The American Health Care Act

House Energy and Commerce Chairman Greg Walden (R-Ore.) and House Ways and Means Committee Chairman Kevin Brady (R-Texas) introduced legislation Monday, March 6, 2017, The American Health Care Act (AHACA), for consideration to repeal and replace many of the provisions from the Affordable Care Act (ACA) that govern the private health insurance market and state Medicaid programs in the U.S. The committees concluded their markups March 9.

Cited as a first step in the process of moving the nation’s health system away from the one created under the ACA, the AHCA contains provisions focusing on market reforms, implementing changes to the funding mechanism for state Medicaid programs, and proposing allotments to states to support the transitional period as the health system moves from the ACA. Of greatest importance to the states, federal funding for the Medicaid program would be altered by establishing a per capita cap block grant program with the amounts based on five groups: (1) children, (2) the elderly, (3) blind and disabled persons, (4) pregnant women and parents, and (5) working adults (the Medicaid expansion population). It establishes expenditure targets along with penalties for exceeding those targets. The ACA Medicaid is not repealed, but the bill would alter the federal funding to states to support the expansion population.

The measure will now be considered by the House Budget Committee. The Congressional Budget Office has not yet published the projected budgetary impact of the provisions.

NCSL summary prepared by Rachel B. Morgan RN, BSN, senior committee director, NCSL Health and Human Services Committee. For questions or comments, contact Rachel Morgan.

<table>
<thead>
<tr>
<th>Title I Energy and Commerce</th>
<th>Subtitle A: Patient Access to Public Health Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 101. The Prevention and Public Health Fund</td>
<td>Repeals Prevention and Public Health Fund appropriations provided for under the Affordable Care Act (ACA) designated for fiscal years (FY) 2019 and beyond.</td>
</tr>
<tr>
<td>Section 102. Community Health Center Program</td>
<td>Provides an additional $422 million to the Community Health Centers Fund during FY 2017. The Community Health Center Fund is the source for grants to Federally Qualified Health Centers (FQHCs).</td>
</tr>
<tr>
<td>Section 103. Federal Payments to States</td>
<td>Imposes a one-year freeze on mandatory funding to a class of providers designated as a prohibited entity. This funding includes Medicaid, the Children’s Health Insurance Program (CHIP), Maternal and Child Health Services Block Grant, and Social Services Block Grants (SSBG).</td>
</tr>
</tbody>
</table>
A prohibited entity is one that meets the following criteria:
- It is an essential community provider primarily engaged in family planning and reproductive health services.
- It provides abortions in cases that do not meet the Hyde amendment exception for federal payment.
- It has received more than $350 million in federal and state Medicaid dollars in FY 2014.

