Healthcare Association of New York State

Summary of H.R. 1628, the American Health Care Act
As Passed by the House of Representatives on May 4, 2017

The American Health Care Act (AHCA, H.R. 1628) passed the House by a vote of 217-213 on May 4, 2017. This summary reflects the amendment that would be made to H.R. 1628 by H.R. 2192, which was passed by the House on the same day. H.R. 2192 provides that if H.R. 1628 is enacted, no exemption would be made for Members of Congress and their staff from the provision in the AHCA that permits certain state waivers.

Table of Contents

Title I – Committee on Energy and Commerce
Subtitle A – Patient Access to Public Health Programs

Sec. 101. The Prevention and Public Health Fund

Subsection (b) of section 4002 of the ACA,[1] as amended by section 5009 of the 21st Century Cures Act, would be further amended to eliminate the authorization and appropriation for the Prevention and Public Health Fund, effective for fiscal year 2019. Unobligated funds at the end of fiscal year 2018 would be rescinded.

Sec. 102. Community Health Center (CHC) Program

An additional $422 million for the CHC Program would be appropriated for fiscal year 2017. (The provision would be effective as if included in the section 221(a) of the Medicare Access and CHIP Reauthorization Act of 2015 (P.L. 114-10)).

Sec. 103. Federal Payments to States

States would be prohibited from using federal funds in making payments to a prohibited entity, which, as specified, describes Planned Parenthood, for the one-year period beginning on the date of enactment of AHCA. Restricted federal funds would be those made as direct spending (i.e., provided by law other than appropriation acts; entitlement authority; and the Supplemental Nutrition Assistance Program) and would include payments made to the states under section 1115 or 1915 waivers.

Subtitle B—Medicaid Program Enhancement

Sec. 111. Repeal of Medicaid provisions

Section 111 would sunset a number of Medicaid provisions that were enacted as part of the ACA:

Hospital Presumptive Eligibility. A provision requiring states to allow hospitals to make presumptive eligibility determinations for all categories of Medicaid beneficiaries would be repealed beginning January 1, 2020. Any existing elections by hospitals to conduct presumptive eligibility determinations under this provision would cease to be effective beginning on that date. States would continue to have the option under separate authority to authorize "qualified entities" including hospitals, to make presumptive eligibility determinations for children, pregnant women, and women qualifying on the basis of having breast and cervical cancer.

Low-Income Children Over Age 6. The requirement that states provide Medicaid to low-income children over age 6 in families with income up to 133% of the federal poverty level (FPL) would

[1] The Patient Protection and Affordable Care Act (P.L. 111-148) and the health care provisions of the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).

end on December 31, 2019. Beginning January 1, 2019, states would only be required to cover those children over age 6 who are in families with income below 100% of the FPL.

Enhanced Federal Matching Payments for Attendant Care Services. Would eliminate the additional 6 percentage point federal match for states that provide community-based attendant services and supports on December 31, 2019. Standard federal matching rates would apply to state spending on these services beginning January 1, 2020.

Sec. 112. Repeal of Medicaid Expansion

(a) In general

The AHCA would sunset the Medicaid expansion provisions of the ACA after December 31, 2019 but would establish a new "Expansion Enrollees" optional coverage group that would become available beginning January 1, 2020.

The Expansion Enrollees option identifies two groups of enrollees:

- Expansion enrollees who are individuals under age 65, not pregnant, not entitled to Medicare, and whose income is below 133% (138% taking into account the standard income disregard) of the FPL applicable to a family of the size involved; and
- Grandfathered expansion enrollees who are those expansion enrollees enrolled as of December 31, 2019 and who do not have a break in coverage in excess of one month after that date.

The state option to extend Medicaid coverage to adults with income *above* 133% of the federal poverty level would be eliminated. The option would no longer be available to states after December 31, 2017.

Enhanced Match Repealed. The bill would repeal the enhanced federal matching payment percentage (EFMAP) for Expansion Enrollees (except for those who are grandfathered) who are enrolled after December 31, 2019. It would retain the enhanced federal matching payment percentages only for grandfathered expansion enrollees in states choosing to cover those individuals before March 1, 2017. Under current law, the federal share of their costs is equal to 95% for calendar quarters in 2017 descending to 90% for calendar quarters in 2020 and in each year thereafter. This provision would reduce the federal share of costs for adults in expansion states to an average of around 57%

Enhanced Match Reduced for Early Adopter States. The AHCA would amend the formula for enhanced federal matching payment percentages for "early adopter states," which are those states that expanded Medicaid for non-pregnant childless adults before March 23, 2010. Under current law, for those states, the federal match for childless adults will phase up from the state's regular federal matching percentage for medical assistance services to the EFMAP for new ACA expansion enrollees so that for calendar year (CY) 2017, a state will receive 80% of the difference between those two percentages; in CY 2018 they will receive 90% of that difference; and beginning in CY 2019 a state will reach the full EFMAP for ACA expansion enrollees. Under the AHCA, an early adopter state would stop phasing up at the 2017 percentage – or 80% of the difference between the state's regular FMAP and the EFMAP. Beginning with spending

for expansion enrollees after January 1, 2020, that enhanced rate would only be available for individuals who are grandfathered expansion enrollees in early adopter states.

(b) Sunset of Essential Health Benefits Requirement
The AHCA would eliminate the requirement that alternative benefit plans under Medicaid include the coverage of essential health benefits after December 31, 2019.

Under current law, states that expand Medicaid to the ACA adult expansion group are required to provide "benchmark benefits" or "benchmark equivalent" coverage to those individuals (also known as Alternate Benefit Plans (ABPs)). States can provide ABP coverage to certain other groups of Medicaid enrollees but some populations, such as people who are blind and disabled, cannot be required to enroll in such plans. ABPs are based on one of the three commercial insurance products, or "Secretary approved" coverage option. The ACA modified the definition of ABPs to include coverage of the essential health benefits as described in section 1302(b) of the ACA , requiring that the following ten benefit categories be part of any ABP: (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.

Sec. 113. Partial Mitigation of DSH Cuts

The cuts in disproportionate share hospital (DSH) allotments specified in current law for 2018 and 2019 would be eliminated for non-expansion states. For expansion states, defined as those providing coverage for ACA childless adults under 1902(a)(10)(A)(i) VIII) or (ii)(XX) as of July 1 of the preceding fiscal year, the share of the DSH reduction would be calculated as if all states continued to be subject to those reductions as under current law. In addition, cuts in DSH allotments would be eliminated for 2020 through 2025 for all states.

Sec. 114. Reducing State Medicaid Costs

(a) Letting States Disenroll High Dollar Lottery Winners
States would be required to count lottery winnings (for lotteries occurring on or after January 1, 2020) or other lump sum income received after that date when determining eligibility for Medicaid based on modified adjusted gross income. States would be required to count income in the month in which it is received if the amount of the lump sum or lottery income is less than $80,000; over a period of 2 months if the amount is equal to $80,000 or over, up to but less than $90,000; over a period of 3 months if the amount is equal to $90,000 or over, up to but less than $100,000; over a period of 3 months plus 1 additional month for each increment of $10,000 received, not to exceed a period of 120 months for amounts greater than or equal to $100,000. Amounts over $80,000 would be counted in equal monthly installments over the number of months specified.

The state Medicaid program and the Secretary of HHS would have the ability to establish hardship standards to provide an exemption to these rules if the denial of Medicaid on account of counting such income would cause an undue medical or financial hardship.

Qualified lump sum payments are defined as income received from gambling or income received as liquid assets from the estate of a deceased individual. The bill specifies that this provision is not intended to prevent states from intercepting lottery winnings to recover amounts paid for Medicaid for an individual and is not intended to affect the determination of eligibility for any other member of the household other than the individual who received the funds or their spouse.

(b) Repeal of Retroactive Eligibility

The period of retroactive eligibility for Medicaid beneficiaries would be shortened. Under current law, Medicaid eligibility begins at the start of the third month before the month in which the person made their application. Under the legislation, effective with applications made on or after October 1, 2017, eligibility would begin at the start of the month in which the individual made their application.

