withdrawals used for non-qualified expenses is reduced from 20% to 10%.
High-risk pools	<ul style="list-style-type: none"> • States may use Patient and State Stability Fund grants to fund high-risk pools, and for other purposes • As part of the Patient and State Stability Fund, establish a new “Federal Invisible Risk Sharing Program,” (FIRSP), a reinsurance program, which CMS will establish for states to operate to offset claims costs of certain high-risk individuals covered by participating individual health insurance companies. <p>FIRSP is funded at \$15 billion over 9 years (2018 through 2026), plus any other unallocated funds under the Patient and State Stability Fund (see below). State matching funding does not appear to be required for FIRSP. No later than 60 days after date of enactment, CMS will establish parameters for FIRSP to operate starting in 2018. Parameters shall include:</p> <ul style="list-style-type: none"> – Health status statements will be developed to identify eligible individuals – In addition, a list of health conditions will be developed; individuals diagnosed with listed conditions will be automatically eligible individuals – Health insurers in the individual market may voluntarily qualify other individuals for the program – Health insurers will pay a percentage (to be determined by CMS) of the premium for eligible individuals to FIRSP – CMS will designate a dollar threshold for claims for eligible individuals, and a proportion of claims above that threshold, that FIRSP will pay to health insurers. – CMS will also designate a process states can use to take over operation of FIRSP within their states starting in 2020 <p>FIRSP funds cannot be used to pay for any abortion or to assist in the purchase, in whole or in part, of health benefit coverage that includes coverage of abortion, except</p>

	if the abortion is needed to save the life of the mother or if the pregnancy resulted from rape or incest.
Selling insurance across state lines	<ul style="list-style-type: none"> No provision
Exchanges/ Insurance through associations	<ul style="list-style-type: none"> State exchanges continue, though premium tax credits can be used for eligible non-group policies regardless of whether they are sold through an exchange. Through 2019, tax credits are only advance payable for policies purchased through an exchange. Single risk pool rating requirement for plans first sold on or after January 1, 2014 is not changed.
Dependent coverage to age 26	<ul style="list-style-type: none"> Requirement to provide dependent coverage for children up to age 26 for all individual and group policies is not changed.
Other private insurance standards	<ul style="list-style-type: none"> Minimum medical loss ratio standards for all health plans are not changed. Requirement for all health plans to offer independent external review is not changed. Requirements for all plans to report transparency data, and to provide standard, easy-to-read summary of benefits and coverage are not changed.
Employer requirements and provisions	<ul style="list-style-type: none"> Tax penalty for large employers that do not provide health benefits is reduced to zero, retroactive to January 1, 2016 Wellness incentives permitted under the ACA are not changed Repeal tax credits for low-wage small employers, effective January 1, 2020. Requires that small business tax credits cannot be used to purchase plans that cover abortions, beyond Hyde limitations, effective in 2018
Medicaid	<p><i>Financing</i></p> <ul style="list-style-type: none"> Codify that the Medicaid expansion is a state option as of January 1, 2020 consisting of “expansion enrollees” and “grandfathered enrollees”; eliminate option to extend coverage to adults above 133% FPL effective December 31, 2017; limit the enhanced match for the Medicaid expansion to 133% FPL to states that adopted expansion as of March 1, 2017, and sunset enhanced FMAP for those states as of January 1, 2020 (except for grandfathered enrollees who were enrolled through the Medicaid expansion as of December 31, 2019 and who do not have a break in eligibility of more than one month). <ul style="list-style-type: none"> Limits the “expansion state” enhanced match rate transition percentage to CY 2017 levels of 80% (instead of phasing up the match to equal the ACA enhanced match rate by 2020). Convert federal Medicaid financing to a per capita cap beginning in FY 2020. <ul style="list-style-type: none"> Per enrollee caps for five enrollment groups—elderly, blind and disabled, children, expansion adults, and other adults—are based on 2016 expenditures (excluding administrative costs, DSH, Medicare cost-sharing, and safety net provider payment adjustments in non-expansion states, and certain categories of individuals, including CHIP, those receiving services through Indian Health Services, those eligible for Breast and Cervical Cancer services, and partial-benefit enrollees) divided by full-year equivalent enrollees in each category and trended forward to 2019 by medical CPI. For states opting to adopt the Medicaid expansion after 2016, the per enrollee amount for this group would be the same as the other adult group under the per capita cap. Per enrollee amounts are adjusted to exclude non-DSH supplemental payments The target expenditures in 2020 are calculated based on the 2019 per enrollee amounts for each enrollment group adjusted for non-DSH supplemental payments and increased by an inflationary factor multiplied by

the number of enrollees in each group. In 2021 and beyond, per enrollee amounts are based on the prior year amounts increased by an inflationary factor. The inflationary factor for the elderly and blind/disabled groups is medical CPI plus 1 percentage point. The inflationary factor for children, expansion adults, and other adults is medical CPI.