### Subtitle B: Medicaid Program Enhancements

<table>
<thead>
<tr>
<th>Section</th>
<th>Provisions</th>
<th>State Action Required/State Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sec. 111.</strong></td>
<td><strong>Presumptive Eligibility Determinations</strong>&lt;br&gt;Repeals states expanded authority to make presumptive eligibility determinations for:&lt;br&gt;  - Family planning services under “Sec. 1920C (a) State Options” of the ACA, and ends the authority as of Jan. 1, 2020.&lt;br&gt;  - Medical assistance by a hospital under Sec. 2202, (1)(2)(C) of the ACA.&lt;br&gt;  - Pregnant women under Sec. 1920(e) of the Social Security Act as of Jan. 1, 2020.&lt;br&gt;&lt;br&gt;<strong>Community First Choice Options</strong>&lt;br&gt;Repeals the six percent enhanced federal match provided for in Sec. 2401 for states that elected to provide home and community based services (HCBS) attendant services and supports for individuals who are eligible for medical assistance under the state plan whose income does not exceed 150 percent of the poverty line, effective Jan. 1, 2020.</td>
<td>Ends state authority to make presumptive eligibility determinations for family planning services as of Jan. 1, 2020, medical assistance by a participating hospital as of Dec. 31, 2019, and pregnant women as of Jan. 1, 2020.&lt;br&gt;Repeals the 6-percentage point enhanced match to states for individuals receiving HCBS who qualified under the expansion population and whose income did not exceed 150 percent of the federal poverty limit (FPL).</td>
</tr>
<tr>
<td><strong>Sec. 112. Repeal of Medicaid Expansion.</strong></td>
<td><strong>Codifies the National Federation of Independent Business (NFIB) v. Sebelius</strong> and makes the Medicaid expansion optional for states.&lt;br&gt;Repeals the state option to extend coverage to adults above 133 percent of federal poverty by Dec. 31, 2019.&lt;br&gt;&lt;br&gt;<strong>Termination of the Enhanced Federal Match (FMAP) for ACA Expansion Population</strong>&lt;br&gt;Repeals the enhanced federal matching rate for newly eligible beneficiaries on Dec. 31, 2019.&lt;br&gt;States can keep the enhanced match for newly eligible expenditures that occur before Jan. 1, 2020.&lt;br&gt;After Jan. 1, 2020, the newly eligible matching rate would only apply to expenditure for newly eligible individuals who were enrolled in Medicaid (under the state plan or a waiver) as of Dec. 31, 2019, and who do not have a break in eligibility for more than one month after that date.</td>
<td>Repeals the provisions from the ACA creating the expansion options for state Medicaid programs as of Dec. 31, 2019.&lt;br&gt;Repeals the sections from the ACA that provided for the enhanced FMAP for the Medicaid expansions population.</td>
</tr>
</tbody>
</table>
After Jan. 1, 2020, the state may only enroll newly eligible individuals at the state’s traditional FMAP for that individual.

After Jan. 1, 2020, the expansion population who are under the age of 65, not pregnant, or eligible for Social Security Disability Income and whose income is less than 133 percent of the FPL and for which the state received a phased enhanced match, the state will have the option to enroll new eligible individuals, but the state would receive the state’s traditional FMAP for those individuals.

**Sunsets Essential Health Benefits Requirements**

Sunsets the requirement that state Medicaid plans must provide the same “essential health benefits” that are required by plans on the exchanges, as of Dec. 31, 2019.

**Sec. 113. Elimination of Disproportionate Share Hospital (DSH) Cuts.**

**Medicaid DSH Reductions**

- Repeals the Medicaid DSH payment reductions for nonexpansion states in 2018.
- Repeals the DSH reductions for states that expanded Medicaid in 2020.


**Sec. 114. Reducing State Medicaid Costs.**

**Letting States Disenroll High Dollar Lottery Winners**

- For lottery winning or lump sum payments on or after Jan. 1, 2020, an individual whose eligibility for medical assistance is determined based on the application of modified adjusted gross income, a state must, in determining their eligibility, include the winnings or income as income received:
  - In the month in which the winning or income is received if the amount is less than $80,000.
  - Over a period of two months if the amount is greater than $80,000 but less than $90,000.
  - Over a period of three months plus one month for each increment of $10,000 of winnings or income, but not exceeding a period of 120 months for winnings or income of $1,260,000 or more.

**Hardship Exemption**—If an individual’s income is less than the applicable eligibility established by the state, they may continue to be eligible for medical assistance if denial would cause an undue medical or financial hardship as determined on-the-basis of criteria established by HHS.

**Retroactive Coverage**—Limits the effective date for retroactive coverage of Medicaid benefits to U.S. citizens or to having satisfactory immigration status and to those who are determined otherwise eligible for Medicaid, within a reasonable opportunity period to provide documentation that

**Amended Eligibility Determination Process**

Amends the process of determining lottery winnings and lump sum payments as income in the determination of Medicaid eligibility.

