

## American Health Care Act Full Summary

### Highlights of the Energy & Commerce portion (text; section by section)

- **Prevention and Public Health Fund (PPHF)** – Repeals PPFH appropriations for fiscal year 2019 and beyond and rescinds unobligated FY 2018 funds.
- **Community Health Centers** – Adds \$422 million in funding for FY 2017.
- **Planned Parenthood** – Specifies a one-year freeze on mandatory federal funding (Medicaid, CHIP, social service block grants) going to “prohibited entities” describing Planned Parenthood.
- **Medicaid** – Repeals expanded presumptive eligibility authority, though still permits such determinations for children, pregnant women, and breast cancer and cervical cancer patients. Reverts the mandatory Medicaid income eligibility level for poverty-related children back to 100 percent of federal poverty level. Specifies that eligible children could be covered in CHIP. Repeals the six percentage point bonus in the federal match rate for community-based attendant services and supports, and returns to prior law without the six percent bonus.
- **Medicaid Expansion** – After Jan. 1, 2020, the enhanced matching rate would only apply to expansion-eligible individuals already enrolled in Medicaid as of Dec. 31, 2019 and do not have a break in eligibility for more than one month after that date. After Jan. 1, 2020, the State could only enroll newly eligible individuals at the State’s traditional FMAP for that individual.

Repeals state option to expand by Dec. 31, 2019. Amends the formula for expansion state matching rates (applicable to states that expanded before March 23, 2010) so the matching rate stops phasing up after CY2017 and the transition percentage would remain at the CY2017 level for each subsequent year.

- **Medicaid EHBs** – Repeals the requirement that essential health benefits must be provided in certain Medicaid plans on Dec. 31, 2019.
- **Disproportionate Share Hospitals** – Repeals DSH cuts in non-expansion states in 2018. Repeals DSH cuts in Medicaid expansion states in 2020.

- **Additional Medicaid Provisions** – Includes certain provisions regarding the consideration of lottery winnings in MAGI; the limitation of effective date for retroactive Medicaid benefits to the date of application; and the “loophole in current practice by requiring individuals to provide documentation of citizenship or lawful presence before obtaining coverage.” Also repeals state authority to elect to substitute a higher home equity limit that is above the statutory minimum in law
- **Safety Net Funding for Non-Medicaid Expansion States** – Provides \$10 billion over five years to non-expansion States for safety net funding used to adjust Medicaid provider payments. Specifically, states that have not expanded Medicaid by July 1 of the preceding year would receive an increased matching rate of 100 percent for CY 2018 through CY 2021 and 95 percent for CY 2022. States’ share would be determined by the number of individuals in the State with income below 138 percent of FPL in 2015 relative to the total number of individuals with income below 138 percent of FPL for all the non-expansion States in 2015.
- **Medicaid Eligibility Redeterminations** – Requires States with Medicaid expansion populations to redetermine expansion enrollees’ eligibility every six months. Provides a temporary five percent FMAP increase to States for activities directly related to complying with this section.
- **Medicaid Per-Capita Allotments** – Starts in FY 2020. Uses each State’s spending in FY 2016 as the base year to set targeted spending for each enrollee category (elderly, blind and disabled, children, non-expansion adults, and expansion adults) in FY 2019 and subsequent years for that State.

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. Starting in FY 2020, any State with spending higher than their specified targeted aggregate amount would receive reductions to their Medicaid funding for the following fiscal year. Exempts DSH payments and administrative payments from caps. Also exempts:

- 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 of Medicare cost sharing;
  - Individuals eligible for premium assistance;
  - Coverage of tuberculosis-related services for individuals infected with TB.

Includes data and reporting provisions, with a temporary increase to the federal matching percentage for these purposes (Oct. 1, 2017-Oct. 1, 2019). Provides for audits in specified years.

- **Patient and State Stability Fund** – Provides for a fund to reduce costs for patients and to stabilize State markets. The fund would provide \$15 billion in 2018 and 2019 and \$10 billion annually for 2020 through 2026. Funding is allocated for first two years based mainly on healthcare spending in the individual market and to a lesser extent on other factors like the state uninsured rate below 100 percent FPL (favoring non-expansion states) and the amount of plans participating in state exchanges. After the first two years, funding is set by the Administrator based on “cost, risk, low income uninsured population, and issuer competition.” In 2020, the bill would phase in a state matching formula, presumably to help assist states that use money to build this own program.

