# Highlights of H.R. 1628: The American Health Care Act of 2017

On Thursday May 4, in a 217–213 vote, the U.S. House of Representatives approved H.R. 1628, the American Health Care Act of 2017 (AHCA). The health care package includes provisions that would repeal or modify parts of the Patient Protection and Affordable Care Act (ACA) including the cost-sharing subsidies for lower-income individuals to enable them to purchase health coverage on the exchanges. The AHCA substitutes the subsidies with a tax credit with different eligibility rules and calculating requirements. The bill fundamentally alters Medicaid financing mechanisms, and repeals the ACA Medicaid expansion options for states. The bill also includes provisions that do not specifically relate to aspects of the ACA, including late enrollment penalties for individuals who do not maintain health coverage, and a health insurance market stabilization fund.

The health package lost momentum in March because of disagreements between House GOP moderates and conservatives over differing opinions on how certain ACA provisions would be handled. Central to the divide were parts of the law that regulated community rating; governed premium rates or additional fees for individuals with chronic medical conditions or other characteristics such as age; the requirement that insurers cover those with pre-existing conditions; and whether to alter requirements on the 10 essential health benefits (EHBs) as outlined in the ACA provisions. The AHCA was revived after Republicans garnered support from conservative and moderate members with amendments aimed at EHBs and pre-existing conditions.

**Amendments**

The MacArthur amendment allows states to seek a limited waiver under which insurance companies in the individual market could charge higher premiums for a person with pre-existing health conditions if they do not maintain continuous coverage. The waiver would be conditional on the state establishing a high-risk pool. The Upton/Long amendment sets aside $8 billion to help lower premiums and other out-of-pocket costs for individuals with pre-existing conditions who do not maintain continuous coverage and live in states that request and receive a waiver. Some moderates had expressed concern over the lack of protection in the bill for those with pre-existing conditions agreed to support the measure because of the amendment.

**Medicaid Financing**

Key provisions pertaining to Medicaid convert the financing to a per-capita-cap model starting in fiscal year (FY) 2020, and provide states the option to receive block grant funding instead of per-capita-cap for nonelderly, nondisabled, nonexpansion adults and children starting in FY2020. The Congressional Budget Office has not yet published its estimate of the House approved provisions that incorporate all the amendments, but the most recent cost estimates report that the AHCA would reduce federal deficits by $150 billion over the FY2017-FY2026 period. Conversely, its effect on health insurance coverage in FY2018 estimate that 14 million more people would be uninsured and, in FY2026, 24 million more people would be uninsured than under current law.

Attention now turns to the Senate. Without Democratic support or a filibuster-proof majority, Senate Republicans would have to pass the measure through budget reconciliation, which requires only a 51-vote majority but is limited to budget-related matters. Some provisions of the AHCA may not clear this hurdle. Some Senators have indicated that they will start from scratch in crafting their own repeal and replace legislation.

Frequently Asked Questions

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## Timeline of Provisions of the American Health Care Act (AHCA) Related to Medicaid

| 180 Days After Enactment | FY2018 | FY2020 |
|---|---|---|
| ▪ Limit the home equity amount that an applicant can shield for purposes of Medicaid eligibility for long-term care. §114(c) | ▪ Limit the effective date for retroactive coverage of Medicaid benefits. §114(b)<br>▪ Establish safety net funding for nonexpansion states to adjust payment amounts for Medicaid providers. (FY2018-FY2022). §115<br>▪ Increase the frequency of Medicaid redeterminations for nonelderly individuals eligible through ACA expansion and state option for coverage for individuals with income >133 percent FPL. §116(a)<br>▪ Increase federal match for administrative activities to carry out the increase in Medicaid eligibility redetermination. (Oct. 1, 2017-Dec. 31, 2019) §116(b)<br>▪ Add new state plan option to permit states to require nondisabled, nonelderly, nonpregnant adults to satisfy work requirements. §117(a)<br>▪ Increase federal match for administrative activities to implement work requirements. §121<br>▪ Repeal the start option for coverage for nonelderly individuals with income >133 percent FPL. §112(a)(1)(A)(ii)<br>▪ Amend formula for expansion state matching rate. §112(a)(2)(B) | ▪ Eliminate Medicaid DSH allotment reductions. §113<br>▪ Reform federal Medicaid financing to per-capita-cap model and the block grant option. §121<br>▪ No longer allow hospitals to elect to make presumptive eligibility determinations. §111(1)(A)<br>▪ Repeal ACA requirement for expanded Medicaid mandatory eligibility for children aged 6-19 from 100 percent FPL to 133 percent FPL. §111(1)(B)<br>▪ Repeal increased FMAP rate for Community First Choice Option. §111(2)<br>▪ Terminate authority for certain states to make presumptive-eligibility determinations for the ACA Medicaid expansion group or the state option for coverage for individuals with income >133 percent FPL. §111(3)<br>▪ Codify the ACA Medicaid expansion as optional for states. §112(a)(1)(A)(i) and (iii)<br>▪ Define expansion enrollee and grandfathered expansion enrollee. §112(a)(1)(B)<br>▪ Amend newly eligible and expansion state matching rates to apply only to expenditures for individuals who were enrolled in Medicaid as of Dec. 31, 2019 and do not have a break in eligibility for more than one month after that date. §112(a)(2)(A) and (B)<br>▪ Repeal the requirement that ABP coverage include at least the 10 EHBs. §112(b)<br>▪ Direct states on how to treat irregular income received as a lump sum when determining MAGI income eligibility. §114(a)<br>▪ Limit the home equity amount that an applicant can shield for purposes of Medicaid eligibility for long-term care. §114(c) |

**Source:** Congressional Research Service (CRS), "H.R. 1628: The American Health Care Act (AHCA)," May, 4, 2017, https://fas.org/sgp/crs/misc/R44785.pdf.

**Notes:** ABP = Alternative Benefit Plan; ACA = Patient Protection and Affordable Care Act (P.L. 111-148, as amended); AHCA = American Health Care Act; DSH = disproportionate share hospital; EHB = essential health benefits; FMAP = federal medical assistance percentage; FPL = federal poverty level; FY = fiscal year; MAGI = modified adjusted gross income.