**Required Notification**

States will be required to notify individuals of the date on which the individual would no longer be considered ineligible by reason of the criteria set for financial eligibility set out in this clause, under the state plan or waiver and the date that the individual would be eligible to reapply.
would verify their citizenship or eligible immigration status. States are required to enroll applicants in Medicaid and are eligible to receive federal matching funding for their care, during this reasonable opportunity period. Thus, individuals who are not citizens or eligible legal permanent resident may be enrolled and received Medicaid benefits.

- Closes the loophole in current practice by requiring individuals to provide documentation of citizenship or lawful presence before obtaining coverage.

**Definition of Qualified Lottery Winnings**

- Qualified lottery winnings are defined as meaning winnings from sweepstakes, lottery, or pool or a lottery operated by a multistate or multijurisdictional lottery association, including amounts awarded as a lump sum payment.

**Repeal of Retroactive Eligibility**

- Amends language in the Social Security Act (SSA) pertaining to the content of state Plans for Medical Assistance Programs (42 U.S.C. 1396a(a)) by changing the period in which assistance for care and services must be made available after the individual is determined eligible from in the third month before the month their application was made to be after the month in which the individual made application.

- This would repeal retroactive eligibility requirements for individuals applying for medical assistance on or after Oct. 1, 2017.

**Amendments Concerning Requirements for Payment of Emergency Services Provided to Aliens**

- Amends language in the SSA that requires payment for medical services if they are necessary for the treatment of an emergency medical condition of the alien, the alien otherwise meets the eligibility requirements for medical assistance, or the care and services are not related to an organ transplant procedure, unless the individual presents their social security number or satisfactory documentary evidence of citizenship or nationality, or the state elects to provide a reasonable additional period for the individual to present their documentation.

**Updating Allowable Home Equity Limits in Medicaid**

- Removes the state option to raise the allowable home equity values that dictate an individual’s eligibility for medical assistance with respect to nursing facility services or other long-term care services.

- Current law does not allow a base value of $500,000, allowing an increase from year to year based on the percentage increase in the
consumer price index for all urban consumers (all items; United States city average), rounded to the nearest $1,000.

- **Effective Date**—This change would become applicable six months after enactment of this measure.
- **Exemption for State Legislation**—In the case that a state plan revision should require state legislation to implement, an exemption is granted for additional time for the state legislature to act.

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

<table>
<thead>
<tr>
<th>Adjustment in payment for inpatient hospital services furnished by disproportionate share hospitals (DSH)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Payment under this provision will not be made in excess of $2 billion to any given state for all calendar quarters in a year.</td>
</tr>
<tr>
<td>- Adds new language that provides $10 million over five years to nonexpansion states for safety net funding.</td>
</tr>
<tr>
<td>- For 2018 through 2021, each state that is one of the 50 states or the District of Columbia and that, as of July 1 of the preceding year, did not provide for eligibility in an expanded Medicaid program may receive safety net funding to adjust payment amounts for Medicaid providers.</td>
</tr>
<tr>
<td>- <strong>Increased FMAP</strong>—For these payment adjustments using the safety net funding, nonexpansion states would receive an increased matching rate (FMAP) of:</td>
</tr>
<tr>
<td>- 100 percent for calendar quarters in 2018, 2019, 2020 and 2021, and</td>
</tr>
<tr>
<td>- 95 percent for calendar year 2022.</td>
</tr>
</tbody>
</table>

**Limitations; Disqualification of States**

- Each nonexpansion state’s allotment from the $2 billion would be determined according to the number of individuals with income below 138 percent of the FPL in 2015 relative to the total number of individuals with income below 138 percent of FPL for all the nonexpansion states in 2015.
- The 2015 American Community Survey 1-year estimate, as published by the Bureau of the Census, would be used to determine the portion of each state’s population that is below 138 percent of the FPL.
- If a nonexpansion state for a year implements the ACA Medicaid expansion during the year, the state shall no longer be treated as a nonexpansion state for safety net funding for subsequent years.

