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The American Health Care Act: Summary of House-Passed Bill to Repeal and Replace Portions of the Affordable Care Act and Next Steps in the Senate

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House Republican leadership earlier this year proposed a plan to fulfill its long-standing promise to repeal and replace the Affordable Care Act (ACA) through a bill titled "The American Health Care Act" (AHCA). The bill was introduced pursuant to reconciliation instructions from the fiscal year (FY) 2017 Budget Resolution, meaning that it could be considered under special procedural rules that limited debate and passed with a simple majority vote in both the House and the Senate. On May 4, after numerous fits and starts over the past several weeks, Republicans narrowly passed an amended version of the bill, by a vote of 217-213, delivering President Trump a political victory that is one step closer to his long-held campaign promise of repealing Obamacare.

Ever since House Speaker Paul Ryan (R-WI), in consultation with President Trump, decided to withdraw the bill from the House floor in late March, factions of the Republican Party worked to develop and negotiate additional amendments in order to secure the 216 votes necessary to pass the bill. During the week ending Friday, April 7, rumors grew regarding revisions to the AHCA and the possibility of an end-of-week floor vote that ultimately did not materialize. However, as a sign of progress, the House Rules Committee voted 9-2 on April 6 to adopt an amendment to the AHCA that would establish a federal risk-sharing fund and appropriate $15 billion for a high-risk pool program from 2018 to 2026.

While the House was on a two-week district work period, the moderate GOP Tuesday Group Co-Chair Tom MacArthur (R-NJ) worked with Freedom Caucus Chair Mark Meadows (R-NC) to put forward an amendment that was aimed to appease conservatives who argued that the AHCA did not go far enough in loosening the ACA's insurance mandates. The negotiated amendment would provide states with flexibility to seek a waiver to opt out of the ACA's regulations on essential health benefits, community rating requirements and how much older Americans are charged for health insurance coverage. In order for states to opt out, the measure would require that states (1) reduce average premiums, (2) increase enrollment in health insurance coverage, (3) stabilize the state's health insurance market, (4) stabilize the premiums for individuals with pre-existing conditions, and/or (5) increase the choice of health plans offered in the state. The amendment also requires states to set up high-risk pools. Additionally, states are no longer compelled to institute the continuous coverage provision that Republicans previously proposed in the original version of the AHCA.

On April 26, the Freedom Caucus confirmed its official support for the amendment, bringing about three dozen conservative members into the "yes" column. While this amendment moved the bill politically to the right, it did nothing to persuade moderate Republicans to support it. Further, Tuesday Group members were angered by what some perceived to be "freelance" negotiations by Rep. MacArthur with the Freedom Caucus. Former Energy and Commerce Committee Chairman Fred Upton (R-MI) publicly announced that he could not support the AHCA as revised by the MacArthur Amendment, but he worked behind the scenes with vocal Trump supporter and fellow AHCA holdout Rep. Billy Long (R-MO) to draft another amendment. The Upton-Long amendment added $8 billion to the bill to help cover the costs

associated with covering individuals with pre-existing conditions. Despite questions about whether $8 billion was enough to protect the sickest Americans, the amendment ultimately secured enough Republican votes to pass the bill. Twenty Republicans joined the Democrats to vote against passage of the AHCA, providing Republicans with only one vote to spare.

The House vote occurred without an official cost estimate from the Congressional Budget Office (CBO). In its evaluation of the March 6 version of the AHCA, the CBO originally estimated that the bill would reduce the federal deficit by $337 billion. On March 23, the CBO issued a revised estimate that took into consideration the March 20 Manager's Amendment and lowered the estimated deficit reduction to $150 billion based on additional substantive policy changes to the bill. Subsequent changes could significantly impact the CBO's prior analyses, and the CBO will not issue its revised estimates for at least another week.

Passage of AHCA was a more politically difficult vote for Republicans than originally expected for a number of reasons. CBO's coverage reduction estimate as well as the public backlash against the potential loss of coverage for individuals with preexisting conditions led more moderate members to raise concerns. On the other side of the GOP Conference, conservative Freedom Caucus members felt that the original version of AHCA did not go far enough in repealing ACA.

After passage of the bill, President Trump held a press conference at the White House attended by Health and Human Services (HHS) Secretary Tom Price, Centers for Medicare and Medicaid Services (CMS) Administrator Seema Verma, Republican leadership, committee chairs, and the rank and file members who voted in favor of the bill. This unprecedented celebration for a bill that has passed only one congressional chamber is indicative of the importance of this achievement for Republicans and the President's strong desire to deliver on a core campaign promise.

Looking Ahead

With House passage secured, the administration and Senate Republicans are wasting no time beginning what will likely be a tedious and lengthy quest to capture 50 votes in the Senate. In lieu of the traditional committee process, Leader Mitch McConnell (R-KY) created a working group of about a dozen Republican senators to develop a consensus package that will become a substitute amendment for the AHCA. Members of that group include Finance Committee Chairman Orrin Hatch (R-UT), HELP Committee Chairman Lamar Alexander (R-TN), and senators who have been outspoken on health care reform from various factions of the party, including Senators Ted Cruz (R-TX) and Cory Gardner (R-CO).

Senate Republicans have a difficult task ahead of them, both substantively and procedurally. Without a CBO score, much remains unknown about the House-passed bill's coverage numbers and deficit reduction impact, in addition to how some of the last-minute provisions may fare under the Senate's Byrd Rule. There are a variety of concerns that GOP senators hope to address in their version of the AHCA, including provisions related to the phaseout of the ACA Medicaid expansion, the new tax credit component and coverage for individuals with pre-existing conditions.