(c) Updating Allowable Home Equity Limits in Medicaid

The bill would eliminate the option of a state to begin counting the equity of an applicant's home once it exceeds $750,000 in determining Medicaid eligibility for individuals in need of nursing home or other long-term care services. Beginning with eligibility determinations made after 180 days after enactment of the bill, all states would be required count equity interest above $500,000. States with legislatures that meet every 2 years would not be considered to be out of compliance with this requirement before the first day of the first calendar quarter beginning after the close of the state's first regular session.

Sec. 115. Safety Net Funding for Non-Expansion States

A total of $2 billion in new "safety net" funding would be made available per year for FYs 2018 – 2022 to states that, as of July 1 of the preceding fiscal year, did not expand coverage for ACA childless adults. The funds would be made available to states to allow for payments to health care providers that provide Medicaid services.

The funds would be available to non-expanding states at a 100% federal matching rate for calendar quarters in FY 2018 through FY 2021 and 95% for calendar quarters in FY 2022. Each state would be eligible to receive an amount in each of those years that is equal to $2 billion multiplied by a ratio based on the state's share of individuals under 138% of poverty in 2015 in non-expansion states. The data used for the calculation would come from using the table entitled "Health Insurance Coverage Status and Type by Ratio of Income to Poverty Level in the Past 12 Months by Age" for the civilian noninstitutionalized population based on the 2015 American Community Survey 1 Year Estimates. Each hospital would be limited to receiving an amount that does not exceed its costs in furnishing health care services to either Medicaid individuals or those who have no health insurance or coverage for such services (net of any other Medicaid payments received and of payments received by uninsured patients.)

Sec. 116. Providing Incentives for Increased Frequency of Eligibility Determinations

States providing Medicaid under the ACA to childless adults (including early expanding states) would be required, beginning on October 1, 2017, to re-determine Medicaid eligibility for those individuals no less frequently than once every 6 months.

Federal matching payments for state spending attributable to increasing the frequency of re-determining eligibility would be increased by 5 percentage points for states for calendar quarters beginning on October 1, 2017 and ending on December 31, 2019.

Sec. 117. Permitting States to Apply a Work Requirement for Nondisabled, Non-elderly, Non-pregnant Adults under Medicaid

States would be permitted to elect, beginning October 1, 2017, to condition medical assistance for adult beneficiaries who are non-disabled, non-elderly, and not pregnant, on their satisfaction of a work requirement.

Work requirements under this section are those defined in section 407(d) of the Social Security Act and include unsubsidized employment, subsidized private or public sector employment, on-the-job or vocational training, job search and job readiness assistance, community services programs, vocational education, job skills training, education related to employment and secondary school attendance.

A state could not apply work requirements to pregnant women through the end of the month in which the 60 day period beginning on the last day of her pregnancy ends; children under age 19; individuals who are the only parent or caretaker of a child under the age of 6 or the only parent or caretaker of a child with a disability; or to individuals under age 20 who are married or the head of the household and who maintain satisfactory attendance at school or participate in education directly related to employment.

The federal matching percentage applicable to administrative costs for carrying out work requirements would be increased by 5 percentage points.

Subtitle C--- Per Capita Allotment for Medicaid Assistance

Sec. 121. Per Capita Allotment for Medical Assistance

Federal financing of the Medicaid program would be reformed by instituting a cap on federal payments for most program spending as described in new section 1903A of the Social Security Act (SSA).

Section 1903A of the SSA Per Capita-Based Cap on Payment for Medical Assistance

(a) Application of Per Capita Cap on Payment for Medical Assistance Expenditures
An aggregate cap would be applied to most federal payments for state Medicaid programs beginning with fiscal year 2020. To the extent that a state Medicaid program makes payments in

excess of its aggregate cap for the portion of the program subject to the cap, federal payments to that state in the following fiscal year would be reduced by the federal share of the amount by which state program spending exceeded the aggregate cap.

(b) Adjusted Total Medical Assistance (MA) Expenditures
Several definitions necessary for calculating caps and spending subject to caps are provided in 1903A(b).

- Would define "Adjusted Total Medical Assistance Expenditures" for a state:
  - For 2016, medical assistance spending excluding DSH payments, Medicare cost sharing payments and safety net provider payment adjustments under new section 115 (see above) multiplied by the 1903A FY 2016 population percentage[2]; and
  - For 2019, medical assistance spending excluding DSH payments, Medicare cost sharing payments, safety net provider payment adjustments under new section 115, and payments for pediatric vaccines; however, the expenditures specifically include non-DSH supplemental payments and other supplemental payments such as delivery system reform incentive payments and uncompensated care fund payments (referred to as "pool payments"). With respect to non-DSH supplemental and pool payments (defined in (d) below), the bill would treat all of those payments as being attributable to 1903A enrollees for 2019.
- Medical Assistance Expenditures are defined as those payments reported by medical service category on Form CMS-64.
- 1903A FY 2016 Population Percentage would be defined as the percentage of medical assistance spending reported on Form CMS-64 for calendar quarters in 2016 attributable to 1903A enrollees (defined in (e) below to be Medicaid beneficiaries who fall into 5 groups: Elderly, Blind or Disabled, Children, Expansion Adults, Other Adults).

(c) Target Total MA Expenditures
Describes each state's cap, or target total MA expenditures for 2020, as equal to the sum of 5 amounts – each the products of a provisional target per capita amount for 2019 for each enrollee category increased by the applicable annual inflation factor for 2020 multiplied by the number of 1903A enrollees in each group. The applicable annual inflation factor would be equal to the medical component of the consumer price index (medical-CPI) for three of the groups: children, expansion adults, and other adults. For the other two groups, the elderly and those who are blind or disabled, the index would be equal to the medical-CPI plus 1 percentage point.

For years after 2020, each state's cap, or target total MA expenditures, would be equal to the target per capita medical assistance expenditures for the prior year increased by the applicable annual inflation factor. The applicable annual inflation factor is the same as for 2020 – the medical-CPI for children, expansion adults, and other adults and medical-CPI plus 1 percentage point for the elderly and for those who are blind or disabled.

(Collins/Faso County Share Amendment): The legislation provides that the target total medical assistance spending for a state that had a 2016 DSH allotment in excess of 6 times the national average and which requires political subdivisions within the state to contribute a share

[2] It is unclear if amounts for 2016 are intended to include all non-DSH and pool supplemental payments and payments for the Vaccines for Children's program.

of the costs of Medicaid be reduced by the amount that those political subdivisions are required to contribute.[3] In calculating this reduction, payments under Medicaid as well as under Medicaid waivers will be taken into account. Funds not taken into account would include:

- Contributions required by the state from a political subdivision that, as of the calendar year in which the fiscal year involved begins, has more than 5 million people in it and imposes a local income tax on its residents; and
- Contributions required by the state from a political subdivision for administrative expenses if the state required such contributions without repayment as of January 1, 2017.

(d) Calculation of FY 2019 Provisional Target Amount for Each 1903A Enrollee Category
This section describes how provisional target per capita amounts for 2019 would be calculated and provides definitions for several other factors used for adjusting the per capita amounts.

1. A 2016 *overall average per capita amount* would be calculated for each state based on adjusted total MA spending for 2016 for the state divided by the number of 1903A enrollees on the state's program in that year. (This amount is used to calculate the non-DSH supplemental and pool percentage described in (4.) below.)
2. The 2016 *overall average per capita amount* for each state would be inflated to 2019 using the medical CPI to produce a FY 2019 *overall average per capita* amount for each state. (This amount is used to adjust the provisional target per capitas for actual audited data described in (5.) below.)
3. The Secretary would calculate, for each state, the FY 2019 adjusted total MA spending amounts for each state using a definition of adjusted total MA expenditures for FY 2019 as described in (b) above and in new 1903A(b)(1)(B). (This amount is used to adjust the provisional target per capitas for actual audited data described in (5.) below.)
4. The Secretary would provide notice to each state no later than January 1, 2020 of the provisional FY 2019 per capita target amount. For each of the five 1903A enrollee groups, the average medical assistance spending per capita for the state for FY 2019 is calculated by dividing FY 2019 medical assistance payments for 1903A enrollees by the number of 1903A enrollees and increasing those amounts by the non-DSH supplemental and pool payment percentage. Those amounts are calculated using the following which must also be included as part of the notice the Secretary provides to states:
    a. For each of the five 1903A enrollee groups, the amount of adjusted total MA spending for FY 2019 (consistent with the definition described in (b)(1)(B) minus non-DSH supplemental and pool expenditures). Non-DSH supplemental expenditures are payments made to providers that are not DSH payments; are not made with respect to a specific item or service; are in addition to payments for specific items or services; and are compliant with requirements related to upper payment limits (defined in (4)(A)(ii)). Pool expenditures are those that are not DSH payments; not made with respect to a specific item or service; are in addition to payments for specific items or services; and are authorized under a waiver that funds delivery system reform, uncompensated care pools, certain designated health programs or a similar expenditure (defined in (4)(A)(iii)).