- States with medical assistance expenditures exceeding the target amount for a fiscal year will have payments in the following fiscal year reduced by the amount of the excess payments.
- Decrease per capita cap target medical assistance expenditures by the amount of certain expenditures required by political subdivisions of certain states that are unreimbursed by the state beginning in FY 2020 – as written appears to apply only to New York.¹
- Add state option to elect Medicaid block grant instead of per capita cap for certain populations for a period of 10 fiscal years, beginning in FY 2020 – if option is not extended at the end of 10 FY period, per capita cap provisions apply.
 - States may elect block grant for children and nonexpansion adults or only for nonexpansion adults. States can set conditions of eligibility (except that states must cover mandatory pregnant women and children and infants born to eligible pregnant woman for 1 year, depending on the category elected),
 - Block grant payments shall only be used for “block grant health care assistance” instead of “medical assistance” under Title XIX (Medicaid). States must provide 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 for children under 18, health care (but not Early, Periodic, Screening, Diagnosis and Treatment services). States determine cost sharing and delivery system. Federal Medicaid requirements for statewideness, amount, duration, and scope, reasonable standards for determining eligibility for and the extent of medical assistance, and free choice of provider do not apply.
 - The total block grant amount for the initial FY is based on the state’s target per capita medical assistance expenditures for the FY multiplied by the number of enrollees in the category(ies) elected and the federal average medical assistance matching rate for the state for FY 2019. In subsequent FYs, the total block grant amount for the prior FY is increased by annual CPI for urban consumers. The federal portion of block grant funds payable to states is based on the CHIP enhanced FMAP, with the state funding the difference. States can rollover unused block grant funds into the next FY as long as they continue to elect the block grant option. States must contract with an independent entity to audit its expenditures for each FY to ensure spending is consistent with these provisions.
 - State must submit plan to Secretary, which is deemed approved unless Secretary determines within 30 days that plan is incomplete or actuarially unsound.
- Provide 100% FMAP for MMIS and eligibility systems for FY 2018 and FY 2019 and increase other administrative matching to 60% for expenses related to implementing new data requirements.
- Repeal Medicaid DSH cuts for FY2020 - FY2025; exempt non-expansion states from DSH cuts for FY2018 - FY 2019
- Provide \$10 billion over 5 years (FY2018 – FY 2022) to non-expansion states for safety-net funding (applies to states not adopting the expansion by July 1 of the previous year). Allotments based on 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. Payments 100% funded by the federal government in FY 2018-2021 and 95% in FY 2022. Payments to providers may not exceed providers’ costs in providing health care services to Medicaid and uninsured patients. States receiving these funds in a year in which they

also adopt expansion shall no longer be eligible to receive these funds in any subsequent year.

Other Changes

- Create state option to require work as a condition of eligibility for nondisabled, nonelderly, nonpregnant Medicaid enrollees as of October 1, 2017, by participating in work activities as defined in the TANF program² for a period of time as determined by the state and as directed and administered by the state.
 - Exempts pregnant women through 60-days post-partum, children under 19, individuals who are only parent/caretaker relative in family of child under age 6 or child with disability, and individuals under age 20 who are married or head of household and maintain satisfactory attendance at secondary school or equivalent or participate in education directly related to employment.
 - Provides 5% enhanced federal matching funds for activities carried out by the state and approved by the Secretary to implement work requirement.
- Repeal the essential health benefits requirement for those receiving alternative benefit packages, including the expansion group, as of December 31, 2019.
- Repeal increase in Medicaid eligibility to 138% FPL for children ages 6-19 as of December 31, 2019. The minimum federal income eligibility limit for these children will revert to 100% FPL.
- Repeal hospital presumptive eligibility provisions and presumptive eligibility for expansion adults, effective January 1, 2020
- Repeal enhanced FMAP for the Community First Choice Option to provide attendant care services effective January 1, 2020
- Prohibit federal Medicaid funding for Planned Parenthood for one year, effective upon date of enactment
- Require states to consider lottery winnings (and other lump sum payments including gambling winnings and liquid assets from an estate) as income over a period of months in determining Medicaid ineligibility for individual and spouse beginning, January 1, 2020. Secretary can establish hardship criteria and state can intercept lottery winnings for Medicaid recoupment.
- Eliminate 3-month retroactive coverage requirement (start eligibility “in or after” the month of application) beginning October 1, 2017.
- Require states to limit home equity to federal minimum (removes the option to expand the limit from \$500,000 to \$750,000 (adjusted for CPI), effective six months after the bill is enacted or longer if states must pass legislation to change.
- Require eligibility redeterminations every 6 months for expansion enrollees beginning October 1, 2017. Expands civil monetary penalties up to \$20,000 per individual for intentionally claiming Medicaid matching funds for an individual not eligible for expansion. Provide a temporary (10/1/17 through 12/31/19) five percentage point FMAP increase for expenditures directly related to complying with this provision.