Beyond the debate over substance, the bill must comply with the Byrd Rule, meaning that the bill must focus on revenue and spending and cannot include any nongermane provisions that produce a merely incidental budgetary change. The Senate Parliamentarian must decide whether certain insurance market regulations—such as those related to EHBs and age banding—pass muster under the Byrd Rule. While the Byrd Rule is controlling, lawmakers can remove provisions in violation of the Rule without procedurally jeopardizing the privileged nature of reconciliation.

With only three session weeks remaining in the Senate before the Memorial Day recess, it is unlikely that the Senate will be prepared to take up the AHCA on the floor until June, with no senators willing to make a prediction about how quickly they can get something passed. Unlike the House, they are unlikely to proceed on the AHCA until the Senate version is scored by the CBO.

Once a substitute amendment is ready for floor consideration, reconciliation rules in the Senate limit debate time to 20 hours, followed by a rapid amendment voting session, known as a "vote-a-rama," which can last for several hours. If the Senate can pass the AHCA, there are two scenarios for advancing it to the finish line. In an ideal world for Republicans, the Senate will find a way to assemble a consensus package that the House can accept "as is" and send to the President for his signature. In the absence of that, the bill will go to a conference committee to resolve differences between the two houses.

The administration is also working on a parallel track to deal with the ACA. HHS recently finalized its market stability rule addressing special enrollment periods, provider networks and other ACA rules that insurers have contended are problematic. Beyond this rule, the administration faces tough decisions on whether to take action to prevent further deterioration of the ACA marketplaces. One key decision, which is the subject of ongoing discussions between the White House and Congress, is how to handle the pending appeal in the *House v. Price* case.

The uncertainty in Washington is being felt in other parts of the country as well. In recent weeks, a number of insurers have indicated that they will stop offering their exchange products, citing financial risk and uncertainty about the future of the markets. This development puts pressure on the administration to act without waiting for Congress; however, President Trump has continued to express concern about maintaining cost-sharing reduction payments for insurers.

The remainder of this memorandum provides an overview of the AHCA, including the adopted amendments and substantive policies outlined therein, the available CBO cost estimates, and a discussion of how the AHCA would impact various health industry stakeholders. Appendices A, B and C offer a side-by-side look at each of the core AHCA provisions and the corresponding ACA provisions that would be impacted.

AHCA Overview

The Patient Protection and Affordable Care Act of 2010—Public Laws 111-148 and 111-152—is made up of nine titles that span nearly 3,000 pages. Like prior ACA repeal bills

introduced by Republicans over the years, the AHCA would not repeal the ACA in its entirety—partially due to conscious policy decisions, and partially because of procedural limits within budget reconciliation rules. For instance, the AHCA would maintain some of the "popular" insurance market reforms in Title I of the ACA, such as rules requiring issuers to offer dependent coverage until age 26; prohibitions on annual and lifetime limits; and prohibition of discrimination based on race, nationality, disability, or sex. The AHCA also would not propose changes to any Medicare provisions from Title III of the ACA, such as those implementing quality- and value-based provider payment reforms (many of which are budget neutral), the Center for Medicare and Medicaid Innovation, and provider rate cuts (repeal of which would add to the deficit outside of the 10-year budget window, in violation of procedural rules).

AHCA's reforms fall into the three broad categories described below:

Coverage and affordability in the (nonpublic) individual and small group insurance markets

In the private insurance marketplace, the AHCA would redesign (and shrink) federal assistance to consumers, eliminate coverage mandates and create a new surcharge on plans for applicants who fail to maintain continuous coverage:

- *New fixed, age-based tax credits* – The AHCA would eliminate the ACA's income-based premium tax credits, which were designed to help low-income individuals afford "quality health insurance coverage." It would also eliminate tax credits available to small employers that fund a portion of their employees' coverage purchased on the Small Business Health Options (SHOP) exchange. The AHCA would replace the ACA premium tax credits with a newly designed credit that varies based on only age, not income level.

- *Elimination of cost-sharing reduction subsidies* – TheAHCA would eliminate cost-sharing reduction subsidies that are payable directly to insurers and help reduce out-of-pocket costs for lower-income enrollees. These subsidies are the subject of federal litigation in *House v. Price*, the House having alleged that funding for the subsidies must go through the federal appropriations process. The district court sided with the House and enjoined further CSR payments, but the injunction has been stayed pending the appeal. The AHCA's new Patient and State Stability Fund, described in greater detail below, would provide federal grant funding that states could use to subsidize cost-sharing.

- *No coverage mandates; new "continuous coverage" incentive* – By setting the individual and employer mandate penalties at $0, the AHCA would deactivate the main tool that the federal government has under the ACA to compel individuals to purchase, and larger employers to offer, minimum essential coverage and disincentivize individuals from purchasing insurance only when they get sick. The AHCA would create a new "continuous coverage" incentive that requires individual market plans to apply a 30 percent markup on premiums for individuals who go without coverage for more than 63 days during a 12-month lookback period.

The AHCA also includes a number of provisions addressing the ACA's insurance market reforms, which Republicans assert have caused dramatic premium increases and pushed healthier

individuals out of the exchange market. Collectively, these provisions aim to keep premium costs down and attract younger, healthier people to purchase insurance:

- *Actuarial value (AV) standards* – The AHCA would sunset the ACA's AV standards, which determine how much cost-sharing is required for consumers in the various types of plans available on exchanges.

- *Age-banding restrictions* – The AHCA would lift the ACA's 3:1 age banding restriction and replace it with a 5:1 standard, meaning a younger enrollee could be charged up to five times less than an older enrollee. Under the April 25 amendment, states may also apply for waivers to set an age ratio higher than the 5:1 standard that would apply in the individual and small-group market.