[3] This provision is understood to apply only to New York.

b. For each of the five 1903A enrollee groups, the number of 1903A enrollees for the state for 2019 in each enrollee category;
c. The state's non-DSH supplemental and pool payment percentage which is defined to be equal to the state's spending for non-DSH supplemental and pool payments in 2016 divided by the state's total adjusted medical assistance spending in 2016 as described in new 1903A(b)(1)(A)[4]; and

5. The FY 2019 provisional target per capita amounts for each state for each enrollee category are later adjusted to reflect actual audited data on the number of 1903A enrollees in 2019 and actual MA spending in 2019. [5] The adjusted per capita targets are equal to the provisional per capita amounts multiplied by:

$$\frac{(\textit{Overall average per capita for } 2019^{6} \textbf{ X } \textit{The number of } 1903A \textit{ enrollees in } 2019)}{\textit{Adjusted total medical assistance in } 2019}$$

(e) 1903A Enrollee; 1903A Enrollee Category

The 5 enrollee groups that would be subject to per capita caps are defined in this section to be

- Enrollees who are 65 years of age or older;
- Enrollees who are blind and disabled (defined as those eligible for medical assistance on the basis of being blind or disabled who are not 65 years of age or older);
- Children under 19 years of age;
- Expansion enrollees; and
- Other non-elderly, non-disabled, non-expansion adults.

The following categories of enrollees would not be considered 1903A enrollees: individuals covered under a CHIP Medicaid expansion program; individuals who receive medical assistance through an Indian Health Service facility; women receiving Medicaid coverage due to screening under the Breast and Cervical Cancer Early Detection Program; and partial benefit enrollees. Partial benefit enrollees are those receiving only family planning services; tuberculosis related services for those infected with TB; those unauthorized aliens receiving coverage for Medicaid emergency medical care; individuals who are dually eligible for Medicaid and Medicare and for whom Medicaid pays only Medicare premiums and cost-sharing; and individuals receiving premium assistance.

(f) Special Payment Rules

Medical assistance spending under waivers approved under section 1115, section 1915, or any other provision of Medicaid would be subject to the per capita caps in the same manner as if such payments had been made under a state plan under title XIX and the per capita caps described in this section would supersede any other payment limitations otherwise applicable under those waivers.

[4] As noted above, it is unclear if amounts for 2016 are intended to include all non-DSH and pool supplemental payments and payments for the Vaccines for Children's program.
[5] The timing for this step is not specified in the legislative language.
[6] It is unclear if these amounts, which are based on 2016 medical assistance spending inflated by the medical-CPI are intended to include all non-DSH and pool supplemental payments and payments for the Vaccines for Children's program.

In the case of states that expand coverage after FY 2016 to include the ACA childless adults, the provisional FY 2019 per capita target amount for that enrollee category would be equal to the provisional FY 2019 per capita target amount for non-disabled adults.

If a state fails to satisfactorily submit data on spending and enrollees as required in subsection (h) (described below) the Secretary would calculate and apply subsections (a) through (e) with respect to the state as if all 1903A enrollee categories for which the spending and enrollee data were not satisfactorily submitted were a single 1903A enrollee category; and the growth factor otherwise applied would be reduced by one percentage point.

(g) Recalculation of Certain Amounts for Data Errors
The Secretary would be permitted to adjust several amounts used to calculate caps based on an appeal by a state filed in such form, manner, time, and containing such information as specified by the Secretary. Any adjustment that the Secretary were to determine to be valid may be made except that the adjustment could not result in an increase of the target total medical assistance expenditures in excess of 2%. Amounts that would be permitted to be adjusted would be: excess spending amounts, federal average medical assistance percentages, non-DSH supplemental and pool payment percentages, adjusted total MA payments under (b); and the number of Medicaid enrollees and 1903A enrollees for 2016, 2019 and subsequent fiscal years.

(h) Required Reporting and Auditing of CMS-64 Data; Transitional Increase in Federal Matching Percentage for Certain Administrative Expenses
Reporting. For each quarter beginning on or after October 1, 2018, states would be required to include data on medical assistance spending within such categories of services and categories of enrollees as the Secretary determines are necessary (including timely guidance published as soon as possible after the date of the enactment of the AHCA) in order to implement this section and to enable States to comply with the requirement of this paragraph on a timely basis.

Auditing. The Secretary would be required to audit each state's reporting of the number of individuals and spending reported through the CMS–64 report for FY 2016, FY 2019, and each subsequent fiscal year. The Secretary could use a representative sample for such audits.

Temporary Increase in Federal Matching Percentage to Support Improved Data Reporting Systems**.** Would provide for the following increases in the federal matching percentages for calendar quarters beginning on or after October 1, 2017 and before October 1, 2019:

- 10 percentage points (to 100%) for the design, development, and installation of mechanized claims processing and information retrieval systems;
- 25 percentage points (to 100%) for the operation of such systems; and
- 10 percentage points (to 60%) for general administration to the extent that such administrative spending is attributable to implementing the data requirements of this subsection.

(i) Flexible Block Grant Option for States
Beginning no earlier than FY 2020, states could opt for additional flexibilities in exchange for a cap on federal Medicaid funds for one or two groups of Medicaid enrollees referred to in this section as a "flexible block grant option." States could elect such option for certain categories of

enrollees for a 10-year period and extend an election for subsequent 10 year periods. States electing this option would need to have a plan approved by the Secretary.

Enrollees under Block Grant Option. A state plan would be required to specify the applicable categories of individuals that the state is choosing to incorporate under their block grant cap. The two categories of Medicaid enrollees that states could choose to apply block grants to would be:

(1) Both children and other non-elderly, non-disabled adults (1903A enrollee categories specified in proposed 1903A(e)(2)(C) and 1903A(e)(2)(E), described above); and
(2) Only other non-elderly, non-disabled adults (1903A enrollee category specified in proposed 1903A(e)(2)(E)).

If a state were to choose the first category, the state plan would be required to provide for coverage of all of the mandatory groups of pregnant women and children as required under current Medicaid law. If a state were to choose the second category, the state plan must provide for coverage for all of the mandatory groups of pregnant women as required under current Medicaid law.

Block grant individuals would not be considered 1903A enrollees for the purposes of setting per capita limits, but if a state elects to discontinue its block grant option after a 10- year period, those individuals would revert to being 1903A enrollees and the per capita limits described above would apply as if the block grant election had never taken place.

State Plan Requirements. The state plan would be required to specify the types of items and services, the amount, duration and scope of such services, the cost-sharing with respect to such services, and the method for delivery of block grant health care assistance under this subsection. In making these specifications state would not need to meet federal Medicaid requirements but would be required to provide assistance for --

- Hospital care;
- Surgical care and treatment;
- Medical care and treatment;
- Obstetrical and prenatal care and treatment;
- Prescribed drugs, medicines, and prosthetic devices;
- Other medical supplies and services; and
- Health care for children under 18 years of age.

A state plan that met those requirements would be deemed approved by the Secretary unless the Secretary determined, within 30 days, that it is incomplete or actuarially unsound. State plans under the block grant option would not be required to meet Medicaid state-wideness, comparability of benefits, and freedom-of-choice requirements.

Amount of Block Grant Funds. For the initial year of a state's block grant, the state would be subject to a cap on federal Medicaid spending for the block grant enrollees equal to:

- the federal share of the target per capita medical assistance spending amount calculated under the per capita cap provisions described above for the state for the applicable category of block grant enrollees for that year multiplied by

- the number of 1903A enrollees in the category in that year.