| Section | Provisions | State Actions Required |
|---|---|---|
| ***ACA Medicaid Expansion*** | | |
| ***Sec. 112. Repeal of Medicaid Expansion.*** | ▪ Codifies the *National Federation of Independent Business (NFIB) v. Sebelius*[i] and makes the Medicaid expansion optional for states.<br>▪ Repeals the state option to extend coverage to adults above 133 percent of federal poverty by Dec. 31, 2019. | Repeals the provisions from the ACA creating the expansion options for state Medicaid programs as of Dec. 31, 2019. |
| | **Termination of the Enhanced Federal Match (FMAP) for ACA Expansion Population**<br>▪ Repeals the enhanced federal matching rate for *newly eligible* beneficiaries on Dec. 31, 2019.<br>▪ States can keep the enhanced match for *newly eligible* expenditures that occur before Jan. 1, 2020.<br>▪ 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.<br>▪ After Jan. 1, 2020, the state may only enroll *newly eligible* individuals at the state's traditional FMAP for that individual.<br>▪ 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. | Repeals the sections from the ACA that provided for the enhanced FMAP for the Medicaid expansions population.<br><br>Continues to permit states to enroll individuals in the expanded category after Jan. 1, 2020, but reverts to the traditional enhanced match. |
| | **Grandfathered Expansion Enrollees**<br>▪ Defines the term "**grandfathered expansion enrollee**" as meaning a Medicaid enrollee under the state expansion population who is enrolled under the state plan as of Dec. 31, 2019, and does not have a break in eligibility for medical assistance under the state plan for more than one month after that period.<br>▪ **Pre-ACA Expansion states**[ii] will continue to receive an **enhanced matching rate of 80 percent** for 2017 and each subsequent year following for grandfathered enrollees, as-long-as an individual remains eligible and enrolled in the program.<br>▪ Places a **qualifier for the receipt of an enhanced FMAP** by limiting its application to states that have expanded Medicaid to cover able-bodied adults as of March 1, 2017. | ▪ If enacted, expansion states with an expanded Medicaid population in place by March 1, 2017 must determine how the new formula for the FMAP will impact their budgets.<br>▪ States must also evaluate their systems for eligibility redeterminations to determine if some potential impediment might exist that would disqualify individuals for the enhanced match if the required enrollment criteria is impacted in the process. |

| Section | Provisions | State Actions Required |
|---|---|---|
| ***ACA Medicaid Expansion*** | | |
| ***Sec. 112. Repeal of Medicaid Expansion. (continued)*** | **Sunsets Essential Health Benefits Requirements**<br>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. | |
| ***Medicaid Financing*** | | |
| ***Sec. 121. Per Capita Allotment for Medical Assistance.*** | **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.<br>▪ **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.<br>▪ 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.<br>▪ **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.<br>▪ States would have the **option to receive block grant** funding instead of per-capita-cap funding for non-elderly, non-disabled, non-expansion adults and children starting in FY2020. Some statutory requirements would not apply under the block grant option<br>**Medicaid Data Reporting Requirements**<br>▪ Each state would be required to report to the Centers for Medicare and Medicaid Services (CMS) data for the numbers of enrollees in each 1903A[iii] Enrollee category[iv].<br>▪ Provides a temporary increase in the FMAP to offset expenses associated with efforts to improve data reporting systems.<br>▪ The temporary increases would impact expenditures on or after Oct. 1, 2017, and before Oct. 1, 2019.<br>**Medical Expenditures Excluded from Caps**<br>Certain payments are exempt from the caps and includes:<br>▪ Administrative or DSH payments. | ▪ Alters the formulation of federal payments to states for support of the Medicaid program.<br>▪ Sets expenditure targets that will be reportable to CMS via new reporting requirements established in this measure.<br>▪ 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.<br>▪ Requires new annual auditing procedures be performed by HHS of each state's enrollment and expenditures reported. |

| Section | Provisions | State Actions Required |
|---|---|---|
| ***Medicaid Financing*** | | |
| ***Sec. 121. Per Capita Allotment for Medical Assistance. (continued)*** | ▪ Individuals covered under a CHIP Medicaid expansion program.<br>▪ Individuals who receive medical assistance through an Indian Health Service facility. | |
| ***Sec. 121. Per Capita Allotment for Medical Assistance. (continued)*** | ▪ Individuals entitled to medical assistance coverage of breast and cervical cancer treatment due to screening under the Breast and Cervical Cancer Early Detection Program.<br>▪ The following partial-benefit enrollees:<br>– Unauthorized aliens eligible for Medicaid emergency medical care.<br>– Individuals eligible for Medicaid family planning options.<br>– Dual-eligible individuals eligible for coverage.<br>– Dual-eligible individuals eligible for coverage of Medicare cost-sharing. Individuals eligible for premium assistance.<br>– Coverage of tuberculosis-related services for individuals infected with TB.<br>▪ **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.<br>**Application in Case of Research and Demonstration Projects and Other Waivers**<br>▪ 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. | ▪ Alters the formulation of federal payments to states for support of the Medicaid program.<br>▪ Sets expenditure targets that will be reportable to CMS via new reporting requirements established in this measure.<br>▪ 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.<br>▪ Requires new annual auditing procedures be performed by HHS of each state's enrollment and expenditures reported. |
| ***Sec. 113. Elimination of Disproportionate Share Hospital (DSH) Cuts.*** | **Medicaid DSH Reductions**<br>▪ Repeals the Medicaid DSH payment reductions for non-expansion states in 2018.<br>▪ Repeals the DSH reductions for states that expanded Medicaid in 2020. | Repeals DSH reductions for non-expansion states in 2018, and expansion states in 2020. |
| ***Sec. 115. Safety Net Funding for Non-Expansion States.*** | ▪ Establishes a safety net fund for non-expansion states to adjust payment amounts for Medicaid providers.<br>▪ The fund would provide up to $2 billion each year starting in FY2018 through FY2022.<br>▪ Non-expansion states would receive an **increased matching rate** (FMAP) of:<br>– 100 percent for calendar quarters in 2018, 2019, 2020 and 2021, and<br>– 95 percent for calendar year 2022. | None. |

| Section | Provisions | State Actions Required |
|---|---|---|
| ***Medicaid Financing*** | | |
| ***Sec. 111. Federal Medicaid Matching Rate for Community First Choice Option.*** | **Community First Choice Options**<br>Repeals the 6 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. | States should examine how the repeal of this provisions will alter their funding for HCBS. |
| ***Sec. 116. Providing Incentives for Increased Frequency of Eligibility Redeterminations.*** | **Frequency of Eligibility Redetermination**<br>▪ Beginning Oct. 1, 2017, requires states with Medicaid expansion populations to redetermine expansion enrollees' eligibility every six months.<br>**Civil Monetary Penalty**<br>▪ 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.<br>**Temporary Enhanced Federal Matching Rate for Transitional Activities**<br>▪ 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. | May potentially alter procedures for eligibility redeterminations. |
| ***Sec. 117. Increase in Matching Rate for Implementation of Work Requirement.*** | ▪ Increases the federal matching rate for administrative activities to implement the Medicaid work requirement by 5 percentage points in addition to any other increase to the federal matching rate.<br>▪ The Manager's Amendment created a **new section** of the SSA that affords states an option to institute a work requirement in Medicaid for nondisabled, nonelderly, nonpregnant adults as a condition for receiving coverage under Medicaid.<br>▪ **Beginning Oct. 1, 2017**, states may elect to condition medical assistance to a nondisabled, nonelderly, nonpregnant individual upon the individual's satisfaction of a work requirement.<br>▪ **Work Requirement Defined**—The term 'work requirement' is defined as meaning, the individual's participation in work activities for the period of time **as determined by the state**, and as directed and administered by the state.<br>▪ The work requirement **may not apply the requirement to**— | ▪ If enacted, states must determine if they will institute the new work requirement on or after Oct. 1, 2017. |