- *Essential Health Benefits (EHB)* – The April 25 amendment permits EHBs to remain in place in the AHCA. However, states can apply to waive EHB requirements and establish their own set of EHBs for all purposes in the individual and small-group market.

- *"Invisible" risk-sharing* – The April 6 amendment establishes a federal "invisible" risk-sharing program under the AHCA. The CMS would provide payments to insurers for costs attributable to high-risk patients (e.g., those with pre-existing conditions that the guaranteed issue rules require them to take). It appropriates $15 billion for calendar years 2018 through 2026 and, beginning in 2020, it allows states to take over operation of the program.

- *Health status underwriting* – The April 25 amendment allows states to waive the ACA's community rating rules to allow health insurers to health status underwrite for one year for consumers who failed to maintain continuous coverage. States are permitted to waive the rules only if they establish a high-risk pool or a reinsurance program, or if they participate in the federal "invisible" risk-sharing program.

As noted above, the version of the AHCA that passed the House on May 4 contained several new provisions that were not included in the March 24 bill that was pulled from the floor. These provisions were added to secure the votes of both the Freedom Caucus and moderate Republicans by adding provisions that affect community rating and EHB requirements while also providing additional funding for states. The newest additions came from amendments on April 6 (offered by Reps. Palmer (R-AL) and Schweikert (R-AZ)), April 25 (offered by Rep. MacArthur (R-NJ)), and May 3 (offered by Reps. Upton (R-MI) and Long(R-MO)). The April 6 amendment establishes a federal risk-sharing program. The April 25 amendment establishes three waivers that states can apply for: (1) a waiver of age-rating requirements; (2) a waiver of community-rating requirements for individuals who do not maintain continuous coverage and (3) a waiver of EHB requirements. To apply for the waiver, states will submit an application to HHS, which will be automatically approved, unless they are disapproved within 60 days of the application for noncompliance with the requirements of the AHCA application instructions. Both the age rating and EHB waivers are subject to a term of no more than 10 years, unless an extension is granted by the Secretary. The community rating waiver may only be effective for a period during which the state is operating a risk mitigation program under the Patient and State Stability Fund or is participating in the federal invisible risk sharing program. The May 3 amendment creates a fund

of $8 billion for the years 2018 to 2023 to be granted to states executing the community rating waiver to permit health status underwriting.

Finally, the AHCA includes reforms to health savings accounts (HSAs), consistent with Republicans' objective to expand choice through consumer-directed health care. Effective for 2018, AHCA would increase the maximum tax-subsidized amounts that can be contributed to HSAs, allow both spouses to make catch-up contributions to the same HSA and allow HSAs to cover medical expenses incurred up to 60 days before HSA coverage begins. Republicans have long championed HSAs as a way to empower consumers and, combined with other provisions in the AHCA that may enable "skinnier" benefit plans, could play a central role in a post-AHCA coverage landscape.

Medicaid expansion and federal participation

The AHCA would not eliminate the option to expand Medicaid to cover nonpregnant, childless adults with incomes under 138 percent of the Federal Poverty Level (FPL) ("*expansion enrollees*"). It would, however, eliminate the enhanced federal matching funds that ACA has made available for these populations. States that have not expanded Medicaid under that ACA as of March 1, 2017, would be ineligible for enhanced matching funds if they subsequently decide to expand; instead, they would receive only the traditional federal matching percentage (FMAP) for the newly eligible population. States that have already expanded could keep the enhanced match for expansion enrollees until December 31, 2019, but, after that, they would receive an enhanced FMAP for only individuals enrolled as of December 31, 2019, who do not become disenrolled for more than a month ("*grandfathered expansion enrollees*"). Beginning in FY 2020, The AHCA would convert federal financing of Medicaid to a per capita cap model for most enrollees, with an option for states to receive block grant funding for certain children and nonexpansion adults.

Revenue (tax) provisions

The AHCA would repeal a number of industry taxes that generate a substantial share of the revenue used to "pay" for theACA's coverage expansion provisions. Specifically, the AHCA would repeal the medical devices tax, prescription medications tax, tanning tax, net investment tax, over-the-counter medications tax and health insurance tax, and the $500,000 cap on deductions for insurance company executive pay.

Notably, the AHCA would not fully repeal the Cadillac tax on high-cost group health plans, but would delay implementation until January 1, 2026. An earlier "leaked" draft, date-stamped February 10, would have fully eliminated the Cadillac tax and put in place a cap on the existing exclusion for employer-sponsored insurance (ESI), making any amounts received above the cap taxable income to the employee. Employer groups and unions came out in strong opposition to the ESI exclusion cap. The cap would have been a significant cost-saver, and it is possible that Republicans will revisit the tax and the cap in the context of broader tax reform.

Finally, the AHCA would repeal the ACA's 0.9 percent Medicare Hospital Insurance tax on individuals earning more than $200,000 and joint filers earning more than $250,000.

Revenues from this tax are deposited into the Medicare Hospital Insurance Trust Fund, which pays hospital claims, and have helped extend the solvency of the HI Fund.

How much would the AHCA cost?

On March 13, 2017, the CBO and the Joint Committee on Taxation issued an estimate of the AHCA's budgetary effects based on the version that passed the House Committees on Ways and Means and Energy and Commerce on March 9, 2017. According to the estimates, the AHCA would reduce federal deficits by $337 billion over the 2017-2027 period. Most of the savings would come from the Medicaid reforms ($880 billion in savings over 10 years) and shrinking of federal tax credits and cost-sharing reduction subsidies (netting $312 billion over 10 years).