The federal share used in calculating this cap would be equal to the average federal medical assistance matching percentage for the state for 2019 which is defined as the average federal share percentage that would apply if spending were not subject to per capita caps. For subsequent years, the state would be subject to a block grant cap equal to the previous fiscal year's block grant cap indexed by the annual increase in the CPI for the fiscal year involved. Block grant cap amounts would remain available to a state until expended as long as a block grant election is in effect.

Federal Payment and State Responsibility. Under the block grant alternative, for each calendar quarter, states would receive federal matching funds for spending on block grant enrollees up to the cap block grant cap. The federal share of that spending would be equal to the enhanced federal matching percentage applicable to the state under the State Children's Health Insurance Program (CHIP).

Auditing. A state receiving funds under the block grant provision would be required to contract with an independent entity to audit its expenditures for each fiscal year to ensure that funds are being used in a manner consistent with the statute. Audits must be made available to the Secretary upon request.

Subtitle D—Patient Relief and Health Insurance Market Stability

Sec. 131. Repeal of Cost-Sharing Subsidy

Cost sharing subsidies provided under section 1402 of the ACA would be repealed effective for plan years beginning after December 31, 2019. (Section 1402 provides for payments to issuers to reduce the cost-sharing amounts for individuals with incomes no less than 100% and not more than 250% of the federal poverty level who buy silver level coverage through the Exchanges.)

Sec. 132. Patient and State Stability Fund

A new title XXII would be added to the Social Security Act (SSA) providing for a Patient and State Stability Fund.

Sec. 2201 of the SSA. Establishment of Program

Provides for the establishment of the Patient and State Stability Fund. It would be administered by the Secretary of Health and Human Services (HHS), acting through the Administrator of the Centers for Medicare & Medicaid Services (referred hereafter in this section as the Administrator). This program would provide funding to the 50 states and the District of Columbia, subject to allocations provided under new section 2204(c), beginning on January 1, 2018 and ending on December 31, 2026 for the purposes described in new section 2202.

Sec. 2202 of the SSA. Use of Funds

(a) In general. A state could use the funds allocated to it under the Patient and State Stability Fund for any of the following:
(1) Helping, through the provision of financial assistance, high-risk individuals who do not have access to health insurance coverage offered through an employer enroll in coverage in the state's individual market (as that market is defined by the state) whether through the establishment of a new mechanism or maintenance of an existing mechanism for such purpose.
(2) Providing incentives to appropriate entities to enter into arrangements with the state to help stabilize premiums for coverage in the individual market.
(3) Reducing the cost for providing health insurance coverage in the individual and small group markets (as defined by the state), to individuals who have, or are projected to have, a high rate of utilization of health services, as measured by cost, and to individuals who have high costs of health insurance coverage due to the low-density population of the state in which they reside.
(4) Promoting participation in the state's individual and small group markets and increasing health insurance options available through such markets.
(5) Promoting access to preventive services; dental care services (whether preventive or medically necessary); vision care services (whether preventive or medically necessary); or any combination of such services.
(6) Maternity coverage and newborn care.
(7) Prevention, treatment, or recovery support services for individuals with mental or substance use disorders, focused on either or both of the following: (A) Direct inpatient or outpatient clinical care for treatment of addiction and mental illness. (B) Early identification and intervention for children of adults with serious mental illness.
(8) Providing payments, directly or indirectly, to health care providers for the provision of such health care services as are specified by the Administrator.
(9) Providing assistance to reduce out-of-pocket costs, such as copayments, coinsurance, premiums, and deductibles, of individuals enrolled in health insurance coverage in the state.

(b) Required use of increase in allotment. A state would have to use the additional allocation provided to it from an additional $15 billion in funds appropriated for 2020 (but such funds would be available for use through 2027) only for the purposes associated with the activities described in items 6 (maternity coverage and newborn care) and 7 (prevention, treatment or recovery of addiction and mental illness).

(c) Required use of additional increase to certain waiver states to provide financial hardship assistance. The additional $8 billion for waiver states (as described in section 2204(a) below; see also section 136) would have to be used to provide assistance in reducing premiums or other out-of-pocket costs of individuals in the state subject to an increase in premiums as a result of the state's waiver.

Sec. 2303 of the SSA. State Eligibility and Approval; Default Safeguard

(a) Encouraging State Options for Allocations. To be eligible for a funding allocation for a year during the period January 1, 2018 through December 31, 2026 for use for one of the purposes

described above, a state would have to submit to the Administrator an application by a specific time.

- For 2018, the application would be required no later than 45 days from enactment; for subsequent years, it would be due no later than March 31 of the year prior to the one for which the application is made.
- The application would have to be in the form and manner specified by the Administrator and contain: a description of how the funds would be used for the required purposes; a certification that the state would make, from non-federal funds, expenditures in an amount not less than the state percentage required under section 2204(e) (see below); and such other information as the Administrator might require.
- The state application would be approved (automatic approval) unless the Administrator notified the state (no later than 60 days after the application's submission) that it had been denied for not being in compliance with the applicable requirements. The notice would also have to include the reason for the denial.
- An application approved for a year would be treated as approved, with respect to the same purpose, for each subsequent year through 2026.
- Any program receiving funds from an allocation for a state would be considered to be a "State health care program" for purposes of sections 1128 (relating to exclusion of certain individuals and entities),1128(A) (relating to civil monetary penalties), and 1128(B) (relating to criminal penalties) of the SSA.

(b) Default Federal Safeguard. For allocations made for 2018, where a state did not meet the application requirements or deadline, the Administrator, in consultation with the state's insurance commissioner, would be required to use the state's allocation for market stabilization payments to insurers. In the case of a state that did not have in effect an approved application for 2019 or for a subsequent year, the Administrator, in consultation with the state's insurance commissioner, also would be required to use the allocated funds for market stabilization payments for that state. For payments for 2018 and 2019, the allocation would fund payments to appropriate entities (issuers) equal to 75% of their claims in excess of $50,000 and no more than $350,000. For 2020-2026, the Administrator would specify the lower and upper limits for stabilization payments.

Sec. 2204 of the SSA. Allocations

(a) Appropriations. The following amounts would be appropriated to provide allocations to the states for the purposes described above: 2018 - $15 billion; 2019 - $15 billion; 2020 - $10; 2021 through 2026, $10 billion. An additional $15 billion would be appropriated in 2020 for maternity coverage and newborn care and prevention, treatment or recovery support services for individuals with mental or substance use disorders.

For the period beginning with 2018 and ending with 2023, there would be an additional $8 billion appropriated to be allocated to states with a waiver in effect under new section 2701(b) of the PHS Act (as added by section 136 of this bill). New section 2701(b)(1)(C) would allow states to waive the continuous coverage penalty called for under section 133 of this bill and instead allow issuers to use health status (presumably meaning an individual's preexisting medical

condition(s))[7] as a factor when developing premiums for individuals subject to an enforcement period.[8] 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.

(b) Allocations. The Administrator would have to provide to a state its allocation from the appropriated amounts for a year and, in the case of 2018, within 45 days after enactment (by January 1, for subsequent years). For 2018 and 2019, 85% of annual funding would be allocated based on the states' relative share of insurers' adjusted incurred claims (reported in Medical Loss Ratios for the third previous year). The remaining 15% would be allocated to states where the number of uninsured below 100% of the FPL increased between 2013 and 2015 or fewer than 3 issuers offered Exchange coverage for 2017. Beginning in 2020, allocations would be based on a formula to reflect cost, risk, low-income insured population and issuer competition. This formula would be established after consultation with health care consumers, health insurance issuers, state insurance commissioners, and other stakeholders. The stakeholders would be required to take into consideration additional cost and risk factors that might inhibit consumer and issuer participation and that reflect the goals of improving the risk pool, promoting a more competitive market and increasing choice for consumers.

(c) Annual distribution of previous year's remaining funds. Any appropriated but unallocated funds for the previous year would be reallocated to states based on the allocation methodology described above. In the case of a state with an approved application for the previous year, the state may use the reallocated funds for any approved purpose described in the state's application for the previous year. In the case of states that in the previous year received section 2203(b) default funding (i.e., those states without an approved application for the previous year), these redistributed funds would be used to carry out the Federal Invisible Risk Sharing Program in such states under new section 2205 of the SSA. This provision would apply with respect to a year beginning with 2020 and ending with 2027. The reallocation would have to be made by March 31 of the year involved.

