Selected Elements of Congressional Health Care Bills

Prepared for the Children, Families, Health, and Human Services Interim Committee
by Sue O'Connell, Research Analyst
June 29, 2017

Background Information

The U.S. House of Representatives passed the American Health Care Act on May 4, 2017, to revise elements of the Patient Protection and Affordable Care Act (ACA) approved by Congress in 2010. A discussion draft of the U.S. Senate's replacement bill, the Better Care Reconciliation Act, was unveiled on June 22, 2017, and revised on June 26. This briefing paper summarizes key changes the two bills would make to ACA.

Topic Area	American Health Care Act (House)	Better Care Reconciliation Act (Senate)
Individual Insurance Mandate/Penalties	**Retroactively Effective to Jan. 1, 2016**: • Mandate for individuals to purchase health insurance is repealed • Penalty for failure to have qualifying health coverage is eliminated **Effective 2019:** • Insurers must charge 30% more for policies for people who have a coverage gap of more than 63 days in a 12-month period	**Retroactively Effective to Jan. 1, 2016**: • Mandate for individuals to purchase health insurance is repealed • Penalty for failure to have qualifying health coverage is eliminated **Effective in 2019:** • Individuals who have a gap of 63 days in the 12 months before applying for an individual insurance policy may not obtain coverage for: ▸ 6 months from the date of application if application is made during an open enrollment or special enrollment period; or ▸ the later of 6 months from the date of application or the start of a new plan year if the individual did not apply during open enrollment or qualify for a special enrollment period
Employer Insurance Provisions	**Retroactively Effective to Jan. 1, 2016:** • Mandate for employers with 50 or more workers to provide insurance or pay a penalty is eliminated **Effective in 2018:** • Small business tax credits may not be used for plans that cover abortion services **Effective in 2020:** • Tax credits are eliminated for employers with 25 or fewer low-wage employees. The benchmark for wages was $50,000 in 2013, increasing annually by the rate of inflation.	**Retroactively Effective to Jan. 1, 2016:** • Mandate for employers with 50 or more workers to provide insurance or pay a penalty is eliminated **Effective in 2018:** • Small business tax credits may not be used for plans that cover abortion services **Effective in 2020:** • Tax credits are eliminated for employers with 25 or fewer low-wage employees. The benchmark for wages was $50,000 in 2013, increasing annually by the rate of inflation • New small business association plans may be offered in the large group market and sold across state lines while meeting only the requirements of the state in which the plan is domiciled

<table>
<tr><th>Topic Area</th><th>American Health Care Act (House)</th><th>Better Care Reconciliation Act (Senate)</th></tr>
<tr><td>Medicaid Expansion</td><td>In General: The current enhanced federal matching rate (FMAP) will continue to step down from 95% in 2017 to 94% in 2018, 93% in 2019 and 90% in 2020 and beyond, but eligibility determination will change in 2020
Effective in 2017:
• States must redetermine eligibility for Medicaid expansion enrollees every 6 months, rather than annually, and will receive a slightly higher administrative matching rate for the additional administrative costs
• States may require the expansion population, with a few exceptions, to participate in work activities and will receive a slightly higher administrative matching rate for the additional administrative costs
Effective in 2020:
• States may no longer make presumptive eligibility determinations for expansion enrollees
• The enhanced FMAP for expansion enrollees is available only for those people who were enrolled in Medicaid on or before Dec. 31, 2019, and who do not have a break in eligibility of more than 1 month after Dec. 31, 2019
• People who would be newly eligible under expansion criteria may continue to enroll in Medicaid after Dec. 31, 2019, but their medical costs will be reimbursed at the state's regular FMAP</td><td>In General: The current enhanced federal matching rate (FMAP) will continue to step down from 95% in 2017 to 94% in 2018, 93% in 2019 and 90% in 2020 and will further decrease through 2024
Effective in 2017:
• States may redetermine eligibility for expansion enrollees every 6 months or more frequently, rather than annually, and will receive a slightly higher administrative matching rate for the additional administrative costs
• States may require the expansion population, with a few exceptions, to participate in work activities and will receive a slightly higher administrative matching rate for the additional administrative costs
Effective in 2020:
• States may no longer make presumptive eligibility determinations for expansion enrollees
Effective in 2021:
• The FMAP reduces to 85%
Effective in 2022:
• The FMAP reduces to 80%
Effective in 2023:
• The FMAP reduces to 75%
Effective in 2024:
• The FMAP reduces to the state's regular Medicaid FMAP (historically about 65% in Montana)</td></tr>
<tr><td>General Medicaid Program</td><td>Effective in 2020:
• Medicaid changes from an open-ended entitlement program to a program with a defined federal funding level based on a per-capita model; states may opt for a block grant model, instead
‣ Per capita funding is based on each state's historical per enrollee cost and number of enrollees, using FY 2016 as the base year
‣ Each state's targeted spending amount will increase annually by the medical CPI
• The reductions in Disproportionate Share Hospital (DSH) payments, for hospitals serving a high number of low-income people, are repealed</td><td>Effective in 2020:
• Medicaid changes from an open-ended entitlement program to a program with a defined federal funding level based on a per-capita model; states may opt for a block grant model, instead
‣ Per capita funding is based on each state's historical per enrollee cost and number of enrollees, using a 2-year period selected by the state
‣ Each state's targeted spending amount for most adults and children will increase annually through 2024 by the medical CPI and for the elderly and disabled by the medical CPI plus 1 percent
• Disproportionate Share Hospital (DSH) payment reductions are repealed for non-Medicaid expansion states
Effective in 2024:
• The per-enrollee amount will increase annually by the general CPI rather than the typically higher medical CPI</td></tr>
</table>