After the March 13 report, a Manager's Amendment made several changes to the AHCA that had the effect of reducing the deficit impact to $150 billion over 10 years. The reduction in savings stemmed primarily from the amendment's accelerated repeal of the ACA's industry taxes and expansion of spending caps on aged and disabled Medicaid enrollees. Despite the new spending estimates, the CBO said in a revised March 23 report that the amendments would not appreciably change its earlier estimates of coverage and premium effects.

Subsequent amendments made after CBO's March 23 report would likely impact the projections, though they have not been officially scored. For example, a March 23 amendment to the Manager's Amendment made a number of other policy changes that could affect the AHCA's CBO score. For instance, the amendment would delay repeal of the 0.9 percent Medicare Hospital Insurance tax until the end of 2022. The Republican Study Committee estimates that this would increase revenues by roughly $63.5 billion. The March 23 amendment would add an additional $15 billion in funding for 2020 to the Patient and State Stability Fund. The April 6 amendment would also increase spending by $15 billion per year for nine years for a new federal risk-sharing program.

The CBO did not provide a score of the March 23 amendment, the April 6 amendment, the April 25 amendment or the May 3 amendment. These amendments incorporated provisions that could greatly add to the cost of the AHCA. The allocation of $15 billion for states to establish invisible high-risk pools could add to the cost of the AHCA, but it could also reduce premiums, which would decrease cost overall. It is also impossible to predict how many states will take advantage of the waiver process created by the April 25 amendment. However, the May 3 amendment also adds an additional $ 8 billion in funding from 2018 to 2023 for states that receive waivers to permit insurers to charge higher premiums to high-cost individuals who have had a gap in coverage based on health status. Without the CBO score, it is difficult to predict how much these additional amendments will add to the cost of the AHCA.

How could the AHCA impact coverage in private markets?

The AHCA stands to impact both the cost of coverage and the number of people who enroll in coverage through plans sold on the individual market. The short- and long-term impacts would vary, since certain provisions, like the repeal of the individual mandate, would be effective on enactment while others, such as the repeal of the cost-sharing subsidies, would have a delayed

effective date. Any impact predictions are also currently limited because the CBO has not scored the version of the AHCA that passed the House on May 4.

Short-term effects (2018-2019): Covered population would remain relatively stable and potentially expand due to availability of "off-exchange" coverage options

The AHCA would repeal the penalties associated with the individual mandate, retroactive to the 2016 tax year. This means that there would be no financial consequences for individuals who opted to forgo coverage in 2016 and 2017. In 2018, however, individuals would have a new reason to purchase coverage under the AHCA's "continuous coverage" incentive. This provision would require individuals seeking to purchase coverage in 2019 or thereafter to show that they had continuous coverage (meaning no more than a 63-day break) during the prior 12-month period to avoid paying a 30 percent premium surcharge for up to one year. The CBO predicts that the number of individual market enrollees will drop in 2017 due to the repeal of the ACA penalties, followed by a one-time "surge" in enrollment due to the AHCA's continuous coverage incentive.

The AHCA would retain cost-sharing subsidies available to individuals with incomes between 100 percent and 250 percent of the FPL through the end of 2019. ACA's premium tax credits, which vary based on income up to 400 percent of FPL, would also be available through the end of 2019. Importantly, however, AHCA would also expand the menu of plans that can be purchased with tax credits.

The AHCA would sever the link between eligibility for tax credits—both the ACA's and the AHCA's—and the purchase of qualified health plans on the exchanges, thereby allowing qualifying individuals to use ACA tax credits to subsidize premiums for plans sold off-exchange, including some catastrophic coverage plans. In the period before the AHCA tax credits become available, the CBO estimates that approximately two million individuals purchasing off-exchange coverage would become eligible to claim ACA tax credits on their tax returns. However, under this proposal, the ACA tax credits for coverage purchased off-exchange would not be advanceable, meaning that they would be available only after tax returns are filed. On net, CBO expects that roughly one million more people would be covered through the individual market than under current law.

While the number of people covered in the individual market in 2018 and 2019 would increase slightly under the AHCA, the CBO predicts that average premiums would rise by 15 percent to 20 percent during this time frame. Its reasoning is that eliminating the individual mandate penalties would incentivize individuals who are younger and healthier to drop coverage. However, enrollees who remain covered in the individual market during this period would largely be insulated from premium increases, since the ACA premium tax credits would remain available, and the credit amount increases with premiums.

State waivers: Age Rating and Community Rating

Under the April 25 amendment, states could apply for a waiver to set an age ratio higher than the federally established ratio for plans beginning on or after January 1, 2018. The amendment is not clear on whether this "higher ratio" is higher than the 3:1 ratio established by

the ACA or the 5:1 ratio established by the AHCA. Presumably, the section referenced by the amendment is the provision of the ACA as amended by the AHCA—meaning the 5:1 ratio—but the summary of the amendment released earlier said that states could not set the ratio above 5:1.

States also have the option to waive the ACA's community rating requirements, but this waiver would apply only to consumers who did not maintain continuous coverage. The ACA's community rating rules prohibit insurers that offer nongrandfathered individual and small-group coverage from basing premiums on an individual's health status (i.e. protecting individuals from being charged higher costs if they have a pre-existing condition). The AHCA allows states to apply to waive these ratings for any year beginning with plan year 2019 (or special enrollment periods beginning with plan year 2018). If approved for the waiver, states can permit insurers to impose health status underwriting on individuals who do not maintain continuous coverage—meaning that they have a gap of at least 63 days in coverage in the preceding year—in lieu of the continuous coverage incentive's 30 percent penalty. The health status rating would only apply during the same "enforcement period" as the continuous coverage requirement, which is generally for one entire plan year. To obtain the community rating waiver, a state would have to operate a program under the AHCA's Patient and State Stability Fund to (1) provide financial assistance to help high-risk individuals get coverage in the individual market, (2) provide incentives to appropriate entities to enter into arrangements with the state to help stabilize premiums in the individual market or (3) participate in the federal invisible high-risk-sharing program.