(d) Availability. Appropriated funds allocated to states in accordance with this section would remain available for expenditures through December 31, 2027.

(e) Conditions for and limitations on receipt of funds. States would be required to make contributions, beginning with 7% of the state allotment for 2020, rising to 14% for 2021, 21%

[7] Because "health status" is not defined in the bill or in the underlying law, it seems that the likely meaning of the term is "preexisting medical condition." However, "health status-related factors," as used in section 2705(a) of the PHS Act relating to "prohibiting discrimination against individual participants and beneficiaries based on health status" in determining eligibility or continued eligibility for health insurance coverage includes "health status, medical condition (including both physical and mental illnesses), 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 Secretary."

[8] 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. However, for enrollments during a special enrollment period in 2018, the enforcement period begins with the first month the individual is enrolled in coverage and ends in the last month of the plan year.

for 2022, 28% for 2023, 35% for 2024, 42% for 2025 and 50% for 2026. For default states, the matching contribution would be 10% for 2020, 20% for 2021, 30% for 2022, 40% for 2023, and 50% for years 2024 through 2026. The Secretary could not make an allocation to a state for a purpose that is not permitted under (c)(7) of section 2105 of the Social Security Act. (It limits payments to states for abortions other than if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.)

Sec. 2205 of the SSA. Federal Invisible Risk Sharing Program

(a) In general. A Federal Invisible Risk Sharing Program would be established within the Patient and State Stability Fund. The program would be administered by the Secretary of HHS, acting through the Administrator of CMS. Its purpose would be to provide payments to health insurance issuers with respect to claims for eligible individuals for the purpose of lowering premiums for health insurance coverage offered in the individual market.

(b) Funding. There would be appropriated $15 billion for the period beginning on January 1, 2018 and ending on December 31, 2026. Funds provided under section 2204(c)(2)(B) to carry out this section would be in addition to this $15 billion appropriation.

(c) Operation of Program. After consultation with health care consumers, health insurance issuers, state insurance commissioners, and other stakeholders, and taking into consideration high cost health conditions and other health trends that generate high cost, the CMS Administrator would be required to establish parameters for the operation of the Federal Invisible Risk Sharing Program. These parameters would have to be consistent with the same limitation on payment with respect to health insurance coverage that would apply to payment with respect to health benefits coverage under section 2015(c)(7) of the SSA, which limits payments to states for abortions other than if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. Sufficient parameters would need to be established by the Administrator not later than 60 days after enactment to specify how the program would operate for plan year 2018. The Administrator would be required to establish a process for a state to operate the Program in each state beginning with plan year 2020.

(d) Details of the Program. Federal Invisible Risk Sharing Program parameters would have to include the following:

1. Definition of *eligible individuals.*
2. Development and use of health status statements with respect to eligible individuals.
3. Standards for qualification, including *automatic qualification* of individuals at the time of application for coverage and *voluntary qualification* where issuers could voluntarily qualify individuals not automatically qualified as eligible at the time of application.
4. Percentage of the premiums paid, to health insurance issuers for coverage by eligible individuals, that would have to be collected and deposited to the credit (and available for the use) of the Program.
5. Dollar amount of claims for eligible individuals after which the Program would provide payments to health insurance issuers and the proportion of the claims above that dollar amount that the Program would pay.

Sec. 133. Continuous Health Insurance Coverage Incentive

This section would amend the section of title XXVII of the PHS Act that provides for individual and group market reforms by redesignating section 2709 as 2710 and adding a new section 2710A, *Encouraging Continuous Health Insurance Coverage.* It would also amend section 2701(a)(1)(B) relating to premium rating requirements to reference new section 2710A with respect to rating for individuals who do not maintain continuous coverage.

New 2710A would apply a penalty in the case of an individual who did not maintain continuous coverage. A health insurance issuer offering health insurance coverage in the individual market, for a plan year beginning with plan year 2019 (or, in the case of an individual enrolling during a special enrollment period, beginning with plan year 2018), would be required to increase the otherwise applicable monthly premium for that individual by 30%. The 30% penalty would apply for coverage for the plan year.

(a) Definitions. A person who did not maintain continuous coverage, with respect to an enforcement period and health insurance coverage, is an individual who is a policyholder of such coverage for such months and cannot demonstrate (through presentation of certifications or in such other manner as may be specified in regulations) that during the look-back period there was not a period of at least 63 continuous days when the individual did not have creditable coverage.

"Creditable coverage" is defined by reference to current law (section 2704(c) of the PHS Act) to mean coverage of the individual under a group health plan; health insurance coverage; Medicare Parts A or B; Medicaid (other than coverage consisting solely of benefits under section 1928 of the Social Security Act); military health care; a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; the Federal Employees Health Benefit Program; a public health plan as defined in regulations; and a Peace Corps plan. Creditable coverage does not include coverage consisting solely of coverage of excepted benefits (e.g., stand-alone dental or vision benefits). In the case of an individual who had been enrolled as an adult child through age 25 as a dependent and that person's coverage ceased as a result of becoming age 26, lack of continuous coverage would result if the individual did not enroll in the new coverage during the first open enrollment period following the date on which the dependent coverage ceased.

The "look-back" period means, with respect to an enforcement period for an individual beginning with plan year 2019 (or 2018 in the case of an individual using a special enrollment period), the 12-month period ending on the date the individual enrolls in the new coverage for the plan year.

"Enforcement period" means, with respect to enrollments during a special enrollment period for plan year 2018, the period beginning with the first month that is during such plan year and that begins subsequent to the date of enrollment and ends with the last month of the plan year. With respect to enrollments for plan year 2019 and subsequent plan years, it is the 12-monhh period beginning on the first day of the respective plan year.

Sec. 134. Increasing Coverage Options

Section 1302 of the ACA relating to the Essential Health Benefits (EHBs) would be amended by ending the requirement as of January 1, 2020 that coverage providing the EHBs meet specified actuarial levels (the "metal levels"). Any reference to that subsection (1302(d)) or level of coverage or plan described in it and any requirement under law applying such a level of coverage or plan would have no force or effect and the EHB requirement would be applied as if the subsection had been repealed. (See also sec. 136 below.)

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

The age rating factors for insurance in the individual and small group markets would be changed. Beginning on or after January 1, 2017, as the Secretary might implement through interim final regulation, the age rating would be changed from 3 to 1 to 5 to 1, or such other ratio as the state involved might provide (or, in the case of a state with a waiver under section 136 of this bill, the ratio applied for the plan year under that waiver).

Sec. 136. Permitting States to Waiver Certain ACA Requirements to Encourage Fair Health Insurance Premiums

(a) In general. The bill would amend section 2701 of the PHS Act to add a new subsection (b).

(b) Permissible State Waiver to Encourage Fair Health Insurance Premiums. A state could apply for a waiver of certain rating rules to the Secretary of HHS for one or more of purposes:

1. For plan years beginning on or after January 1, 2018, a state 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 age ratio allowed under section 135 of this legislation (that section changes the existing limit of 3 to 1 for age rating of adults to 5 to 1 or such other ratio as the state involved may provide).

2. For plan years beginning on or after January 1, 2020, a state could specify the essential health benefits to apply to coverage offered in the individual or small group markets, thereby providing for different benefits than those specified under the ACA's section 1302 which defines 10 specific categories of essential health benefits.

3. A state that met one of three conditions could modify the penalty for individuals who fail to maintain continuous coverage. The conditions are: (a) elected to use Patient and State Stability funding to provide financial assistance to high-risk individuals without access to health insurance coverage offered through an employer so that these individuals could enroll in individual market coverage or (b) used that funding to provide incentives to appropriate entities to enter into arrangements with the state to help stabilize individual health insurance market coverage or (c) participated in the Federal Invisible Risk Sharing Program established under section 2205 of the Act. Under the modification, instead of

imposing a 30% penalty on an individual failing to maintain continuous coverage for an enforcement year, the state could instead provide that the premium paid by such an individual be adjusted for their health status.[9] This provision would apply to enrollments in the individual and small group markets in the state for the plan year beginning with plan year 2019 (or in the case of enrollments during special enrollment periods, beginning with plan year 2018).