Medicare

Revenues

- Repeals the HI payroll tax on high earners, beginning after December 31, 2022
- Repeals the annual fee paid by branded prescription drug manufacturers, beginning after December 31, 2016
- Reinstates the tax deduction for employers who receive Part D retiree drug subsidy (RDS) payments to provide creditable prescription drug coverage to Medicare beneficiaries, beginning after December 31, 2016.

Coverage enhancements

- ACA benefit enhancements (no-cost preventive benefits; phased-in coverage in the Part D coverage gap) are not changed

Reductions to provider and plan payments

- ACA reductions to Medicare provider payments and Medicare Advantage payments are not changed

Other ACA provisions related to Medicare are not changed, including:

- Increase Medicare premiums (Parts B and D) for higher income beneficiaries (those with incomes above \$85,000/individual and \$170,000/couple).
- Authorize an Independent Payment Advisory Board to recommend ways to reduce Medicare spending if the rate of growth in Medicare spending exceeds a target growth rate.
- Establish various quality, payment and delivery system changes, including a new Center for Medicare and Medicaid Innovation to test, evaluate, and expand methods to control costs and promote quality of care; Medicare Shared Savings Accountable Care Organizations; and penalty programs for hospital readmissions and hospital-acquired conditions.

State role

- States may determine age rating ratio; otherwise federal standard of 5:1 applies.
- Establish new Patient and State Stability Fund. Funds can be used by states for financial help for high-risk individuals, to stabilize private insurance premiums, promote access to preventive services, provide cost sharing subsidies, for maternity coverage and newborn care, for mental health and substance use disorder services, and for other purposes. In states that do not successfully apply for grants, funds will be used for a default reinsurance program, administered by CMS, that will pay 75% of claims between \$50,000 and \$350,000 (starting in 2020, CMS Administrator can establish different reinsurance rate and claims thresholds.)
Funding available through the Patient and State Stability Fund includes:
 - \$100 billion over 9 years (\$15 billion per year for 2018-2019, \$10 billion per year for 2020-2026) for grants to states or for default reinsurance program;
 - \$15 billion for a new Federal Invisible Risk Sharing Program (see below);
 - \$8 billion over 5 years (2018-2023) for states that elect community rating waivers (see below) to provide financial assistance to people whose premiums are surcharged based on health status under that waiver;
 - \$15 billion for the year 2020 to be used solely for maternity coverage and newborn care and mental health and substance use disorders.
 - State matching funding of 7% required in 2020, phasing up to 50% in 2026. A different state matching schedule applies for the CMS-administered default reinsurance program (10% in 2020, phasing up to 50% in 2024.) Grants cannot be made to a state unless it agrees to make matching funds available. Any remaining funds at year end will be re-allocated to the Federal Invisible Risk Sharing Program.
- State option to establish a state based health insurance exchange remains, but premium subsidies are also available for plans sold outside of exchanges, effective January 1, 2018.
- As part of the Patient and State Stability Fund, establish a new “Federal Invisible Risk Sharing Program,” (FIRSP) funded at \$15 billion over 9 years, plus any other unallocated funds under the Patient and State Stability Fund. State matching funding does not appear to be required for FIRSP. (See above)
- Establish new state waiver authority under PHSA section 2701.
 - Starting in 2018 states may apply for waivers to permit age rating ratios higher than 5:1 (note, elsewhere, the bill permits states to adopt any age rating ratio they want)