| Section | Provisions | State Actions Required |
|---|---|---|
| ***Medicaid Financing*** | | |
| ***Sec. 117. Increase in Matching Rate for Implementation of Work Requirement. (continued)*** | – a woman during pregnancy through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends;<br>– an individual who is under 19 years of age;<br>– an individual who is the only parent or caretaker relative in the family of a child who has not attained 6 years of age or who is the only parent or caretaker of a child with disabilities; or<br>– an individual who is married or a head of household and has not attained 20 years of age and who— ”<br>▪ maintains satisfactory attendance at secondary school or the equivalent; or<br>▪ participates in education directly related to employment.’’<br>▪ **Increase in Matching Rate for Implementation**—Provides a 5 percent administrative FMAP increase to states who choose to implement a work requirement. | |
| ***Medicaid Eligibility and Enrollment*** | | |
| ***Sec. 112. State Option for Coverage for Nonelderly Individuals with Income That Exceeds 133 percent of the FPL.*** | ▪ Removes language in the SSA pertaining to **the mandatory requirement for states to expand Medicaid** for certain childless nondisabled, nonelderly, nonpregnant adults up to 133 percent of the FPL.<br>▪ Sunsets the option for a state to cover adults above 133 percent of the FPL, effective Dec. 31, 2017.<br>▪ Amends the SSA to designate a **new optional category** which permits states to cover a Medicaid expansion group (childless nondisabled, nonelderly, nonpregnant adults) at the state’s regular Federal Medical Assistance Percentage (FMAP). | Repeals the provisions from the ACA creating the expansion options for state Medicaid programs as of Dec. 31, 2019.<br><br>Repeals the sections from the ACA that provided for the enhanced FMAP for the Medicaid expansions population. |
| ***Sec. 111. Federal Payments to States: Presumptive Eligibility.*** | **Presumptive Eligibility Determinations**<br>Repeals states expanded authority to make presumptive eligibility determinations for:<br>▪ Family planning services under “Sec. 1920C (a) State Options” of the ACA, and ends the authority as of Jan. 1, 2020.<br>▪ Medical assistance by a hospital under Sec. 2202, (1)(2)(C) of the ACA.<br>▪ Pregnant women under Sec. 1920(e) of the Social Security Act as of Jan. 1, 2020. | 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.<br><br>Would not modify the authority of the states to elect to make presumptive-eligibility determinations for the mandatory foster care group under the age of 26 or for low-income families eligible under Section 1931 of the Social Security Act. |

| Section | Provisions | State Actions Required |
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| ***Medicaid Eligibility and Enrollment*** | | |
| ***Sec. 111. Federal Payments to States: Presumptive Eligibility. (continued)*** | **Children's Eligibility for Medicaid**<br>▪ Reverts the mandatory Medicaid income eligibility level for poverty-related children back to 100 percent of federal poverty level.<br>▪ States could cover this population in their State Children's Health Insurance Program. | 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. |
| ***Sec. 111. Federal Payments to States: Stairstep Children.*** | Repeals the ACA requirement that expands the mandatory Medicaid income eligibility level for poverty-related children aged 6 to 19 from 100 percent to 133 percent of the FPL, specifying the end date of the ACA requirement as of Dec. 31, 2019. | State eligibility systems will require alteration to comply with the change. |
| ***Sec. 114. Letting States Disenroll High-Dollar Lottery Winners.*** | **Letting States Disenroll High Dollar Lottery Winners**<br>▪ 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:<br>– In the month in which the winning or income is received if the amount is less than $80,000.<br>– Over a period of two months if the amount is greater than $80,000 but less than $90,000.<br>– 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.<br>▪ **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.<br>▪ **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 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. | **Amended Eligibility Determination Process**<br>Amends the process of determining lottery winnings and lump sum payments as income in the determination of Medicaid eligibility.<br><br>**Required Notification**<br>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. |

| Section | Provisions | State Actions Required |
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| ***Medicaid Eligibility and Enrollment*** | | |
| ***Sec. 114. Letting States Disenroll High-Dollar Lottery Winners. (continued)*** | ▪ Closes the loophole in current practice by requiring individuals to provide documentation of citizenship or lawful presence before obtaining coverage.<br>**Definition of Qualified Lottery Winnings**<br>▪ 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.<br>**Amendments Concerning Requirements for Payment of Emergency Services Provided to Aliens**<br>▪ 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. | |
| ***Sec. 114. Repeal of Retroactive Eligibility.*** | **Repeal of Retroactive Eligibility**<br>▪ 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) (34)) 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.**<br>▪ This would repeal retroactive eligibility requirements for individuals applying for medical assistance on or after Oct. 1, 2017. | Eliminates retroactive eligibility for medical assistance for individuals who apply on or after Oct. 1, 2017. |

| Section | Provisions | State Actions Required |
|---|---|---|
| ***Medicaid Eligibility and Enrollment*** | | |
| ***Sec. 114. Updating Allowable Home Equity Limits in Medicaid.*** | **Updating Allowable Home Equity Limits in Medicaid**<br>▪ 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.<br>▪ 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.<br>▪ **Effective Date**–This change would become applicable **six months after enactment** of this measure.<br>▪ **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 take action. | **Amended Eligibility Determination Process**<br>Takes away the state option to raise the allowable home equity values in determining an individual's eligibility for medical assistance. |
| ***Sec. 116. Providing Incentives for Increased Frequency of Eligibility Redeterminations.*** | **Frequency of Eligibility Redetermination**<br>▪ Beginning Oct. 1, 2017, requires states with Medicaid expansion populations to redetermine expansion enrollees' eligibility every six months.<br>**Civil Monetary Penalty**<br>▪ 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.<br>**Temporary Enhanced Federal Matching Rate for Transitional Activities**<br>▪ 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. | May potentially alter procedures for eligibility redeterminations. |

| Section | Provisions | State Actions Required |
|---|---|---|
| ***Medicaid Eligibility and Enrollment*** | | |
| ***Sec. 117. State Option for Work Requirements.*** | ▪ Creates a **new section** of the SSA that affords states an option to institute a work requirement in Medicaid for nondisabled, nonelderly, nonpregnant adults as a condition for receiving coverage under Medicaid.<br>▪ **Beginning Oct. 1, 2017**, states may elect to condition medical assistance to a nondisabled, nonelderly, and nonpregnant individual upon the individual's satisfaction of a work requirement.<br>▪ **Work Requirement Defined**–The term 'work requirement' is defined as an individual's participation in work activities for the period of time **as determined by the state**, and as directed and administered by the state.<br>▪ The work requirement **may not apply the requirement to**—<br>– a woman during pregnancy through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends;<br>– an individual who is under 19 years of age;<br>– an individual who is the only parent or caretaker relative in the family of a child who has not attained 6 years of age or who is the only parent or caretaker of a child with disabilities; or<br>– an individual who is married or a head of household and has not attained 20 years of age and who— "<br>▪ maintains satisfactory attendance at secondary school or the equivalent; or<br>▪ participates in education directly related to employment.''<br>▪ **Increase in Matching Rate for Implementation**–Provides a 5 percent administrative FMAP increase to states who choose to implement a work requirement. | If enacted, states must determine if they will institute the new work requirement on or after Oct. 1, 2017. |