Topic Area	American Health Care Act (House)	Better Care Reconciliation Act (Senate)
General Medicaid Eligibility and Benefit Provisions	**Effective in 2017:** • The current 3-month retroactive eligibility period for Medicaid benefits ends and coverage will instead begin in the month that a person applies for Medicaid **Effective in 2018:** • The amount of home equity that is excluded when determining eligibility for long-term care is capped at the federal maximum, currently $560,000; states may no longer set a higher limit **Effective in 2020:** • The mandatory income eligibility level for children 6 to 19 years of age is reduced from 133% FPL to 100% FPL • Hospitals may no longer make presumptive eligibility determinations related to Medicaid • Alternative benefit plans no longer need to include the 10 Essential Health Benefits required under ACA • The 6% enhanced FMAP for Community First choice attendant care services is repealed • Certain lottery and lump sum income must be counted in specific months, depending on the amount	**Effective in 2017:** • The current 3-month retroactive eligibility period for Medicaid benefits ends and coverage will instead begin in the month that a person applies for Medicaid **Effective in 2018:** • States may request federal Medicaid reimbursements of 50% for qualified adult psychiatric hospital stays of up to 30 days at a time and 90 days in a calendar year if they maintain the number of beds and level of funding that existed on the date of application **Effective in 2020:** • The mandatory income eligibility level for children 6 to 19 years of age is reduced from 133% FPL to 100% FPL • Hospitals may no longer make presumptive eligibility determinations related to Medicaid • Alternative Benefit Plans no longer need to include the 10 Essential Health Benefits required under ACA • The 6% enhanced FMAP for Community First Choice attendant care services is repealed
General Public Health Changes	**Effective in 2017:** • The Prevention and Public Health Fund appropriations provided under ACA are repealed • An extra $422 million is appropriated for federally qualified health centers • A one-year freeze is placed on all federal funding for providers that offer family planning services, provide abortions that don't meet the Hyde amendment exception for federal funding, and received more than $350 million in federal and state Medicaid funds in FY 2014; the requirements essentially limit the prohibition to Planned Parenthood	**Effective in 2017:** • The Prevention and Public Health Fund appropriations provided under ACA are repealed • An extra $422 million is appropriated for federally qualified health centers • A one-year freeze is placed on all federal funding for providers that offer family planning services, provide abortions that don't meet the Hyde amendment exception for federal funding, and received more than $350 million in federal and state Medicaid funds in FY 2014; the requirements essentially limit the prohibition to Planned Parenthood • Up to $2 billion is available in federal grants to states for substance abuse disorder treatment and recovery services