The amendment specifies that gender underwriting is still prohibited. Specifically, it states that, "nothing in this Act shall be construed as permitting health insurance issuers to discriminate its rates for health insurance coverage." It also notes that nothing in the Act "shall be construed as permitting health insurance issuers to limit access to health coverage for individuals with preexisting conditions." However, it is not clear how these protections previously established by the ACA will be affected by the waivers.

Without a CBO score of the AHCA in its current form, it is challenging to predict how the waivers will affect coverage on the individual and small group market. It is difficult, if not impossible, to predict how many states will take advantage of these waivers, but changes to community rating or EHBs will likely result in lower premiums for beneficiaries. Lower premiums, combined with the AHCA's fixed tax credit, may encourage more people to enroll in health insurance, which would provide more coverage, but with less generous insurance.

Long-term effects: Enrollment in individual market could shrink, and skew toward younger, higher-income individuals

According to the CBO, for 2020 and beyond, the composition of the individual insurance market under the AHCA would shift to cover more younger, higher-income individuals and fewer older, lower-income individuals. Because of this shift, average premiums would decrease by 2026. The changing composition relates to the combined effect of a number of factors, including the fixed, age-based structure of the new tax credits, the elimination of federal cost-sharing subsidies and the new 5:1 age rating rule.

Flat Tax Credits

For 2020 and beyond, the AHCA would create a flexible-use tax credit that allows consumers to purchase "any health insurance coverage" that meets the definition in Section 9832(b) of the Internal Revenue Code, subject to certain limited exceptions. The tax credit would be refundable and advanceable on a monthly basis for individuals who are covered by state-approved individual health insurance; ineligible for employer coverage or government programs; U.S. citizens or nationals and not incarcerated.

Unlike their ACA counterpart, which varied based on income and local premium costs, the AHCA tax credits would vary based on only age. The credits would, however, phase out for individuals and households that earn above a specified income threshold.

AGE RANGE	AMOUNT OF TAX CREDIT	WEALTH ADJUSTMENT
Under 30	$2,000	Credit reduced by 10 cents for every dollar of income above $75,000 (individual) or $150,000 (household)
30 – 39	$2,500	
40 – 49	$3,000	
50 – 59	$3,500	
Over 60	$4,000	

The fixed structure of the AHCA tax credits was a deliberate decision that ties back to Speaker Ryan's Better Way proposal. Republicans generally dislike the ACA tax credit structure because it creates a limitless entitlement that grows as premiums grow and therefore eliminates cost pressures that exist in a typical marketplace. The Better Way proposal envisions a tax credit structure that levels the playing field for everyone, regardless of income, who does not receive the tax benefits that accrue to those with employer-sponsored insurance.

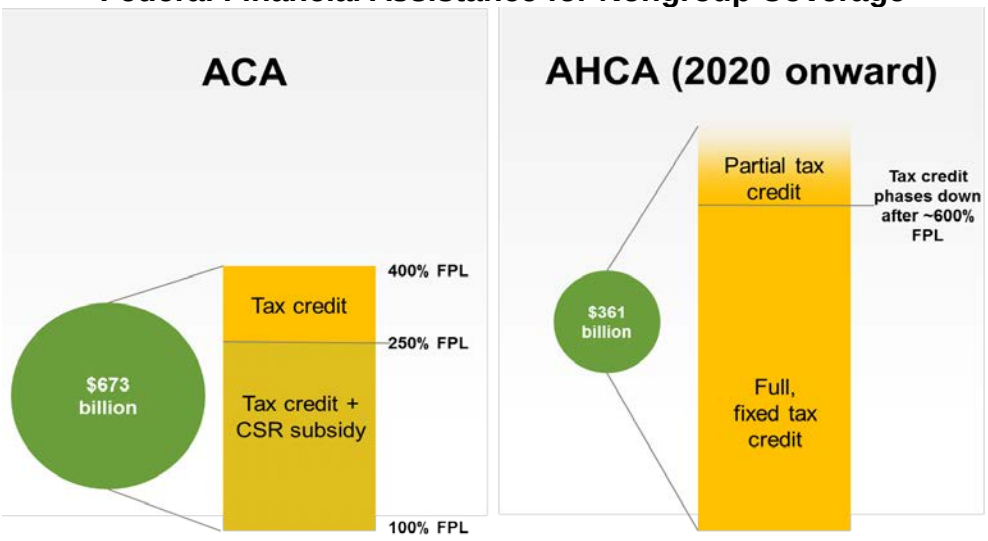
The AHCA tax credits would serve as an incentive to younger individuals who previously may not have been eligible for credits because of their income or because they purchased off-exchange coverage. However, if the cost of coverage remains roughly the same as today, lower-income and older individuals are likely to see a decrease in the value of the credit compared to the cost of coverage. Because these credits do not vary based on the cost of insurance in a particular geographic area (unlike the ACA premium tax credits), lower-income individuals living in higher-cost areas could find them inadequate to make coverage affordable.