A state waiver application would be considered (deemed) approved unless the Secretary notified the state, not later than 60 days after the date of its submission, that the application had been denied for not being in compliance with any of the following requirements and of the reason for the denial. These include that the application:

- Be submitted at such time, and in such manner, as the Secretary might require.
- Specify how the approval of such application would provide for one or more of the following for coverage in that state: (1) reducing average premiums; (2) increasing enrollment; (3) stabilizing the market; (4) stabilizing premiums for individuals with preexisting conditions; or (5) increasing the choice of health plans.
- Specify the period for which the waiver was effective, consistent with terms of the waiver (see below).
- Specify the higher age rating ratio if the state was applying for a higher age rating ratio than 5 to 1.
- Specify the essential health benefits if the state was applying to waive the essential health benefits required under section 1302(b) of the ACA.
- Demonstrate that the state had in place a program that carried out the purposes described in paragraph (1) or (2) of section 2202(a) of the SSA (relating to financial assistance to high-risk individuals without access to employer coverage so that they can enroll in individual coverage or providing incentives to entities to enter into arrangements to stabilize individual market premiums) or participated in the new Federal Invisible Risk Sharing Program.

Term of the waiver. No waiver for a state could extend for longer than 10 years unless the state requested its continuation. Such a request would be deemed granted unless the Secretary, within 90 days after the date of the request's submission, either denied it in writing or informed the state in writing with respect to any additional information needed to make a final determination on the request. A continuation of the waiver could only be effective for a period during which the state had in place a program that carried out the purpose described in paragraph (1) or (2) of section 2202(a) of the SSA or participated in the new Federal Invisible Risk Sharing Program.

[9] In applying health status as a rating factor, the bill would not apply section 2705(b) of the PHS Act which states that a group health plan, and a health insurance issuer offering group or individual health insurance coverage cannot require any individual (as a condition of enrollment or continued enrollment under the plan) to pay a premium or contribution which is greater than such premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-related factor in relation to the individual or to an individual enrolled under the plan as a dependent of the individual. It also prohibits a group health plan, and health insurance issuer offering group or individual health insurance coverage, from adjusting premium or contribution amounts for the group covered under such plan on the basis of genetic information.

Non-Application Rules. The state waiver described above would not apply to section 1301 of the ACA to the extent that such section applies to qualified health plans (QHPs) offered through the CO-OP program or through Multi-State plans. The state waivers under this section also would not apply to section 1312(d)(3)(D) of the ACA requiring Members of Congress and congressional staff to obtain their coverage through an Exchange. However, the non-application of the waiver provision to Members of Congress and congressional staff would not take effect if the AHCA becomes law. On the same day that the House passed the AHCA (H.R. 1628), it also passed H.R. 2192, which would amend the proposed AHCA Section 136 state waiver authority, if it is enacted, to remove ACA Section 1312(d)(3)(D) from the list of provisions to which proposed AHCA Section 136 does not apply.

In addition, the waiver described in this section would not apply with respect to any of the following sections of the ACA:

- 1331 relating to state flexibility to offer coverage for low income programs that through Basic Health Programs;
- 1332 relating to state innovation waivers;
- 1333 and relating to Health Care Choice Compacts that states could enter into for the purposes of enabling issuers to offer health insurance coverage in more than one state; and
- 1334 relating to Multi-State plans.

This section further provides that any standard or requirement adopted by a state pursuant to the terms of a waiver approved under this subsection would be deemed to comply with section 1252 of the ACA (related to uniform rating rules) and section 1324(a) of the ACA, insofar as such standard or requirement is related to a federal or state law described section 1324(b)(2) of the ACA (which specifies that state rating rules would not apply to a private health insurer if they also do not apply to a QHP offered under a CO-OP plan or a QHP offered under a Multi-State plan).

(b) Application to Essential Health Benefits. Section 1302(a)(1) of the ACA would be amended to provide that the term essential health benefits, means with respect to any health plan, coverage that provides for essential health benefits under current law, or in the case of health insurance coverage offered in the individual or small group market in a state for which there is an applicable waiver in effect for a plan year, coverage that meets the state's specification for essential health benefits.

Sec. 137. Constructions.

(a) No gender rating. This section provides that nothing in the AHCA shall be construed as permitting health insurance issuers to discriminate in rates for health insurance coverage by gender.

(b) No limiting access to coverage for individuals with preexisting conditions. This section provides that nothing in the AHCA shall be construed as permitting health insurance issuers to limit access to health insurance coverage for individuals with preexisting conditions.

Subtitle E—Implementation Funding

Sec. 141. American Health Care Implementation Fund

An American Health Care Implementation Fund would be established within HHS to carry out the following sections of this legislation:
121 -- Per Capita Allotment for Medicaid
132 -- Patient and State Stability Fund
202 -- Additional Modifications to the Premium Tax Credit
and
214 -- Refundable Tax Credit for Health Insurance Coverage

A total of $1,000,000,000 would be appropriated to the Fund for federal administrative expenses to carry out implementation of those sections (including amendments made by those sections).

Title II – Committee on Ways and Means
Subtitle A – Repeal and Replace of Health-Related Tax Policy

Sec. 201. Recapture Excess Advance Payments of Premium Tax Credits

Limits on recapture of advance payments of premium tax credits would be repealed. Any advance payments of the current premium tax credits under section 36B of the Internal Revenue Code (IRC)) to a household in excess of the final amount determined on the household's tax return would be fully subject to recapture, effective with tax years 2018 and 2019. Under current law, the recapture is limited for individuals with income below 400% of the federal poverty level (FPL). Specifically, for the 2017 tax year, the "recapture" of excess advance payments is limited to the following amounts:

2017 limits on recapture of advanced payments of premium tax credits		
Household income as % of FPL	Tax Filing Status	
	Single	All other
Less than 200%	$300	$600
At least 200% but <300%	$750	$1,500
At least 300% but <400%	$1,275	$2,550

It is these limits that would be repealed.

Sec. 202. Additional Modifications to Premium Tax Credit

Modifications would be made to the premium tax credits available under section 36B of the IRC for 2018 and 2019. The coverage that is eligible for premium tax credits would be expanded to include coverage sold outside the Exchange and to catastrophic plans (section 1302(e) of the

ACA) and would be restricted to exclude grandfathered and grandmothered health plans and any plan that includes coverage for abortions (other than those necessary to save the life of the mother or with respect to a pregnancy that is the result of rape or incest).

- The definition of grandfathered health plans would be unchanged from current law. (Under section 1251 of the ACA, grandfathered plans are health plans that were in existence on March 23, 2010, and have not been changed in ways that substantially cut benefits or increase costs for plan holders.)
- A grandmothered health plan is defined as one offered in the individual market as of October 1, 2013, and permitted to be offered in the individual market as of January 1, 2014 under the guidance issued by CMS in a letter to the State Insurance Commissioners on November 14, 2013, as subsequently modified, Modifications include a bulletin issued by the Director of the Center for Consumer Information and Insurance Oversight (CCIIO) on February 29, 2016 regarding extension of the transitional policy through 2017.
- The restriction on coverage for abortion services could not be construed to prohibit the purchase of separate coverage for restricted abortions by an individual as long as no credit is allowed toward the premiums for such coverage, and health insurance issuers may offer separate coverage for abortions or a plan that covers abortions as long as the premiums for abortion coverage are not paid for with tax credit amounts. For purposes of the restriction on use of the tax credit for abortion coverage, the treatment of infection, injury, disease, or disorder caused or exacerbated by abortion would not be treated as abortion coverage.

While premium tax credits would be expanded to include coverage sold outside the Exchange, for 2018 and 2019, advance payment of the tax credit and advance determination of tax credit eligibility (sections 1412 and 1411 of the ACA, respectively) would continue to be limited to coverage purchased through the Exchange. An issuer of a qualified health plan sold to an individual outside the Exchange would be required to provide a report to the Secretary of the Treasury for the individual including a statement that the plan is qualified for the credit; the premiums paid; the months during which the coverage was provided; the adjusted monthly premium for the applicable second-lowest cost silver plan for each month for the individual; and other information the Secretary of the Treasury may require.