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

### FY2016

- Effectively eliminates the individual mandate penalty. §204
- Effectively eliminates the employer tax penalties. §205

### On Enactment

- Restricts a prohibited entity from receiving direct spending. (Enactment to 1 year) §103

### FY2017

- Provides additional funds to the Community Health Center Fund. §102
- Repeals the 10 percent tax on indoor tanning services. §231
- Repeals prohibition on using tax-advantage funds for over-the counter medication. §207
- Reduces the tax rate for distributions from Archer MSAs and HSAs. §208
- Repeals health FSA maximum contribution limit. §209
- Repeals the limit on employee remuneration that certain insurance providers can deduct. §241
- Repeals the annual fee on certain health care insurers. §222
- Repeals tax on certain manufacturers or importers of branded prescription drugs. §221
- Repeals the 3.8 percent net investment tax. §251
- Repeals the 2.3 percent medical device tax. §210
- Repeals the elimination of employer deduction for expenses allocable to Medicare Part D subsidy. §211
- Reduces the AGI threshold for medical care deductions to 7.5 percent. §212
- Establishes a Patient and State Stability Fund. (FY2018-FY2026) §132

### FY2018

- Allows ACA premium tax credits to apply to certain off-exchange plans. §202
- Disregards the income-related caps for excess ACA premium tax credit repayments. (2018-2019) §201
- HHS Secretary may implement age rating ratio of 5:1 for premiums in individual and small group markets. **States may apply for a waiver** to implement a higher age rating ratio. §135 and §136
- Provides funds, via the Patient State Stability Fund, to **states with a waiver** that would allow insurers to take health status into account when determining premiums for certain individuals. (2018-2023) §132 and §136
- Increases the HAS annual contribution limits. §215
- Amends HSA contribution rules for married individuals. §216
- Allow HSA withdrawals to be used for certain expenses incurred before the HSA was established. §217

**Source:** Congressional Research Service (CRS), "H.R. 1628: The American Health Care Act (AHCA)," May, 4, 2017, https://fas.org/sgp/crs/misc/R44785.pdf.

## Timeline of Provisions of the American Health Care Act (AHCA) Related to Private Health Insurance, Public Health, and Taxes (continued)

**FY2019**

- Repeals all Prevention and Public Health Fund appropriations; rescind unobligated balance remaining at the end of FY2018. §101
- Amends the premium tax credit formula by specifying income and age as factors. §202
- Assess penalty on applicable policyholders with gap in creditable coverage by increasing monthly premiums by 30 percent during a specified period. **States may apply for a waiver** that would allow insurers to take health status into account when determining premiums, in lieu of the 30 percent penalty charge, for applicable policyholders. §133 and §136

**FY2020**

- **States may apply for a waiver** to allow states to define EHBs for the individual and small-group market plans offered in the state. §217
- Repeals ACA cost-sharing subsidies. §131
- Amends ACA premium tax credits to be based on age and adjusted by a formula that takes into account income. §214
- Sunsets the ACA small business tax credit. §203
- Plans in the individuals and small-group markets no longer need to meet certain generosity levels. §134
- Further delays implementation of Cadillac tax. (2020-2025) §206

**FY2023**

- Repeal the 0.9 percent Medicare surtax. §213

**No date associated with the following section.**

- Establishes the American Health Care Implementation Fund. §141

**Source:** Congressional Research Service (CRS), "H.R. 1628: The American Health Care Act (AHCA)," May, 4, 2017, https://fas.org/sgp/crs/misc/R44785.pdf.

| Section | Provisions | State Actions Required |
|---|---|---|
| ***Health Insurance Tax Credit and Cost-Sharing Subsidies*** | | |
| ***Sec. 202. Additional Modifications to Premium Tax Credit.*** | **Modifies Definitions of QHP for Tax Credit Purposes**<br>▪ Modifies the definition of QHP for tax credits for 2018 and 2019 by excluding grandfathered and grand-mothered (transitional) plan, short-term limited duration coverage, as well as any coverage that includes abortion services.<br><br>**Prohibitions on the Use of Premium Tax Credits to Purchase Abortion Services Benefits**<br>▪ Adds a new prohibition for the use of premium tax credits for the purchase of a health plan that includes a benefit for abortion services with an exception granted in the case of saving the life of the mother or for rape or incest.<br>▪ Clarifies that the treatment of infection, injury, disease, or disorder that has been caused by or exacerbated by the performance of an abortion will not be treated as an abortion under this provision.<br><br>**Advance Determination and Payment of Premium Tax Credits and Cost Sharing Reductions.**<br>▪ Adds language to Section 1412 of the ACA and adds new language that amends the Internal Revenue Service (IRS) Code by requiring reporting of enrollment information by a health plan that is not enrolled in through an exchange.<br>▪ **Off-Exchange Premium Credit Eligible Coverage**–If *minimum essential coverage* is provided to an individual in a QHP that is not enrolled in through an exchange, there must be a statement provided to HHS that the plan qualifies as a QHP, the amount of premiums paid for the coverage provided, the months in which the coverage was provided, the adjusted monthly premium for the applicable second lowest cost silver plan for each month, and any information deemed necessary by HHS.<br>▪ Prohibits the use of tax credits to be used for purchasing coverage through a grandfathered or grand-mothered plan sold outside of the exchange.<br>▪ Only individuals enrolled in exchange QHPs could receive the credit in advance.<br>▪ This section will not apply with respect to coverage provided for any month beginning after Dec. 31, 2019. | None. |

| Section | Provisions | State Actions Required |
|---|---|---|
| ***Health Insurance Tax Credit and Cost-Sharing Subsidies*** | | |
| ***Sec. 202. Additional Modifications to Premium Tax Credit. (continued)*** | **Other Conforming Amendments**<br>▪ Revises the schedule under which an individual's or family's share of premiums is determined by adjusting the household income and the age of the individual or family members.<br>▪ Unlike the ACA which had no fixed cap amount, the AHCA proposal provides a credit that is capped at the lower of the taxpayer's cost to purchase eligible health insurance for themselves for a month or the combined monthly limitation amount for the family unit (for up to five persons).<br>▪ Beginning in FY2020, individuals are eligible for a flat dollar tax credit, adjusted for age:<br>– $2,000 per year for individuals up to age 29,<br>– $2,500 for individuals age 30-39,<br>– $3,000 for individuals age 40-49,<br>– $3,500 for individuals age 50-59, and<br>– $4,000 for individuals age 60 and older.<br>▪ Credits will be payable monthly.<br>▪ Family credits are available for up to the five oldest family members (capped at $14,000).<br>▪ Married couples must file jointly to claim the credit.<br>▪ Eligibility for the **tax credit phases-out** for incomes $75,000 and above as follows:<br>– **individuals up to the age of 29**–the credit is reduced by 10 cents for every dollar off income above this threshold and zero out for incomes of $95,000,<br>– **individuals age 60 and older**–the credit is reduced by 10 cents for every dollar off income above this threshold and zero out for incomes of $115,000,<br>– **couples filing jointly**–the credits begin to phase-out at $150,000,<br>– **couples up to the age of 29 filing jointly**–the credit zeros out at $190,000, and<br>– **couples age 60 or older**–the credit zeros out for incomes $290,000 for couples claiming the maximum family credit.<br>▪ **Additional Eligibility Requirements**–Credit is available for eligible coverage[v] to those not eligible for coverage otherwise in any month through in which they are eligible for Medicare, Medicaid, CHIP, TRICARE, VA, the Peace Corps, DoD, and health sharing ministries. | None. |