- Starting in 2020, states may apply for waivers to redefine essential health benefits for health insurance coverage offered in the individual and small group market
- Starting in 2019, or for SEP enrollments in 2018, states that use Patient Stability Fund grants to establish high-risk pools or reinsurance programs, or that participate in the FIRSP, may apply for waiver of the ACA community rating requirement. States could allow insurers to use health status as a rating factor for applicants in the individual market who have not maintained continuous coverage. For these individuals, health status rating could be used instead of the 30% late enrollment penalty. The health status rating would only apply during the “enforcement period” – generally for one entire plan year, or in the case of SEP enrollments, for the remainder of the plan year.
 - For states electing the community rating waiver, which can be granted for 10 years, then extended, an additional \$8 billion in Patient and State Stability grants is allocated over 5 years, 2018-2023. Community rating waiver states may only use this additional allocation to provide assistance to reduce premiums or other out of pocket costs of individuals who are subject to health status rating under the waiver. States are not required to completely offset health status rating surcharges, nor are they required to establish high-risk pools for these individuals.
- State waiver applications would be deemed approved within 60 days of submission unless the Secretary denies the application. Applications must specify how the waiver would achieve at least one of the following goals: reduce average health insurance premiums, increase health coverage enrollment, stabilize the health insurance market, stabilize premiums for people with pre-existing conditions, or increase choice of health plans.
- State waiver programs (to change age rating bands, redefine essential health benefits, or apply health status rating in the individual market) cannot apply with respect to the following ACA provisions
 - Waivers may not be applied to health plans offered through CO-OP plans, multi-state plans, or to ACA innovation waivers (Section 1332), Basic Health Plan programs (Section 1331), interstate compact programs (Section 1333).
 - In addition, waivers may not apply with respect to Section 1312(d)(3)(D) of ACA, which requires the federal government to provide health benefits to Members of Congress through health plans created under the ACA or offered through Exchanges. Note that a separate amendment, proposed by Rep. McSally, would eliminate this provision upon enactment of the AHCA.
- State consumer assistance/ombudsman program is not changed, and is not funded.
- State option to establish a Basic Health Program is not changed. State option to obtain a five-year waiver of certain new health insurance requirements (Section 1332 waiver) is not changed.
- States continue to administer the Medicaid program with Federal matching funds available up to the federal cap with the choice of a per capita cap or block grant for certain populations.

Financing

- ACA taxes repealed, effective January 1, 2017, except where otherwise noted:
 - Tax penalties associated with individual and large employer mandate, reduced to zero effective on January 1, 2016
 - Cadillac tax on high-cost employer-sponsored group health plans is suspended for tax years 2020 through 2025, no revenues shall be collected during this period
 - Increase in Medicare payroll tax (HI) rate on wages for high-wage individuals, effective January 1, 2023; also 3.8% tax on unearned income for high-income taxpayers
 - Tax on tanning beds

- Tax on health insurers
- Tax on pharmaceutical manufacturers
- Excise tax on sale of medical devices
- Provision excluding costs for over-the-counter drugs from being reimbursed through a tax preferred health savings account (HSA)
- Provision increasing the tax (from 10% to 20%) on HSA distributions that are not used for qualified medical expenses.
- Chronic care tax
- Codification of economic substance doctrine and penalties
- Annual limit on contributions to Flexible Spending Accounts (FSAs) repealed
- Annual limit on deduction for salary in excess of \$1 million paid to employees of publicly held corporations repealed
- Income threshold for medical expense deduction reduced from 10% to 5.8%
- Federal Medicaid funding capped, effective FY 2020; enhanced match for Medicaid expansion population eliminated beginning January 1, 2020; and Medicaid DSH cuts repealed, effective FY 2020
- Manager's amendment appropriates \$1 billion for federal administration of the premium tax credit changes, Patent and State Stability Fund, Medicaid changes, and other implementation responsibilities.

Endnotes

¹ State must have had FY 2016 DSH allotment more than six times the national average. Contributions required by the state from political subdivisions that, as of the 1st day of the CY in which the FY begins, has a population of more than 5,000,000 and imposes a local income tax and those for administrative expenses if required as of January 1, 2107 are included.

² Work activities under the TANF program include unsubsidized employment, subsidized private sector employment, subsidized public sector employment, work experience (including refurbishing 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 for any individual), job skills training directly related to employment, education directly related to employment for those who have not received a high school diploma or certificate of high school equivalency, satisfactory attendance at secondary school or in a general equivalency certificate course for those who have not already completed, and provision of child care services to an individual participating in a community service program.

Sources of information

<http://docs.house.gov/billsthisweek/20170501/Upton%20Amendment.pdf> (Upton et al amendment proposed May 3, 2017)

<http://docs.house.gov/billsthisweek/20170424/MacArthur%20Amendment.pdf> (MacArthur amendment proposed April 26, 2017)

http://docs.house.gov/billsthisweek/20170424/BILLS-115hr__ih.pdf (McSally amendment proposed April 26, 2017)

<https://rules.house.gov/bill/115/hr-1628>

<https://waysandmeans.house.gov/event/markup-budget-reconciliation-recommendations-repeal-replace-obamacare/>

<http://docs.house.gov/meetings/IF/IF00/20170308/105679/BILLS-115-CommitteePrint-W000791-Amdt-1.pdf>