For 2019, the premium tax credit amounts, which are based on income and the cost of health insurance[10], would be modified to provide that the premium contribution required for an individual would also be based on age according to the following table. In the case of joint

[10] The premium tax credit amount equals the premium of the second-lowest cost "silver" level plan available to the taxpayer in the Exchange, reduced by the household's required contribution toward the premium, which is calculated as a percentage of income. Taxpayers may choose to enroll in any Exchange plan with the credit, but cost sharing subsidies are separately available for certain low income individuals only if they are enrolled in silver level Exchange plans. Under this legislation, for 2018 and 2019, the tax credit would be made available for off-Exchange coverage, making it possible for insurers to discontinue offering plans through Exchanges for individuals otherwise eligible for the premium tax credit. In a case where no insurers offered Exchange coverage in 2018 or 2019, it is unclear how the amount of the tax credit would be calculated.

returns, the age of the older spouse would be used to determine the amount of the credit. The current law methodology for indexing the required contribution percentages would be applied.

"In the case of household income (expressed as a percent of the poverty line) within the following income tier:	Up to Age 29		Age 30-39		Age 40-49		Age 50-59		Over Age 59	
	Initial %	Final %	Initial %	Final %	Initial %	Final %	Initial %	Final %	Initial %	Final %
Up to 133%	2	2	2	2	2	2	2	2	2	2
133%-150%	3	4	3	4	3	4	3	4	3	4
150%-200%	4	4.3	4	5.3	4	6.3	4	7.3	4	8.3
200%-250%	4.3	4.3	5.3	5.9	6.3	8.05	7.3	9	8.3	10
250%-300%	4.3	4.3	5.9	5.9	8.05	8.35	9	10.5	10	11.5
300%-400%	4.3	4.3	5.9	5.9	8.35	8.35	10.5	10.5	11.5	11.5

For purposes of comparison, the 2017 premium tax credit household contribution is determined using the following table. (See IRS Revenue Procedure Publication 2016-24.)

Household income percentage of Federal poverty line:	**Initial percentage**	**Final percentage**
Less than 133%	2.04%	2.04%
At least 133% but less than 150%	3.06%	4.08%
At least 150% but less than 200%	4.08%	6.43%
At least 200% but less than 250%	6.43%	8.21%
At least 250% but less than 300%	8.21%	9.69%
At least 300% but not more than 400%	9.69%	9.69%

Sec. 203. Small Business Tax Credit

The small business tax credit provided under section 45R of the IRC would be repealed for amounts paid or incurred in taxable years beginning after December 31, 2019.
In the interim, for taxable years beginning in 2018 and 2019, the credit would be modified to exclude plans that include coverage for abortions (other than those necessary to save the life of the mother or with respect to a pregnancy that is the result of rape or incest). The restriction could not be construed to prohibit an employer from purchasing separate coverage for restricted abortions as long as no credit is allowed with respect to employer contributions toward such separate coverage, and health insurance issuers could offer separate coverage for abortions or a plan that covers abortions as long as the premiums for abortion coverage are not paid for with an employer contribution eligible for the small business tax credit. The treatment of infection, injury, disease, or disorder caused or exacerbated by abortion would not be treated as abortion coverage.

Sec. 204. Individual Mandate

The penalty for individuals who fail to maintain minimum essential coverage (the "individual mandate") would be reduced to zero for months beginning after December 31, 2015.

Sec. 205. Employer Mandate

The penalty for employers failing to meet the shared responsibility requirements regarding health coverage under section 4980H of the IRC (the "employer mandate") would be reduced to zero for months beginning after December 31, 2015.

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

The excise tax on high-cost employer-sponsored coverage (section 4980I of the IRC- also known as the "Cadillac tax"), scheduled under current law to apply for taxable years beginning after December 31, 2019 would apply only for taxable years beginning after December 31, 2025.

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

Subparagraph (A) of section 223(d)(2) 17 of the IRC would be amended to allow reimbursements from health Flexible Spending Accounts (FSAs) and Health Reimbursement Arrangements (HRAs) and distributions from HSAs or Archer Medical Savings Accounts (MSAs) to be used for over-the-counter medications and those amounts would be excluded from the taxpayer's income. In the case of HSAs and MSAs, the provision would be effective for amounts paid with respect to taxable years beginning after December 31, 2016. In the case of health FSAs and HRAs, it would be effective for expenses incurred for taxable years beginning after December 31, 2016.

Sec. 208. Repeal of Increase in Tax on Health Savings Accounts

The tax imposed on distributions from HSAs for nonqualified medical expenses (section 223(f)(4)(A) of the IRC) would be reduced from 20% to 10%. The tax imposed on distributions from Archer MSAs (Section 223(f)(4)(A) of the IRC) would be reduced from 20% to 15%. These changes would apply for distributions made after December 31, 2016.

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

Section 125 of the IRC would be amended to repeal the dollar limitation on the maximum amount an employee may contribute through salary reduction (for 2017, that amount is $2,600). This change would apply to taxable years beginning after December 31, 2016.

Sec. 210. Repeal of Medical Device Excise Tax

Section 4191 of the IRC providing for an excise tax on medical devices would be amended by providing that the tax not apply to sales after December 31, 2016.

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

Section 139A of the IRC currently provides that a deduction for qualified retiree health prescription drug expenses that would otherwise be allowable to a taxpayer (i.e., an employer) is not available if the taxpayer excludes from income qualified retiree prescription drug plan subsidies received from HHS with respect to those expenses (i.e. the taxpayer cannot deduct prescription drug expenses if the retiree also has prescription drug coverage through an employer that is subsidized by HHS) . This section would be amended effective for taxable years beginning after December 31, 2016 to provide that such a taxpayer would be able to claim a deduction for covered retiree prescription drug expenses even though that taxpayer excluded from income qualified retiree prescription plan subsidies received from HHS.

Sec. 212. Reduction of Income Threshold for Determining Medical Expense Deduction

Under current law, taxpayers may deduct unreimbursed qualified medical expenses that exceed 10% of adjusted gross income. The deduction threshold would be changed to 5.8% of adjusted gross income effective for taxable years beginning after December 31, 2016.

Sec. 213. Repeal of Medicare Tax Increase

The increased Medicare hospital insurance (HI) taxes (0.9% FICA tax and self-employment tax) owed by taxpayers whose wages exceed a certain threshold (e.g., $250,000 in the case of a joint return) would be repealed effective with respect to remuneration received after, and taxable years beginning after, December 31, 2022.

Sec. 214. Refundable Tax Credit for Health Insurance Coverage

The refundable premium tax credit for health insurance coverage provided under section 36B of the IRC would be substantially modified beginning after December 31, 2019.

Eligibility for Credit. The credit would be available for months during which a taxpayer who is a citizen or qualified alien is covered by a qualified health plan and is not eligible for a group health plan[11] (other than one for which substantially all the coverage is for excepted benefits), or for certain government coverage identified in current law as minimum essential coverage (Medicare Part A, Medicaid, CHIP; TRICARE and related military coverage; the Nonappropriated Fund Health Benefits Program of the Department of Defense; veteran's health care (as defined by the Secretary of Veterans Affairs in consultation with the Secretaries of HHS and Treasury); and coverage for Peace Corps volunteers).

[11] Under current law, individuals eligible for group health coverage are generally ineligible for the refundable premium assistance tax credit under section 36B, but there are exceptions permitting eligibility for the credit when: 1) the employee contribution is considered to be "unaffordable" because it is more than 9.69% of household income (2017) or 2) the employer sponsored plan does not provide minimum value, meaning the plan's share of the cost of covered benefits is less than 60%.

- A qualified health plan would be defined as any health insurance coverage sold in the individual market with the following exclusions: grandfathered and grandmothered plans (using the same definitions as under section 202 above); plans for which substantially all the coverage consists of excepted benefits (e.g., dental, vision, accident-only, long-term care only, disease-specific benefits); and coverage consisting of short-term limited duration insurance. Further, the coverage may not include abortions (other than those to save the life of the mother or those resulting from rape or incest). Qualified health plans would have to be certified by the state in which they are offered, and certifications would have to be made available to the public and meet other requirements that the Secretary of the Treasury may provide.
- The language added to section 36B in section 202 of this bill (described above) restricting coverage for abortion services would continue to apply (i.e., rule of construction regarding separate coverage and certain treatments that would not be considered abortion coverage).