| Section | Provisions | State Actions Required |
|---|---|---|
| ***Health Insurance Tax Credit and Cost-Sharing Subsidies*** | | |
| ***Sec. 202. Additional Modifications to Premium Tax Credit. (continued)*** | ▪ Directs HHS to establish a program for making advanced payment of tax credits no later than Jan. 1, 2020.<br>▪ Permits excess credits above the cost of premiums to be deposited into the taxpayer's health savings account at their request unless a serious delinquent tax credit exists.<br>▪ Reporting to the IRS is required annually by health insurance issuers and on a monthly basis as to individuals receiving advanced health insurance coverage credits.<br>▪ Employers are required to report in Form W-2 each month that an employee is eligible for other specified coverage in connection with employment with the employer. | None. |
| ***Sec. 201. Recapture Excess Advance Payments of Premium Tax Credits*** | **Refundable Credit for Coverage Under a Qualified Health Plan (QHP)**<br>▪ The ACA sets certain limits on the amount households with an income up to 400 percent of the federal poverty level must repay the federal government for excess premium tax credits[vi] received if their income increases during the tax year (26 U.S.C. §36B).<br>▪ The AHCA provisions requires any individual who was overpaid in premium tax credits to repay the entire excess amount, regardless of income, for tax years 2018 and 2019.<br>▪ Repeals the provision effective Jan. 1, 2020 and thereafter. | None. |
| ***Sec. 131. Repeal of Cost-Sharing[vii] Subsidy.*** | 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. | None. |
| ***SEC. 214 Refundable Tax Credit for Health Insurance Coverage.*** | ▪ Amends Sec. 36 B of the Internal Revenue Code pertaining to Refundable Tax Credit for Health Insurance Coverage.<br>▪ Effective in 2020, it replaces the existing ACA premium subsidies with the new subsidies under a different formulation.<br>▪ Creates a new verification regimen.<br>▪ **Monthly Limitation Amounts**–The monthly limitation amount for an eligible individual during any taxable year is 1/12 of:<br>– $2,000 in the case of an individual who has not attained age 30 as of the beginning of the taxable year,<br>– $2,500 in the case of an individual who has attained age 30 but who has not attained age 40,<br>– $3,000 in the case of an individual who has attained age 40 but who has not attained age 50, | None. |

| Section | Provisions | State Actions Required |
|---|---|---|
| ***Health Insurance Tax Credit and Cost-Sharing Subsidies*** | | |
| ***SEC. 214 Refundable Tax Credit for Health Insurance Coverage. (continued)*** | – $3,500 in the case of an individual who has attained age 50 but has not attained age 60, and<br>– $4,000 in the case of an individual who has attained age 60.<br>▪ **Limitation Based on Modified Adjusted Gross Income (MAGI)**[viii]–the credit allowed to any taxpayer for any taxable year will be reduced by 10 percent of the excess of:<br>– The taxpayer's MAGI for the taxable year,<br>– $75,000 (or twice the amount in a joint return),<br>– Other limitations:<br>▪ **Aggregate Dollar Limitation**–Prohibits the monthly amount taken into account from exceeding $14,000,<br>▪ **Maximum number of individual taken into account**–The monthly limitation amounts will be taken into account with respect to the 5 oldest individuals.<br>▪ **Eligible Coverage Month**–refers to the first day of the first month the individual meets the following requirements:<br>– The individual is covered with health insurance that is certified by the state in which the insurance is offered that meets the requirements for qualified health plans (QHPs),<br>– The individual is not eligible for coverage under a group health plan, or a government sponsored health plan,<br>– The individual is a citizen or national of the U.S., or is a qualified alien, and<br>– The individual is not incarcerated, other than incarceration pending the disposition of charges.<br>▪ **Qualifying Family Member**–Refers to the taxpayer's spouse, any dependents, and any child of the taxpayer who as of the end of the taxable year has not attained age 27 if they are covered under a QHP that also covers the taxpayer.<br>▪ **Qualified Health Plan (QHP)**–QHPs are defined as meaning any health insurance coverage that:<br>– Offers coverage in the individual insurance market within the state,<br>– Provides coverage that is not of excepted benefits[ix],<br>– The coverage is not of short term limited duration,<br>– The coverage is not a grand-fathered[x] health plan or a grand-mothered health plan, and | None. |

| Section | Provisions | State Actions Required |
|---|---|---|
| ***Health Insurance Tax Credit and Cost-Sharing Subsidies*** | | |
| ***SEC. 214 Refundable Tax Credit for Health Insurance Coverage. (continued)*** | – Does not include coverage for abortion.<br>▪ **Special Rules**<br>– Married couples must file a joint return,<br>– Coordination with rule for older children–in determining the amount of any credit allowable to for older children for any taxable year, the monthly limitation amount with respect to the older child will be zero and no amount paid for any QHP with respect to the child for the month will be taken into account.<br>▪ **Special Rules for Qualified Small Employer Health Reimbursement Arrangements**–If any taxpayer or qualifying family member of the taxpayer is provided a qualified small employer health reimbursement arrangement for an eligible coverage month, the sum will be reduced by half of the permitted benefit.<br>– **Qualified Small Employer Health Reimbursement Arrangement**–The term qualified small employer health reimbursement arrangement "means an arrangement which-<br>▪ is described in subparagraph (B), and<br>▪ is provided on the same terms to all eligible employees of the eligible employer."<br>▪ **Certain Rules Related to Non-Qualified Health Plans**–Effective Jan. 1, 2020. | None. |
| ***Section 203. Small Business Tax Credit.*** | ▪ Repeals the ACA's small business tax credit beginning in 2020. | None. |
| ***Repeal Mandates*** | | |
| ***Section 204. Individual Mandate.*** | ▪ Repeals the ACA individual mandate[xi] effective Jan. 1, 2016. | None. |
| ***Section 205. Employer Mandate.*** | ▪ Repeals the ACA employer mandate[xii] effective Jan. 1, 2016. | None. |