### Sec. 116. Providing Incentives for Increased Frequency of Eligibility Redeterminations.

<table>
<thead>
<tr>
<th>Frequency of Eligibility Redetermination</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Beginning Oct. 1, 2017, requires states with Medicaid expansion populations to redetermine expansion enrollees’ eligibility every six months.</td>
</tr>
</tbody>
</table>

May potentially alter procedures for eligibility redeterminations.
Civil Monetary Penalty
- Increases the allowable civil monetary penalty after Oct. 1, 2017. The HHS inspector general is permitted to levy the penalty if someone intentionally defrauds the program by claiming Medicaid matching funds for an individual not eligible for expansion, to $20,000 for each individual or claim.

Temporary Enhanced Federal Matching Rate for Transitional Activities
- This policy also provides, beginning Oct. 1, 2017, and ending Dec. 31, 2019, a temporary 5 percent FMAP increase to states for activities directly related to complying with this section and related to determinations of eligibility.

### Subtitle C: Per Capita Allotment

<table>
<thead>
<tr>
<th>Section</th>
<th>Provisions</th>
<th>State Action Required/State Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sec. 121. Per Capita Allotment for Medical Assistance</td>
<td>Application of Per Capita Cap on Payments for Medical Assistance Expenditures—Creates a per capita cap model (i.e., per enrollee limits on federal payments to states) starting in FY2020, based on each state’s historical per enrollee cost and the number of enrollees in the state using a base year of FY 2016.</td>
<td>Alters the formulation of federal payments to states for support of the Medicaid program.</td>
</tr>
<tr>
<td></td>
<td>HHS Established Spending Targets—Uses each state’s spending in FY2016 as the base year to set targeted spending for each enrollee category (elderly, blind and disabled, children, non-expansion adults, and expansion adults) in FY2019, and in subsequent years for that state.</td>
<td>Sets expenditure targets that will be reportable to CMS via new reporting requirements established in this measure.</td>
</tr>
<tr>
<td></td>
<td>Each state’s targeted spending amount would increase by the percentage increase in the medical care component of the consumer price index for all urban consumers from September 2019 to September of the next fiscal year.</td>
<td>Creates a penalty of a 25 percent reduction of the margin above current level to Medicaid funding for excess expenditures beyond those targets established for the state program by HHS.</td>
</tr>
<tr>
<td></td>
<td>Excess Aggregate Medical Assistance Expenditure Penalty—Starting in FY2020, any state with spending higher than their specified targeted aggregate amount would receive reductions of 25 percent of the margin above current levels for each successive year to their Medicaid funding.</td>
<td>Requires new annual auditing procedures be performed by HHS of each state’s enrollment and expenditures reported.</td>
</tr>
<tr>
<td></td>
<td>Medicaid Data Reporting Requirements</td>
<td></td>
</tr>
</tbody>
</table>
Medical Expenditures Excluded from Caps
Certain payments are exempt from the caps and includes:

- Administrative payments.
- DSH payments.
- Individuals covered under a CHIP Medicaid expansion program.
- Individuals who receive medical assistance through an Indian Health Service facility.
- Individuals entitled to medical assistance coverage of breast and cervical cancer treatment due to screening under the Breast and Cervical Cancer Early Detection Program.
- The following partial-benefit enrollees:
  - Unauthorized aliens eligible for Medicaid emergency medical care.
  - Individuals eligible for Medicaid family planning options.
  - Dual-eligible individuals eligible for coverage.
  - Dual-eligible individuals eligible for coverage of Medicare cost-sharing.
  - Individuals eligible for premium assistance.
- Coverage of tuberculosis-related services for individuals infected with TB.
- Audits—Finally, the secretary of HHS would conduct audits of each state’s enrollment and expenditures reported on the Form CMS-64 for FY2016, FY2019, and subsequent years.

Application in Case of Research and Demonstration Projects and Other Waivers

- In the case of a state with a waiver of the state plan approved under section 1115, section 1915, or another provision of the SSA, the per capita cap model will apply to medical expenditures and medical assistance payments under the waiver, in the same manner.