Topic Area	American Health Care Act (House)	Better Care Reconciliation Act (Senate)
Individual Subsidies/ Tax Credits	**In General**: Premium assistance and cost-sharing subsidies will be phased out and replaced in 2020 with refundable tax credits for insurance coverage/medical expenses. **Effective in 2018:** • Premium assistance (and, later, tax credits) may not be used for plans that cover abortion services • The entire amount of premium assistance received above the cost of insurance must be repaid, rather than the sliding repayment schedule used under ACA • Premium assistance payments can be used to buy certain health plans outside of the insurance exchange **Effective in 2019:** • Premium contributions are adjusted for age and income so that lower-income individuals receive more assistance **Effective in 2020:** • Premium assistance for plans on the individual market transitions to flat tax credits based on household size, income, and age, up to a maximum of $14,000 a year per family; married couples must file jointly to claim the credit • Tax credits are reduced by 10% for each $1,000 increase in income above $75,000 for single people and $150,000 for married couples • Tax credits that exceed insurance premiums may be deposited in health savings accounts (HSAs) • Cost-sharing subsidies for people below 250% FPL are repealed	**In General**: Eligibility for premium assistance will change in 2020 and will be tied to plans with lower benefits. Cost-sharing subsidies will be eliminated in 2020. **Effective in 2018:** • Premium assistance may not be used for plans that cover abortion services • The entire amount of premium assistance received above the cost of insurance must be repaid, rather than the sliding repayment schedule used under ACA • The penalty for erroneously claiming a tax credit is increased from 20% to 25% of the excess amount **Effective in 2020:** • Premium assistance is available to people with incomes of 0% to 350% of the FPL, rather than the current levels of 100% to 400% FPL • Assistance is tied to the median-priced marketplace plan with an actuarial value of 58%, rather than the current 70% • Individuals with incomes above 150% FPL will pay different amounts for coverage based on age ranging from 2% to 16.2% of their income, with older people paying a higher percentage of income than younger people. • Individuals who have access to employer coverage are not eligible for tax credits regardless of the affordability or value of the employer coverage • Only qualified aliens, rather than any noncitizens legally present in the U.S., are eligible for tax credits, meaning some workers and students on visas will no longer qualify • Cost-sharing subsidies for people below 250% FPL are repealed

Topic Area	American Health Care Act (House)	Better Care Reconciliation Act (Senate)
Insurance Market Changes	**Effective in 2017**: • The federally funded Patient and State Stability Fund is created to assist with insurance costs for low-income, high-cost individuals in states that waive certain coverage requirements. States must provide a match for the funds that increases over time, ranging from a low of 7% in 2020 to 50 percent by 2024 or 2026, depending on the program. **Effective in 2018:** • The HHS Secretary may establish an age rating ratio of 5:1 for premiums in individual and small group markets, rather than the 3:1 ratio currently allowed • States may apply for a waiver to implement a higher age rating ratio • States may apply for a waiver allowing insurers to take health status, including pre-existing conditions, into account when setting premiums • States that obtain waivers may receive funds from the Patient and State Stability Fund to help certain people with insurance costs through a reinsurance program or high-risk pool • The HSA contribution limits are raised to equal the limit on out-of-pocket cost sharing under high-deductible health plans **Effective in 2019:** • States may apply for a waiver allowing insurers to take health status into account when setting premiums, rather than charging the 30% premium for a gap in coverage **Effective 2020:** • States may apply for a waiver allowing them to define Essential Health Benefits in their states • Plans no longer need to meet certain actuarial levels	**Effective in 2017:** • States that apply for waivers of federal requirements under Sections 1332 of ACA must be granted the waiver unless the HHS secretary determines the waiver would increase the federal deficit; applications may be submitted upon approval of governor and the state insurance commissioner without legislative action • Section 1332 waivers are valid for 8 years • Up to $2 billion would be available in grants to states to submit a 1332 waiver and implement the resulting state plan **Effective in 2018:** • The State Stability and Innovation Program is created to provide short- and long-term funding to the states. Shorter-term funding of $50 billion is available from 2018-2021 for a reinsurance program to provide federal payments directly to insurers • The HSA contribution limits are raised to equal the limit on out-of-pocket cost sharing under high deductible health plans **Effective in 2019:** • Insurers may use an age rating of 5:1, rather than the 3:1 ratio currently allowed, unless states adopt a different ratio • States may receive federal funds for long-term state stability and innovation programs that reduce premium costs for high-risk individuals, stabilize insurance premiums and promote market participation, provide payments to health care providers, or help reduce out-of-pocket costs for insured individuals. States must provide a match for the funds that increases over time, starting at 7 percent in 2022 and increasing to 35 percent in 2026. • The federal medical loss ratio of 85% is repealed and states must set their own ratios, which essentially determine the amount of an insurer's funds that may be spent on administrative costs