| Section | Provisions | State Actions Required |
|---|---|---|
| ***Continuous Coverage*** | | |
| ***Sec. 133. Continuous Health Insurance Coverage Incentive.*** | ▪ The continuous coverage incentive is designed to limit adverse selection in health care markets.<br>▪ **Lookback Period**–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.<br>▪ **Penalty Applied**–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. | None. |
| ***Other Market Reforms*** | | |
| ***Sec. 135. Change in Permissible Age Variation in Health Insurance Premium Rates.*** | ▪ Permits HHS to implement through rule to permit insurers to vary premiums based on age by up to a 5-to-1 ratio for the individual and small group markets for plan years beginning in Jan. 2018. The current limit is 3-to-1.<br>▪ That is, a plan would not be able to charge an older individual more than five times the premium that the plan charges a 21-year old individual.<br>▪ States would have the option to implement a different ration for adults. | Offers states an option to implement a different ration for adults. |
| ***Sec. 134. Increasing Coverage Options.*** | ▪ Sunsets the ACA provisions that required issuers to label offerings by metal tiers that were determined by a specific actuarial value.<br>▪ Under Sec. 134, plans offered after Dec. 31, 2019, would no longer need to meet certain generosity levels. | None. |
| ***Sec. 132. Patient and State Stability Fund.*** | **The Patient and State Stability Fund**<br>Amends the SSA by inserting a new title, Title XXII–Patient and State Stability Fund.<br>▪ Establishes the Patient and State Stability Fund that will be administered by CMS beginning Jan. 1, 2018, and ending on Dec. 31, 2026.<br>▪ **Use of Funds**–States may use the funds for the following purposes:<br>– **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.<br>– **Providing incentives to appropriate entities** to enter into arrangements with the state to help stabilize premiums for health insurance coverage in the individual market. | Requires a state match. |

| Section | Provisions | State Actions Required |
|---|---|---|
| ***Other Market Reforms*** | | |
| ***Sec. 132. Patient and State Stability Fund. (continued)*** | – **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).<br>– **Promoting participation in the individual and small group market** in the state and increasing health insurance options available through the insurance market.<br>– **Promoting access to**:<br>▪ Preventive services,<br>▪ Dental care services (whether preventive or medically necessary).<br>▪ Vision care services (whether preventive or medically necessary).<br>▪ Prevention, treatment, or recovery support services for individuals with mental or substance use disorders.<br>▪ A combination of these services.<br>– **Providing payments**, directly or indirectly, **to health care providers** for the provision of the health care services as are specified by CMS.<br>– **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.<br>**State Eligibility and Approval Default Safeguard**<br>▪ **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.<br>▪ The application must include:<br>– A description of how the funds will be used for such purposes.<br>– A certification that the state will make, from nonfederal 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.<br>▪ 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.<br>▪ If an application is approved, the application will be treated as approved for each subsequent year through 2026.<br>▪ Any program receiving funds from the allocation for a state will be considered to be a "State health care program" for purposes of this act. | |

| Section | Provisions | State Actions Required |
|---|---|---|
| ***Other Market Reforms*** | | |
| ***Sec. 132. Patient and State Stability Fund. (continued)*** | ▪ **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.<br>▪ **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.<br>▪ **Allocations**–Appropriated funding for $15 billion for 2018 and 2019, and $10 billion for 2020 through 2026.<br>▪ Amounts appropriated for the allocations will remain available for expenditure through Dec. 31, 2027.<br>▪ **Payment 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.<br>▪ **To receive the funding a state must meet one of two triggers**:<br>– Their uninsured population for individuals below 100 percent of the FPL increased from 2013-2015, or<br>– Fewer than three plans are offering coverage on the on-exchange individual market in 2017.<br>▪ 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.<br>▪ Provides an **additional $8 billion** for the period 2018-2023 to states with a waiver in effect under proposed AHCA Sec. 136 relating to **allowing issuers to use health status as a factor when developing premiums** for certain individuals **are projected to have a high rate of utilization** of health services (as measured by cost). | |

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| ***Other Market Reforms*** | | |
| ***Sec. 136. Permitting States to Waive Certain ACA Requirements to Encourage Fair Health Insurance Premiums.*** | ▪ Allows states to apply to the HHS secretary for a waiver for one or more of the following purposes:<br>– A state could apply for a **waiver to implement an age rating ratio** for adults that is higher than the ratio specified in the ACA, as would be amended by the AHCA Sec. 135. This waiver could apply to plan years beginning on or after Jan. 1, 2018.<br>– A state could **apply from the EHB** and instead specify its own EHBs. This waiver could apply to plan years beginning on or after Jan. 1, 2020.<br>– A state could **apply to waive the continuous coverage penalty**, as would be implemented under AHCA Section 133, and instead allow issuers to use health status as a factor when developing premiums for individuals subject to an enforcement period. This waiver could apply to coverage obtained during special enrollment periods for plan year 2018 and for all coverage beginning plan year 2019. | States must determine if one of the optional waivers would be applied to their state markets. |
| ***Sec. 137. Construction.*** | Provides that nothing in the AHCA is to be construed as allowing issuers to vary **health insurance rates by gender** or as permitting issuers to **limit access to coverage for individuals with preexisting conditions.** | None. |
| ***Implementing Funding*** | | |
| ***Sec. 141. American Health Care Implementation Fund.*** | **Establishes an American Health Care Implementation Fund** within HHS to be used to implement the following AHCA provisions:<br>▪ Per capita allotment for medical assistance.<br>▪ Patient and state stability fund; additional modifications to the premium tax credit.<br>▪ Refundable tax credit for health insurance coverage.<br>Section 141 would **appropriate $1 billion to the fund**. | None. |

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| ***Public Health*** | | |
| ***Sec. 101. The Prevention and Public Health Fund.*** | ▪ Repeals Prevention and Public Health Fund appropriations provided for under the Affordable Care Act (ACA) designated for fiscal years (FY) 2019 and beyond. | None. |
| ***Sec. 102. Community Health Center Program.*** | ▪ 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)[xiii]. | None. |
| ***Sec. 103. Federal Payments to States.*** | 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).<br>A prohibited entity is one that meets the following criteria:<br>▪ It is an essential community provider primarily engaged in family planning and reproductive health services.<br>▪ It provides abortions in cases that do not meet the Hyde amendment[xiv] exception for federal payment.<br>▪ It has received more than $350 million in federal and state Medicaid dollars in FY 2014. | This may require examination on how this impacts state programs and their network of providers. |
| ***Tax Advantage Accounts*** | | |
| ***Sec. 207. Repeal of Tax on Over-the-Counter Medications.*** | The ACA imposed the requirement that amounts paid for medicine or drugs are qualified expenses only in the case of prescribed drugs and insulin and not in the case of over-the-counter medications.<br>This provisions would repeal the requirement, effective beginning tax year 2017. | None. |
| ***Sec. 208. Repeal of Increase of Tax on Health Savings Accounts (HSA).*** | ▪ Prior to the ACA, distributions from flexible spending accounts (FSAs), HSAs, and Archer Medical Savings Accounts (MSAs) for qualified medical expenses[xv] which included over-the-counter medications.<br>▪ In 2011, the ACA modified the definition of qualified medical expenses restricted the definition of qualified distributions and excluded the use of funds for over the counter medications.<br>▪ The ACA also increased the percentage of tax on non-qualified distributions from HSAs, and from 10 to 20 percent. | None. |