### Subtitle D: Patient Relief and Health Insurance Market Stability

<table>
<thead>
<tr>
<th>SECTION</th>
<th>PROVISIONS</th>
<th>STATE ACTION REQUIRED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sec. 131. Repeal of Cost-Sharing Subsidy.</td>
<td>Repeals the cost-sharing subsidy program established in the ACA. The program was designed to lower out-of-pocket costs for those who purchase Silver plans through an exchange established by the law.</td>
<td></td>
</tr>
</tbody>
</table>
▪ **Use of Funds**—States may use the funds for the following purposes:
  - **Financial assistance to high-risk individuals** who do not have access to coverage through an employer to enroll in health insurance coverage in the individual market in the state, as the market is defined in the state.
  - **Providing incentives to appropriate entities** to enter into arrangements with the state to help stabilize premiums for health insurance coverage in the individual market.
  - **Reducing the cost** for providing health insurance coverage in the individual market and small group market to **individuals who have, or are projected to have a high rate of utilization** of health services (as measured by cost).
  - **Promoting participation in the individual and small group market** in the state and increasing health insurance options available through the insurance market.
  - **Promoting access to**:
    - Preventive services,
    - Dental care services (whether preventive or medically necessary).
    - Vision care services (whether preventive or medically necessary).
    - Prevention, treatment, or recovery support services for individuals with mental or substance use disorders.
    - A combination of these services.
  - **Providing payments**, directly or indirectly, to **health care providers** for the provision of the health care services as are specified by CMS.
  - **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.

**State Eligibility and Approval Default Safeguard**

▪ **Application Process**—States must submit an application to CMS to be eligible to receive funding not later than **45 days after the date of enactment** of this measure, and for allocations for subsequent years, not later than **March 31** of the previous year.
  - The application must include:
    - A description of how the funds will be used for such purposes.
    - A certification that the state will make, from non-federal funds, expenditures for these purposes in an amount that is not less than
the state percentage required for the year. Any additional information required by CMS.

- A complete application will be approved unless CMS notifies the state, not later than 60 days after submission, that the application has been denied with the reasons for denial.
- If an application is approved, the application will be treated as approved for each subsequent year through 2026.
- Any program receiving funds from the allocation for a state will be considered a “state health care program” for purposes of this act.
- **Default Federal Safeguard**—In the case of a state that does not apply by the 45-day submission date or has their application denied, CMS in consultation with the state insurance commissioner, will use the allocation that would have been provided to the state for market stabilization payments to issuers.
- **Required use for market stabilization payments to issuers**—Requires that an allocation made to a state that had not applied or had been denied an allocation, be used for the purpose of providing incentives to an issuer in the state. Payments would be provided to the issuer to cover 75 percent of claims that exceed $50,000 but not to exceed $350,000.
- **Allocations**—Appropriated funding for $15 billion for 2018 and 2019, and $10 billion for 2020 through 2026.
- Amounts appropriated for the allocations will remain available for expenditure through Dec. 31, 2027.
- Payments formulas used to calculate a state’s allotment for years 2018 and 2019 uses two criteria. The first is for 85 percent of the annual funding and is based on incurred claims for benefit year 2015, and subsequently 2016, which provides for the latest medical loss ratio (MLR) data available that reflects total costs for the on-exchange individual market. The second is for states to access a proportion of the remaining 15 percent.
- To receive the funding a state must meet one of two triggers: Their uninsured population for individuals below 100 percent of the FPL increased from 2013-2015, or fewer than three plans are offering coverage on the on-exchange individual market in 2017.
- Beginning in 2020, CMS will set an allocation methodology to reflect cost, risk, low-income uninsured population, and issuer competition. To determine the methodology, CMS will consult with health care consumers, health insurance issuers, state insurance commissioners, and other stakeholders and after taking into consideration additional cost and
risk factors that may inhibit health care consumer and health insurance issuer participation.