Relaxation of federal age-rating rules may also impact the effectiveness of the AHCA credits in keeping coverage affordable for the older population. Effective 2018, theAHCA changes the 3:1 age rating rules to 5:1, meaning that, under federal law, issuers would be able to charge older individuals up to five times as much as they charge younger individuals. Under the

tax credit structure, however, older individuals would be entitled to a credit that is only two times what a young adult would receive.[1]

For this reason, the CBO expects that fewer lower-income people would obtain coverage through the nongroup market, while lower out-of-pocket payments toward premiums would increase enrollment in the nongroup market among higher-income people. Further, according to the CBO, the total federal subsidies for nongroup health insurance would be significantly smaller under the AHCA than under the current law. In 2020, the CBO estimates that the average AHCA subsidy would be about 60 percent of the average ACA subsidy and would grow more slowly.

Federal Financial Assistance for Nongroup Coverage



Source: Congressional Budget Office Cost Estimate 2017

Essential Health Benefits Waiver

The April 25 amendment establishes a waiver for states of the federal EHB requirements. After January 1, 2020, states could specify their own set of essential health benefits for the individual and small-group markets. This is a change from the earlier March 23 amendment, which permitted states to establish their own sets of EHBs for tax credit purposes. The April 25 amendment permits EHBs to remain the federal standard for plans, while also permitting states to apply to waive them.

The waiver permits states to define which categories of benefits would have to be covered by insurers, but also the benefits that would have to be covered within each category. For example, states would be able to set the kinds of drugs that must be covered by an insurance

[1] The March 20 Manager's Amendment further expanded an existing tax expenditure (lowering the medical expense deduction threshold to 5.8 percent of adjusted gross income from 10 percent under current law), and the House was set to instruct the Senate to use the funding to address needs of older, lower-income recipients of the tax credits.

plan in the individual and small-group markets. The waiver may also affect other ACA provisions. Specifically, the ACA's prohibitions of lifetime and annual limits and the cap on out-of-pocket expenditures apply only to EHBs; thus, states that are granted an EHB waiver may be able to define these protections as well. Independent analysts predict that limiting EHBs and permitting medical underwriting based on health status would likely make insurance coverage unaffordable for many individuals, who would then require some form of public financial assistance. The AHCA's allocation of $15 billion to establish high-risk pools as added by the April 6 amendment and the additional $8 billion in funding to the states to assist with premiums and cost-sharing for individuals with pre-existing conditions is meant to assist individuals whose coverage may become unaffordable as a result of the waivers. However, it is unclear whether these amounts will be enough to cover individuals with pre-existing conditions.

Patient and State Stability Fund

The AHCA would provide states with tools to help keep the individual (and small-group) market stable. From 2018 through the end of 2026, it would establish a new state and federal matching fund called the Patient and State Stability Fund and direct the Secretary, through the CMS, to allocate money to states for programs[2] that would help stabilize commercial insurance markets and keep premiums affordable. Funding allocations would be based on a formula related to a state's uninsured rate. The AHCA identifies several categories of programs that would qualify for the funding:

- providing financial assistance to high-risk individuals who do not have employer-sponsored coverage
- providing incentives to appropriate entities to enter into arrangements with the state to help stabilize premiums in the individual market
- reducing the cost of providing insurance in individual and small-group markets to individuals with high utilization of health services
- promoting participation in the individual and small-group markets and increasing health insurance options
- promoting access to preventive services, dental care services, vision care services or any combination of such services
- maternity coverage and newborn care[3]
- prevention, treatment or recovery support services for individuals with mental or substance abuse disorders, or any combination of such services.

Notwithstanding the broad list of permissible uses, the CBO predicts that many states would use these funds for reinsurance programs.

[2] Significantly, the AHCA provides that programs funded under this section would be considered "state health care programs," thus bringing them within the reach of the federal Anti-Kickback Statute and Civil Monetary Penalties provisions.

[3] The March 23 amendment to the Manager's Amendment added maternity coverage and newborn care to the list of eligible uses and clarified that the funds could be used for inpatient and outpatient care of mental illness. Further, it appropriated an additional $15 billion in 2020 for these uses.

The AHCA would make available $15 billion per fiscal year in 2018 and 2019, which would be allocated based on a state's relative incurred claims amounts compared to other states, the state's relative uninsured population and how it changed from 2013-2015, and issuer participation in the state. The funds would be used for a reinsurance program, unless a state chooses a different option. After 2019, $10 billion would be available annually (plus an additional $15 billion in 2020 for maternity coverage and newborn care and mental health/substance abuse disorders, as called for by the March 23 amendment), and these amounts would be allocated based on the adjusted incurred claims in a state, the percent of uninsured below 100 percent FPL, and the number of participating insurers in a state's insurance market.

States would apply for the federal funding and would commit to matching federal funding in an amount equal to 7 percent for 2020, increasing to 50 percent in 2027. Applications would automatically be approved if they are not denied within 60 days. Once a program is approved, it would remain approved for all subsequent years until 2026. If a state did not apply for funding, its allocated funding would be distributed to insurers participating in the individual market, or other "appropriate entities," to stabilize the market. Notably, any program receiving funding through the Patient and State Stability Fund would be considered a state health care program, meaning that federal fraud and abuse laws like the Anti-Kickback Statute and Civil Monetary Penalties provisions would apply.

Invisible Risk-Sharing Program

In the final days before Congress adjourned for spring recess, a new amendment to the AHCA was voted on by the House Rules Committee. The amendment, approved on April 6, would establish a federal "invisible" risk-sharing program within the Patient and State Stability Fund program. Annual appropriations of $15 billion per year would fund the program, which would begin on January 1, 2018, and last through the end of 2026. It would also allocate to the program any other Patient and State Stability Fund program funds that were appropriated for any particular year that remain unallocated at the end of that year. The CMS would be charged with developing a federal invisible risk-sharing program within 60 days after the enactment of the legislation, and states would be able to take over the program beginning in 2020.