| Section | Provisions | State Actions Required |
|---|---|---|
| ***Tax Advantage Accounts*** | | |
| ***Sec. 208. Repeal of Increase of Tax on Health Savings Accounts (HSA). (continued)*** | **AHCA Revisions**<br>▪ This provision permits the use of HSA funds for the purchase of over the counter medications effective for tax years beginning after Dec. 31, 2017, and returns the tax rate of HSAs and MSAs to 10 percent. | None. |
| ***Sec. 209. Repeal of Limitations on Contributions to Flexible Savings Accounts.*** | ▪ The ACA limited contributions to Flexible Spending Accounts to $2,500, indexed for cost-of-living adjustments.<br>▪ This provisions repeals the limitation on FSA contributions for taxable years beginning after Dec. 31, 2017. | Would impact state employee Flexible Spending Account contribution allowances and require changes to state employee benefit systems. |
| ***Sec. 215. Maximum Contribution Limit to HSAs Increased to Amount of Deductible and Out-of-Pocket Limitation.*** | ▪ Increases the basic limit on the aggregate HSA contribution for a year to equal the maximum on the sum of the annual deductible and out-of-pocket expenses permitted under a high deductible health plan.<br>▪ The basic limit will be at least $6,550 in the case of self-only coverage and $13,100 in the case of family coverage beginning in 2018. | Would impact state employee HSA contribution allowances and require changes to state employee benefit systems. |
| ***Sec. 216. Allow Both Spouses to Make Catch-Up Contributions to the Same Health Savings Account.*** | ▪ Married individuals would not have to take into account whether their spouse is also covered by an HSA-qualified high deductible health plan.<br>▪ Creates an allowance for both spouses to make catch-up contributions to one HSA beginning in 2018. | Would impact state employee HSA contribution allowances and require changes to state employee benefit systems. |
| ***Sec. 218. Special Rule for Certain Medical Expenses incurred Before Establishment of Health Savings Account.*** | ▪ Permits HSA withdrawals under certain circumstances to pay qualified medical expenses incurred before the HSA was established.<br>▪ Beginning in 2018, during the 60-day period beginning on the date that an individual's coverage under a high deductible health plan begins, the HSA will be treated as having been established on the date coverage in the high deductible health plan for purposes of determining if an expense that was incurred is a qualified medical expense. | Would impact state employee HSA contribution allowances and require changes to state employee benefit systems. |
| ***Tax Provisions*** | | |
| ***Sec. 241. Remuneration from Certain Insurers.*** | **Repeal of the ACA Provision Limitation on Excessive Remuneration Paid by Certain Health Insurance Providers**<br>▪ Repeals the ACA provisions that limited certain health insurance providers that exceeded $500,000 paid to an officer, director, or employee.<br>▪ The limit on the deduction of a covered health insurance provider for compensation attributable to services performed by an applicable individual starting in 2018.<br>▪ The repeal would be effective for tax years beginning after Dec. 31, 2017. | None. |

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| ***Tax Provisions*** | | |
| ***Sec. 231. Repeal of Tanning Tax.*** | **Repeal of the Excise Tax on Indoor Tanning Facilities**<br>▪ Repeals the 10 percent sales tax on indoor tanning services effective for services performed after Dec. 31, 2017. | None. |
| ***Sec. 221. Repeal of Tax on Prescription Medications.*** | **Tax on Pharmaceutical Manufacturers and Importers of Branded Medications**<br>▪ Repeals the annual fee or tax imposed on pharmaceutical manufacturers and importers of branded drugs imposed by the ACA effective Dec. 31, 2017.<br>▪ The ACA provisions required a company with more than $5 million in annual branded prescription drug sales made to or covered by specified government programs pay a share of the fee relative to its share of all such sales. The specified government programs are defined as including Medicare Part B; Medicare Part D; Medicaid; any program under which branded prescription drugs are procured by the Department of Veterans Affairs or the Department of Defense; and the TRICARE retail pharmacy program. Companies are required to pay their fees to the Treasury by September 30 each fee year, which is defined as the calendar year in which the fee must be paid.<br>**Repeal of an Annual Fee on Health Insurance Providers**<br>▪ Repeals the annual fee or tax on certain health insurers effective Dec. 31, 2017.<br>▪ The fee was imposed on for profit insurers starting in 2014 and was set at $8 billion and indexed to the annual rate of U.S. premium growth thereafter.<br>▪ The ACA fee generally include health insurance issuers such as an insurance company, insurance service, or insurance organization (foreign or domestic) that are required to have a state license and are subject to the laws of such jurisdictions that regulate health insurance.<br>▪ The Congressional Budget Office (CBO) had estimated that insurers may pass on the ACA insurer fee to consumers in the form of "slightly" higher premiums for coverage. | None. |
| ***Sec. 222. Repeal of Health Insurance Tax.*** | **Repeal of an Annual Fee on Health Insurance Providers**<br>▪ Repeals the annual fee or tax on certain health insurers effective Dec. 31, 2017.<br>▪ The fee was imposed on for profit insurers starting in 2014 and was set at $8 billion and indexed to the annual rate of U.S. premium growth thereafter. | None. |

| Section | Provisions | State Actions Required |
|---|---|---|
| ***Tax Provisions*** | | |
| ***Sec. 222. Repeal of Health Insurance Tax. (continued)*** | ▪ The ACA fee generally includes health insurance issuers such as an insurance company, insurance service, or insurance organization (foreign or domestic) that are required to have a state license and are subject to the laws of such jurisdictions that regulate health insurance.<br>▪ The Congressional Budget Office (CBO) had estimated that insurers may pass on the ACA insurer fee to consumers in the form of "slightly" higher premiums for coverage. | None. |
| ***Sec. 251. Repeal of Net Investment Income Tax.*** | **Repeal of the Unearned Income Medicare Contribution**<br>▪ The ACA imposed a 3.8 percent tax on the net investment income of certain individuals, estates, and trusts.<br>▪ The tax applies to single taxpayers with a modified adjusted gross income (MAGI) in excess of $200,000 and married taxpayers with an MAGI in excess of $250,000. MAGI includes wages, salaries, tips, and other compensation, dividend and interest income, business and farm income, realized capital gains, and income from a variety of other passive activities and certain foreign earned income. Taxpayers with a MAGI below these thresholds were not subject to the 3.8 percent tax. | None. |
| ***Sec. 206. Repeal of the Tax on Employee Health Insurance Premiums and Health Plan Benefits.*** | ▪ Repeals the 40 percent excise tax on high-cost employer-sponsored coverage, commonly referred to as the Cadillac tax originally scheduled to take effect in 2018.<br>▪ Changes the effective date from 2020 to 2026. | None. |
| ***Sec. 210. Repeal of the Medical Device Tax.*** | ▪ Repeals the 2.3 percent excise tax on the sale of certain medical devices imposed by the ACA beginning Dec. 31, 2017. | None. |
| ***Sec. 211. Repeal of Elimination of Deduction for Expenses Allocable to Medicare Part D Subsidy.*** | ▪ Repeals the changes made in the ACA to employer incentives to offer retiree drug coverage, employers who offered sufficient prescription drug coverage to their employees qualified for the Retiree Drug Subsidy to help cover actual spending for prescription drug costs.<br>▪ Re-instates the business expense deduction for the retiree prescription drug cost beginning after Dec. 31, 2017. | None. |

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|---|---|---|
| ***Tax Provisions*** | | |
| ***Sec. 212. Repeal of Increase in Income Threshold for Determining Medical Care Deduction.*** | ▪ The ACA increased the adjusted gross income (AGI) threshold for claiming medical-expense deductions that exceeded that threshold from 7.5 to 10 percent if the taxpayer was 65 years of age or older.<br>▪ This provision changes the threshold back to 7.5 percent for all taxpayers beginning in 2018. | None. |
| ***Sec. 213. Repeal of the Medicare Tax Increase.*** | ▪ Under the ACA, a Medicare Hospital Insurance surtax is imposed at a rate equal to 0.9 percent of an employee's wages or a self-employed individual's self-employment income.<br>▪ Repeals the 0.9 percent Medicare surtax, with respect to remuneration received after, and taxable years beginning after Dec. 31, 2022. | None. |

[i] 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.