The fund can be used by states for the following purposes:

- Provide financial assistance, high-risk individuals who do not have access to health insurance coverage in the individual market.
  - To help incentivize stable premiums.
  - To lower insurance costs in the individual and small group markets.
  - To promote participation in state insurance markets.
  - To provide access to preventive, dental, vision, and mental health services.
  - To pay providers.
  - To reduce cost sharing and premiums.
- **ACA Cost-Sharing Subsidies** – Repeals cost-sharing subsidies in 2020.
  - **Continuous Coverage** – For Benefit Year 2019, implements a 12-month lookback period to assess whether an applicant went without coverage for greater than 63 days. If such a break in coverage occurred, there will be a flat 30 percent late-enrollment surcharge applied to their base premiums for 12 months. The surcharge is the same for all those having such a break (it does not vary by health status). The surcharge applies for special enrollment applicants in Benefit Year 2018.

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- **Actuarial Value** – Repeals the AV levels that correspond to metallic levels of coverage under the ACA. Note: This is not likely eligible for reconciliation and thus would not be in any final enacted bill.
- **Age Rating** – Changes age-rating bands to 5:1 (they are 3:1 under the ACA) and permits states to set their own. As above, this is not likely eligible for reconciliation and thus would not be in any final enacted bill.

*Highlights of the Ways & Means portion ([summary](#); [section by section](#))*

- **Recapture of ACA Excess Advance Premium Subsidies** – For tax years 2018 and 2019, requires repayment of full amount, regardless of income.
- **Current ACA Premium Subsidies** – Repeals current ACA premium subsidies beginning in 2020. In the meantime, revises calculation of individual or family income contribution to premiums so it considers both household income as well as age. Allows current subsidies to be applied to catastrophic plans and certain plans not sold through Exchanges. Prohibits subsidies' application to plans that cover abortion services.
- **Refundable Tax Credits** – Creates an advanceable, refundable tax credit for the purchase of state-approved, major medical health insurance and unsubsidized COBRA coverage. **Credits are newly means tested** and are available in full to those making \$75,000 per year (\$150,000 for joint filers). They phase down by \$100 for every \$1,000 in income higher than those thresholds.

Eligibility is based on not having access to government or employer coverage and being a citizen, national, or qualified alien. Credits are age-adjusted:

- Under age 30: \$2,000
- Between 30 and 39: \$2,500
- Between 40 and 49: \$3,000
- Between 50 and 59: \$3,500
- Over age 60: \$4,000

Credits are “additive for a family” and **capped at \$14,000**. They are indexed at CPI plus one percent.

- **Small Business Tax Credit** – Repeals beginning in 2020. Makes it unavailable 2018-2020 for plans providing coverage of elective abortion.

- **Individual Mandate** – Reduces the penalty to zero for 2016 and beyond.
- **Employer Mandate** – Reduces the penalty to zero for 2016 and beyond.
- **Cadillac Tax** – Modifies the effective date to delay it to 2025. The Cadillac tax will not apply for any taxable period beginning after Dec. 31, 2019, and before Jan. 1, 2025.
- **HSA, Other Taxes** – “Effectively repeals” the over-the-counter medicine tax as of 2018 tax year and lowers HSA distribution tax to pre-ACA levels as of Dec. 31, 2017. Repeals limits on contributing to FSAs as of Dec. 31, 2017. Restores pre-ACA medical deductibility percentage beginning in 2018. Repeals the additional the additional 0.9 percent Medicare tax beginning in 2018. Repeals the net investment tax beginning in 2018.
- **Device Tax** – Repeals for taxable years beginning after Dec. 31, 2017.
- **Pharma Tax** – Specifies that the tax would not apply for years beginning after Dec. 31, 2017.
- **Insurer Tax** – Repeals the health insurance tax beginning after Dec. 31, 2017.
- **Insurer Remuneration** – Repeals the limit on the deduction of a covered health insurance provider for compensation attributable to services performed by an applicable individual starting in 2018.
- **HSAs** – Sets basic limit at at least \$6,550 in the case of self-only coverage and \$13,100 in the case of family coverage beginning in 2018. Both spouses would be able to make catch-up contributions, among other policies.