Similar to a program implemented in Maine, the "invisible" program would not segregate high-risk individuals into a separate market and thus would avoid the problems associated with traditional risk pools (e.g., higher premiums and interrupted care). Rather, it would operate more like a reinsurance program that reimburses insurers for claims associated with certain high-cost individuals (CMS would define what qualifies a person as high-cost). Eligible high-cost individuals could access the same coverage and provider network as healthy individuals in the same plan for the same premium. By reducing the total cost of claims that insurers would have to cover from their premiums and the risk margins that insurers would otherwise build into their premiums, the intended result is more affordable premiums for all enrollees. Analysts, however, have questioned whether $15 billion per year is enough to make the program successful.

Additional Funding for States with the Community Rating Waiver

The May 3 amendment creates an $8 billion fund within the Patient and State Stability Fund from 2018 to 2023. The fund will be available to states that have waivers allowing insurers

to charge higher premiums based on health status to certain high-cost individuals, and may be used to provide assistance to reduce premiums or other out-of-pocket costs for such individuals. The funds would be apportioned to the states, taking into account other stabilization fund grants. Essentially, the amendment provides funding for state high-risk pools, but the money could also be used to directly subsidize premiums or cost-sharing that high-cost consumers might have to pay for commercial insurance. Analysts, however, have questioned whether an additional $8 billion allocated to assist with premiums and cost sharing is enough to cover individuals with pre-existing conditions.

How could AHCA impact coverage under Medicaid?

Under the ACA, Medicaid eligibility rules were expanded to include a new category of enrollees: nonpregnant, childless adults with incomes of up to 138 percent of the FPL.[4] The federal government currently pays an "enhanced" share of the cost of covering this newly eligible population. Whereas the traditional FMAP ranges from 50 percent to 75 percent across states, this newly eligible population was financed at 100 percent FMAP for 2014 through 2016. After 2016, the FMAP phases down until it reaches 90 percent in 2020. Thirty-one states, plus the District of Columbia, have expanded their Medicaid programs to cover these newly eligible individuals. Nineteen states have opted not to take advantage of the ACA expansion and enhanced FMAP.

The majority of AHCA-related coverage losses that the CBO is predicting stem largely from the changes to Medicaid. On the whole, the CBO estimates that the bill would decrease direct federal spending on state Medicaid programs by $880 billion between 2017 and 2026, and would result in 14 million fewer Medicaid enrollees by 2026. Most of the changes in spending and enrollment would begin in 2020, when the enhanced FMAP ends and the per capita caps begin.

Short-term effects (2018-2019): Limited changes to current enrollment; extra funding for nonexpansion states

Overall, the CBO predicts that there may be a small drop in enrollment through the end of 2019 due to the elimination of the individual mandate penalties, which would apply to some Medicaid-eligible individuals (e.g., single individuals with income above approximately 90 percent FPL). The 31 expansion states would continue to receive their enhanced FMAP through the end of 2019. The 19 nonexpansion states would be eligible to expand Medicaid, but ineligible to receive the enhanced FMAP rates. In a purported attempt to balance this inequity, the AHCA makes certain funding available to nonexpansion states.

[4] Congress had made this new category a mandatory beneficiary category under the ACA, but the Supreme Court ruled that this was unconstitutional in *National Federation of Independent Business v. Sebelius*; expansion became an option rather than a federal mandate.

- *Safety Net Fund*

Beginning in 2018, nonexpansion states can access "safety net" funding. Safety net funding includes $10 billion over five years, from 2018 through 2022. Each state that has not implemented the ACA Medicaid expansion as of July 1 of the preceding year may receive safety net funding to adjust payment amounts for "eligible providers." [5] For these payment adjustments using the safety net funding, nonexpansion states would receive an increased matching rate of 100percent for FY 2018 through FY 2021 and 95percent for FY 2022. Each nonexpansion state's allotment from the annual $2 billion would be determined according to 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 of the nonexpansion states in 2015.[6] If a nonexpansion state later implements the ACA Medicaid expansion, the state would no longer be treated as a nonexpansion state for safety net funding for subsequent years.

- *Repeal of ACA cuts to Medicaid DSH allotments*

The ACA reduced allotments for Medicaid disproportionate share hospital (DSH) payments. The rationale was that hospitals would have less uncompensated care because of the ACA's coverage expansion provisions. The AHCA would repeal the Medicaid DSH cuts for nonexpansion states in 2018 and for expansion states in 2020. While this repeal would benefit states that have historically received high Medicaid DSH payments, states that have historically been "low DSH" states (e.g., Wisconsin) would not see a commensurate benefit.

Long-term effects: Reduction in federal expenditures for Medicaid

The CBO predicted that, under current law, some nonexpansion states would eventually opt to expand their Medicaid populations such that, by 2026, roughly 80 percent of newly eligible enrollees would be in expansion states. The AHCA would drastically alter these projections and potentially reverse the enrollment trend.

- *Maintains option to expand, but eliminates enhanced FMAP*

The AHCA would retain the ACA expansion category as an optional enrollee category for states. However, after December 31, 2019, the AHCA would end the enhanced FMAP for most expansion enrollees and immediately foreclose the enhanced FMAP to states that have not yet expanded. States could keep the enhanced FMAP for expansion enrollees who were enrolled as of December 31, 2019, granting such enrollees grandfathered status, but only so long as those individuals do not disenroll for longer than a one-month period. The CBO predicts that all but

[5] Eligible providers are defined as providers that provide health care services to individuals who are in a state that did not expand Medicaid under the ACA or a waiver of a state plan under Section 1115 (i.e., a nonexpansion state). Sec. 115 amendment to Title XIX of the SSA, Sec. 1923A(a). The amount of a payment adjustment for an eligible provider may not exceed the provider's costs incurred in furnishing health care services to individuals who are either eligible for medical assistance under the state plan or have no health insurance or health plan coverage for such services.