[ii] **Pre-ACA expansion states-**Prior to the ACA, some states used Section 1115 waivers to provide Medicaid coverage to adults without dependent children and to parents with incomes above the threshold for the Section 1931 pathway. As a result, these states have few or no individuals who will qualify for the "newly eligible" FMAP rate. As of 2014, these states receive an increased FMAP rate, which is referred to as the "expansion state" FMAP rate. As of early Dec. 2013, the CMS determined the following states met the definition of "**expansion state**" and would be eligible for the "expansion state" FMAP rate if the state implements the ACA Medicaid expansion: Arizona, Delaware, District of Columbia, Hawaii, Maine, Massachusetts, Minnesota, New York, Pennsylvania, Vermont, and Washington**.**

[iii] **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.

[iv] **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 Non-elderly, Non-disabled Non-Expansion Adults.

[v] **Eligible health coverage** is defined as insurance offered in the individual market or unsubscribed COBRA coverage, that is not a grandfathered or grandmothered health plan, does not consist of excepted benefits and does not include coverage for abortion. Each state would need to certify that the insurance meets these requirements.

[vi] The **premium tax credit** is a refundable tax credit designed to help eligible individuals and families with low or moderate income afford health insurance purchased through the Health Insurance Marketplace, also known as the Exchange, beginning in 2014. The size of your premium tax credit is based on a sliding scale. Those who have a lower income get a larger credit to help cover the cost of their insurance. When you enroll in Marketplace insurance, you can choose to have the Marketplace compute an estimated credit that is paid to your insurance company to lower what you pay for your monthly premiums (advance payments of the premium tax credit, or APTC). Or, you can choose to get all of the benefit of the credit when you file your tax return for the year. If you choose to have advance payments of the premium tax credit made on your behalf, you will reconcile the amount paid in advance with the actual credit you compute when you file your tax return. Either way, you will complete Form 8962, Premium Tax Credit (PTC) and attach it to your tax return for the year.

The credit is "refundable" because, if the amount of the credit is more than the amount of your tax liability, you will receive the difference as a refund. If you owe no tax, you can get the full amount of the credit as a refund. However, if advance credit payments were made to your insurance company and your actual allowable credit on your return is less than your advance credit payments, the difference, subject to certain repayment caps, will be subtracted from your refund or added to your balance due.

[vii] **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.

[viii] **Modified adjusted gross income-***The term "modified adjusted gross income" means adjusted gross income increased by-*

(i) any amount excluded from gross income under section 911,
(ii) any amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax, and
(iii) an amount equal to the portion of the taxpayer's social security benefits (as defined in section 86(d)), which is not included in gross income under section 86 for the taxable year.

[ix] **Excepted benefits**

For purposes of this chapter, the term "excepted benefits" means benefits under one or more (or any combination thereof) of the following:

**(1) Benefits not subject to requirements**

(A) Coverage only for accident, or disability income insurance, or any combination thereof.
(B) Coverage issued as a supplement to liability insurance.
(C) Liability insurance, including general liability insurance and automobile liability insurance.
(D) Workers' compensation or similar insurance.
(E) Automobile medical payment insurance.
(F) Credit-only insurance.
(G) Coverage for on-site medical clinics.
(H) Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

**(2) Benefits not subject to requirements if offered separately**

(A) Limited scope dental or vision benefits.
(B) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.
(C) Such other similar, limited benefits as are specified in regulations.

**(3) Benefits not subject to requirements if offered as independent, non-coordinated benefits**

(A) Coverage only for a specified disease or illness.
(B) Hospital indemnity or other fixed indemnity insurance.

**(4) Benefits not subject to requirements if offered as separate insurance policy**

Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act), coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code, and similar supplemental coverage provided to coverage under a group health plan.

[x] The provisions of sections 2715 [42 U.S.C. 300gg–15] and 2718 [42 U.S.C. 300gg–18] of the Public Health Service Act (as added by subtitle A) apply to grandfathered health plans for plan years beginning on or after March 23, 2010.

[xi] The **individual mandate** was established under the ACA (ACA; P.L. 111-148, as amended). The individual mandate is often described as working in conjunction with other ACA provisions. Under the ACA, a number of market reforms went into effect intending to improve access to private health insurance for sick individuals or those at high risk of becoming ill.

[xii] **Employer Mandate**–The ACA required employers either to offer individual and family coverage under a QHBP (or current employment-based plan) to their employees or to pay a set amount into the Exchange, with some exceptions. Employers would include private-sector employers, churches, and federal, state, local and tribal governments. For those employers that chose to offer health insurance, the following rules would apply:

• Employers could offer employment-based coverage or, for certain small businesses, they could offer coverage through an Exchange plan (see section on rules for employer eligibility for Exchange plans).
• Current employment-based health plans would be grandfathered for five years, at which time any plan offered by an employer would have to meet (and could exceed) the requirements of the essential benefits package.
• Employers would have to contribute at least 72.5 percent of the lowest-cost QHBP or current employment-based plan they offered (65 percent for those electing family coverage) —prorated for part-time employees.

[xiii] 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)(I) 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].

[xiv] **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.

[xv] **Qualified medical expenses** are those expenses that generally would qualify for the medical and dental expenses deduction. These are explained in Pub. 502, Medical and Dental Expenses. Also, non-prescription medicines (other than insulin) aren't considered qualified medical expenses for HSA purposes. A medicine or drug will be a qualified medical expense for HSA purposes only if the medicine or drug: 1. Requires a prescription, 2. Is available without a prescription (an over-the-counter medicine or drug) and you get a prescription for it, or 3. Is insulin. For HSA purposes, expenses incurred before you establish your HSA aren't qualified medical expenses. State law determines when an HSA is established. An HSA that is funded by amounts rolled over from an Archer MSA or another HSA is established on the date the prior account was established. If, under the last-month rule, you are considered to be an eligible individual for the entire year for determining the contribution amount, only those expenses incurred after you actually establish your HSA are qualified medical expenses. Qualified medical expenses are those incurred by the following persons. 1. You and your spouse. 2. All dependents you claim on your tax return. Any person you could have claimed as a dependent on your return except that: a. The person filed a joint return, b. The person had gross income of $4,050 or more, or c. You, or your spouse if filing jointly, could be claimed as a dependent on someone else's 2016 return.

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