Individuals who are incarcerated would not be eligible for the credit unless they are incarcerated pending the disposition of charges.

To qualify for the credit, married couples would have to file a joint return, with an exception for taxpayers certifying that they are living apart and victims of domestic abuse or spousal abandonment. This exception would no longer be available if it had been met for the three preceding tax years. Credits would not be available to individuals who are dependents of another taxpayer or to individuals under age 27 who are not dependents but who are covered under another taxpayer's health insurance plan.

Health insurance premiums covered by the tax credit would not be eligible for the medical expense deduction; any premiums exceeding the amount of the credit would be eligible for the deduction.

Amount of Credit. Monthly credit amounts would be the lower of the sum of the monthly limitation amounts applicable to the taxpayer or the monthly premium paid by the taxpayer for eligible health insurance.

The table below shows the base limitation amounts by age and income. Monthly limits are 1/12 of the amounts shown. The limitations would be the sum of those that apply to the five oldest individuals in the filing household (includes the taxpayer, spouse, dependents, and any child up to age 27 enrolled in the taxpayer's eligible health insurance plan), with an overall annual limit of $14,000.

For individuals with a modified adjusted gross income (MAGI) above $75,000 ($150,000 for joint returns) the limitations would be phased out. Specifically, the credit would be reduced by 10% of the difference between the taxpayer's MAGI and $75,000 ($150,000 for joint returns). (The MAGI definition used is unchanged from current law.)

The following table illustrates how the phase out schedule would work for single filers at certain income levels.

Single filer Income	Age <30	Age 30-39	Age 40-49	Age 50-59	Age 60 and older
≤$75,000	$2,000	$2,500	$3,000	$3,500	$4,000
$80,000	*$1,500*	*$2,000*	*$2,500*	*$3,000*	*$3,500*
$85,000	*$1,000*	*$1,500*	*$2,000*	*$2,500*	*$3,000*
$90,000	*$500*	*$1,000*	*$1,500*	*$2,000*	*$2,500*
$95,000	*$0*	*$500*	*$1,000*	*$1,500*	*$2,000*
$100,000		*$0*	*$500*	*$1,000*	*$1,500*
$105,000			*$0*	*$500*	*$1,000*
$110,000				*$0*	*$500*
$115,000					*$0*

For taxable years beginning in calendar year 2021 or later, the limitation dollar amounts, the $75,000/$150,000 amounts to start the phase out of the credit, and the $14,000 aggregate credit limit would all be indexed to growth since 2019 in the Consumer Price Index (CPI) plus 1 percentage point.[12]

Tax credit amounts would be reduced by any amounts that had been advanced; to the extent that amounts that were advanced exceed the credit allowed, that excess would be recaptured (i.e., added to the amount of the taxes otherwise owed.)

Tax credit amounts would also be reduced (but not below zero) by any amount the taxpayer or a qualifying family member was provided through a qualified small employer health reimbursement arrangement (HRA), for the number of months for which the HRA was provided. The deduction for health insurance costs of self-employed individuals would also be reduced (but not below zero) by the amount of the credit allowed under section 36B, determined without regard to any advance payments.

Taxpayers electing (for themselves or for qualifying family members) the existing Trade Adjustment Assistance health insurance tax credit available under section 35(g) for a month would not be eligible for the credit under 36B for that month. To the extent that the sum of any advance payments of the credits under sections 35(g) and 36B exceed the sum of the total credits allowed to the taxpayer under these sections, that excess would be added to taxes owed.

Advance Payment of the Health Insurance Tax Credit. The Secretaries of HHS and Treasury would be directed to establish (through regulations as necessary) and operate an advance payment program under section 1412 of the ACA for individuals covered under qualified health plans (whether enrolled through an Exchange or otherwise). The directions require that the program protect taxpayer information, provide robust verification of all information necessary to

[12] Under current law, income-based caps on premium contributions are indexed so that the share of the premiums paid by enrollees in each income band is maintained over time, unless, beginning in 2018, aggregate payments for premium tax credits and cost sharing subsidies exceed a cap. Specifically, if those aggregate federal amounts exceed .504% of gross domestic product (GDP) in a year, then premium contributions for households will be adjusted in the following year to maintain spending on those aggregate federal amounts below that threshold.

establish taxpayer eligibility, ensure proper and timely payment to health providers and protect program integrity to the maximum extent possible.

Reporting Requirements for Employers. Employers would be required to report on each employee's annual W-2 form information for each month for which the employee was eligible for a group health plan (or specified government coverage as described under eligibility for credit) in connection with their employment. (Note that the section 36B reporting requirements established in section 202 above for issuers selling off-Exchange qualified health plans would continue.)

Penalties for Erroneous Claims of Credit. In the case of a taxpayer who files a tax return claiming a section 36B credit in excess of the allowed amount, the penalty would be 25% of the excess, unless the excess claim is shown to be for a reasonable cause. (In general, under the IRC, the penalty associated with excess claims for a tax credit is 20% of the excess.)

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

Sections 223(b)(2)(A) and (B) of the IRC (relating to HSAs) would be amended to increase the maximum contribution limit to a qualified HSA (which, for 2017, is $3,400 for self-only coverage and $6,750 for family coverage) to the sum of the annual deductible and out-of-pocket limit permitted under the taxpayer's high deductible health plan. For 2017, those deductible/out-of-pocket limit amounts are $6,650 in the case of self-only coverage and $13,100 in the case of family coverage. As under current law, the basic HSA contribution limits would be increased by $1,000 for an eligible individual who has attained age 55 by the end of the taxable year. The changes would apply for taxable years beginning after December 31, 2017.

Sec. 216. Allow Both Spouses to Make Catch-up Contributions to the Same Health Savings Account

Section 223(b) of the IRC would be amended to provide that, if both spouses are eligible for catch-up contributions to their HSAs and either has family coverage, the annual contribution limit that can be divided between them would include the catch-up contribution amount of both spouses. (Catch-up contributions increase the basic HSA contribution limit by $1,000 for an eligible individual who has attained age 55 by the end of the taxable year.) The provision applies for taxable years beginning after December 31, 2017.

Sec. 217. Special Rule for Certain Medical Expenses Incurred Before Establishment of Health Savings Account

Section 223(d)(2) of the IRC would be amended by adding a new paragraph (D) providing that if an HSA is established during the 60-day period beginning on the date that coverage of the account beneficiary under a high deductible health plan begins, then solely for purposes of determining whether an amount paid is used for a qualified medical expense, the HSA would be treated as having been established on the date that the coverage began. In other words, if a taxpayer with a high deductible health plan established an HSA within 60 days of the date that

the high deductible plan coverage began, any payment made by the taxpayer from the HSA for a qualified medical expense incurred during that 60-day period would be excludible from their gross income. Applies with respect to coverage beginning after December 31, 2017.

Subtitle B – Repeal of Certain Consumer Taxes

Sec. 221. Repeal of Tax on Prescription Medications

The annual fee on covered entities engaged in the business of manufacturing or importing branded prescription drugs for sale to any specified government program, or pursuant to coverage under any such program, would be repealed with respect to any calendar year beginning after December 31, 2016.

Sec. 222. Repeal of Health Insurance Tax

The annual fee on entities engaged in the business of providing health insurance in the U.S. would be repealed for any calendar year beginning after December 31, 2016.

Subtitle C – Repeal of Tanning Tax

Sec. 231 Repeal of Tanning Tax

The 10% retail sales tax on indoor tanning services would be repealed for services performed after June 30, 2017.

Subtitle D – Remuneration from Certain Insurers

Sec. 241 Remuneration from Certain Insurers

The limitation on deductibility of compensation paid by health insurers would be repealed effective for taxable years beginning after December 31, 2016. (In general, health insurance providers may currently only deduct as a business expense for a year the compensation paid to any officers, employees, directors, and other workers or service providers (such as consultants) performing services for or on behalf of the insurer up to $500,000.)

Subtitle E – Repeal of Net Investment Income Tax

Sec. 251 Repeal of Net Investment Income Tax

The 3.8 percent tax on net investment income of certain high-income taxpayers ($250,000 joint return or surviving spouse, $125,000 in the case of a married individual filing a separate return, and $200,000 in any other case) would be repealed effective for tax years beginning after December 31, 2016.