Topic Area	American Health Care Act (House)	Better Care Reconciliation Act (Senate)
Individual and Business Taxes	**Effective in 2017:** • The prohibition on using HSAs for over-the-counter medication is repealed • The tax rate for distributions from HSAs and Medical Savings Accounts (MSAs) for non-qualified expenses is reduced from 20% to 10% for HSAs and 15% for MSAs • The adjusted gross income threshold for determining whether a person may claim itemized deductions for unreimbursed medical expenses is reduced from 10% to 7.5% • The limit on contributions to Flexible Spending Accounts is repealed • The following ACA-imposed taxes are repealed: ‣ 10% tax on indoor tanning services ‣ 3.8% tax on certain net investment of individuals, estates, and trusts above a certain income level ‣ 2.3% excise tax on certain medical devices ‣ tax on certain manufacturers or importers of branded prescription drugs ‣ annual fees on certain health insurers • HSAs may be used without tax penalty to cover over-the-counter drug csots **Effective in 2020:** • The 40% tax on high-cost employer-sponsored health plans (the so-called "Cadillac tax"), scheduled to go into effect in 2020, is delayed until 2026 **Effective in 2023:** • The 0.9% Medicare surtax on certain high-income earners is repealed	**Effective in 2017:** • The prohibition on using HSAs for over-the-counter medication is repealed • The tax rate for distributions from HSAs and Medical Savings Accounts (MSAs) for non-qualified expenses is reduced from 20% to 10% for HSAs and 15% for MSAs • The adjusted gross income threshold for determining whether a person may claim itemized deductions for unreimbursed medical expenses is reduced from 10% to 7.5% • The following ACA-imposed taxes are repealed: ‣ 10% tax on indoor tanning services ‣ 3.8% tax on certain net investment of individuals, estates, and trusts above a certain income level ‣ annual fees on certain insurers • The limitation on deduction of health insurer employee salaries in excess of $500,000 is repealed **Effective in 2018:** • The limit on contributions to Flexible Spending Accounts is repealed • HSA amounts withdrawn for qualified medical expenses are not subject to income tax; over-the-counter drugs included as medical costs • The following ACA-imposed business taxes are repealed: ‣ 2.3% excise tax on certain medical devices ‣ tax on certain manufacturers or importers of branded prescription drugs is repealed **Effective in 2020:** • The 40% tax on high-cost employer-sponsored health plans (the so-called "Cadillac tax"), scheduled to go into effect in 2020, is delayed until 2026 **Effective in 2023:** • The 0.9% Medicare surtax on certain high-income earners is repealed

Topic Area	American Health Care Act (House)	Better Care Reconciliation Act (Senate)

Required and Optional State Actions	**In General:** A state decision to apply for a waiver for certain insurance coverage provisions would require the state to establish or participate in a high-risk pool, reinsurance program, or other method of ensuring coverage for lower-income individuals
	Effective in 2017:
	• States must conduct eligibility determinations for Medicaid expansion enrollees every 6 months, rather than annually
	• States may:
	  ▸ apply work requirements to the Medicaid expansion population
	  ▸ apply for a waiver from the age rating ratio of 5:1 for insurance plans offered in 2018 and later
	Effective in 2018:
	• States may choose to apply for a waiver from the continuous coverage penalty so that health insurers can use health status, including pre-existing conditions, in setting insurance premiums for plans offered in 2019 and later
	Effective in 2019:
	• States may choose to apply for a waiver from the Essential Health Benefit requirements for plans offered in 2020 and later
	Effective in 2020:
	• States that choose to participate in a federally funded program for rate stabilization for certain individuals must begin matching the federal funds they receive
		In General: A state decision to apply for a Section 1332 waiver for certain insurance coverage provisions would require the state to establish or participate in a high-risk pool, reinsurance program, or other method of ensuring coverage for lower-income individuals
		Effective in 2017:
		• States may conduct eligibility determinations for Medicaid expansion enrollees every 6 months or more frequently, rather than annually
		• States may apply work requirements to the Medicaid expansion population
		Effective in 2018:
		• States may begin receiving, upon application, funds from the federal State Stability and Innovation Program
		Effective in 2019:
		• States may apply for a waiver from the age rating ratio of 5:1 for insurance plans offered in 2019 and later
		Effective in 2020:
		• States that choose to participate in a federally funded program for rate stabilization for certain individuals must begin matching the federal funds they receive

Sources: Compiled from the House and Senate versions of H.R. 1628 and related House and Senate summaries and from materials developed by the Kaiser Family Foundation, National Conference of State Legislatures, State Academy of State Health Policy, and National Congressional Research Service