<table>
<thead>
<tr>
<th>Sec. 133. Continuous Health Insurance Coverage Incentive.</th>
<th>The continuous coverage incentive is designed to limit adverse selection in health care markets.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Lookback Period</strong>—Beginning in open enrollment for benefit year 2019 or in a special enrollment period beginning with plan year 2018, there will be a 12-month lookback period to determine if the applicant went longer than 63 days without continuous health insurance coverage.</td>
</tr>
<tr>
<td></td>
<td><strong>Penalty Applied</strong>—Requires an insurer to charge a premium penalty of 30 percent to certain individuals who cannot demonstrate continuous, credible coverage. The penalty would be discontinued after a 12-month period.</td>
</tr>
<tr>
<td>Sec. 134. Increasing Coverage Options.</td>
<td>Sunsets the ACA provisions that required issuers to label offerings by metal tiers that were determined by a specific actuarial value.</td>
</tr>
<tr>
<td>Sec. 135. Change in Permissible Age Variation in Health Insurance Premium Rates.</td>
<td>Permits HHS to implement through rule to permit insurers to vary premiums based on age by up to a 5-to-1 ratio for plan years beginning in 2018. The current limit is 3-to-1.</td>
</tr>
</tbody>
</table>

---

1 The term “Federally qualified health center” means an entity which—
(A)(i) is receiving a grant under section 330 of the Public Health Service Act, or
(ii) is receiving funding from such a grant under a contract with the recipient of such a grant, and (II) meets the requirements to receive a grant under section 330 of such Act;
(B) based on the recommendation of the Health Resources and Services Administration within the Public Health Service, is determined by the Secretary to meet the requirements for receiving such a grant;
(C) was treated by the Secretary, for purposes of part B, as a comprehensive federally funded health center as of January 1, 1990; or
(D) is an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act or by an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act.[281]

2 The Hyde Amendment—Congress has attached abortion funding restrictions to various appropriations measures. The greatest focus has arguably been on restricting Medicaid abortions under the annual appropriations for the Department of Health and Human Services. This restriction is commonly referred to as the “Hyde Amendment” because of its original sponsor. Similar restrictions affect the appropriations for other federal entities, including the Department of Justice, where federal funds may not be used to perform abortions in the federal prison system, except in cases of rape or if the life of the mother would be endangered. Hyde-type amendments also have an impact in the District of Columbia, where federal funds may not be used to perform abortions except in cases of rape, incest, or where the life of the mother would be endangered, and affect international organizations like the United Nations Population Fund, which receives funds through the annual Foreign Operations appropriations measure. Congressional Research Service (CRS) report number RL33467, www.crs.gov.

3 In NFIB v. Sebelius, the Court largely affirmed the constitutionality of ACA, including its individual mandate provision. In a move that was unexpected to many, the Court upheld the mandate as a valid exercise of Congress’s taxing power, but not its Commerce Clause power. https://www.supremecourt.gov/opinions/11pdf/11-393c3a2.pdf.

4 1903A Enrollee is defined as meaning, with respect to a state and a month, any Medicaid enrollee for the month, other than such an enrollee who for such month is in any of the following categories of excluded individuals: (1) CHIP; (2) Indian Health Service (HIS); (3) Breast and Cervical Cancer Services Eligible Individual, and; (4) Partial Benefit Enrollees.

5 1903A Enrollee Category is defined as meaning each of the following: (1) Elderly; (2) Blind and Disabled; (3) Children; (4) Expansion Enrollees, and; (5) Other Nonelderly, Nondisabled Non-Expansion Adults.
**Cost-Sharing**—The term “cost-sharing” includes— (i) deductibles, coinsurance, copayments, or similar charges; and (ii) any other expenditure required of an insured individual which is a qualified medical expense with respect to essential health benefits covered under the plan. The term does not include premiums, balance billing amounts for non-network providers, or spending for non-covered services.