[6] The 2015 American Community Survey one-year estimates as published by the Bureau of the Census would be used to determine the portion of each state's population that is below 138 percent of the FPL.

one-third of expansion enrollees would lose grandfathered status by the end of 2021 and that only 5 percent of expansion enrollees would receive enhanced FMAP by the end of 2024.

AHCA "Near-Term Implications for Expansion and Non-Expansion States"

	Expansion State	Non-Expansion State
Option to expand Medicaid to adults up to 138 percent FPL	Yes	Yes
Enhanced FMAP for expansion enrollees	Yes, for all expansion enrollees through December 31, 2019, and grandfathered enrollees thereafter	No
Safety net funding for providers	No	Yes, unless and until the state opts to expand
Repeal of Medicaid DSH cuts	Yes, in 2020	Yes, in 2018

- *Establishes per capita cap model, with optional block grants*

Beginning in 2020, the Medicaid program in every state would largely be financed under a per capita cap model, meaning that the total federal share of a state's Medicaid spending would be limited to fixed annual targets. The per capita cap model would account for the expansion population—meaning that the federal government would continue to share in the cost of these individuals, but at a lower FMAP and subject to a state-specific cap on aggregate spending.

The AHCA would create a new Section 1903A under the Social Security Act: "Per Capita-Based Cap on Payments for Medical Assistance." Under this section, if a state has excess Medicaid expenditures in a given year (starting with FY 2020), the federal government would reduce payments to that state the following year by the amount that the federal government "overpaid" in matching funds for those excess expenditures. Each state would have target expenditures based on total historical spending on five "1903A enrollee" categories:

- elderly
- blind and disabled
- children under 19
- expansion enrollees (nonpregnant adults eligible for enhanced FMAP)
- other nonelderly, nondisabled, nonexpansion adults.

The per capita cap model would not apply to certain populations, such as individuals covered under the Children's Health Insurance Program (CHIP), those who receive care through Indian Health Services facilities and some partial-benefit enrollees (such as dual-eligibles).

The CMS would use FY 2016 spending (trended forward to 2019) as a baseline for each state's total per capita spending in each enrollee categories. For states that expand their Medicaid populations after 2016, the AHCA instructs the CMS to use FY 2016 spending data attributed to the "other nonelderly, nondisabled, nonexpansion adults" category of the 1903A categories as a proxy. In 2020, target expenditures would equal the aggregate of the baseline amounts for each enrollee category, multiplied by the number of enrollees in each category. The CMS would use that baseline to compare each state's total actual per capita spending (exempting certain payments, such as Medicaid DSH[7] and administrative payments) with its spending target. Any state with total spending that exceeds its specified target amount would receive reductions in its Medicaid funding equal to "excess" aggregate payments (excess spending multiplied by applicable FMAP), applied the following fiscal year.

Each year, the baseline amounts for each enrollee category would be increased by an inflationary factor. The inflationary factor for children, expansion adults, and other adults would be set at the medical consumer price index (CPI-M). The inflationary factor for the elderly, blind and disabled groups would be bigger, set at CPI-M +1, allowing for more variation in actual spending in a given year. The CBO estimates that Medicaid spending on a per-enrollee basis would grow at a faster rate than CPI-M (4.4 percent compared to 3.7 percent) over the 2017-2026 period, meaning that federal outlays would decrease as compared to current law.[8]

In response to demand by some Republican governors and other lawmakers in Congress for increased flexibility in Medicaid program administration, the March 20 Manager's Amendment added a block grant option for states that would become available in FY 2020. A state could elect a Medicaid block grant instead of a per capita cap for the children and nonexpansion adult enrollee categories. Subject to certain restrictions, states could set the conditions of eligibility for individuals covered under the block grant. States would also be able to design the benefit structure, subject to a list of broadly defined minimum benefits (i.e., hospital care, surgical care and treatment, medical care and treatment, obstetrical/prenatal care and treatment, prescription drugs and prosthetics, other medical supplies and services, and health care) for children under 18 years of age. States that want to pursue a block grant option would submit plans to the HHS Secretary and those plans would be deemed approved, unless the Secretary determines within 30 days that the plan is incomplete or actuarially unsound.

The total block grant amount for the initial fiscal year would be based on the state's target per capita medical assistance expenditures for the fiscal year multiplied by the number of enrollees in the category or categories elected and the FMAP rate for the state for FY 2019. In subsequent fiscal years, the total block grant amount for the prior fiscal year would be increased by annual CPI for urban consumers. The federal portion of block grant funds payable to states would be based on the state's enhanced CHIP FMAP (typically ranging from 65 percent to 81 percent), with the state funding the difference. States could roll over unused block grant funds into the next fiscal year as long as they continue to elect the block grant option. States must

[7] The Manager's Amendment specifies that non-DSH supplemental payments are accounted for and are attributed to individuals enrolled in the per capita allotment. Thus, the bill ensures that, in the per capita allotment calculation, funding for all non-DSH supplemental payments in 2016 is included under the allotment calculation.

[8] The CBO did not estimate the impact of the CPI-M +1 inflation factor for elderly and disabled enrollees because this policy was added through the Manager's Amendment after the CBO's report.

contract with an independent entity to audit expenditures for each fiscal year to ensure that spending is consistent with these provisions.

- *Eliminates enhanced FMAP for community-based services and supports*

The ACA established the Community First Choice (CFC) under Section 1915(k) of the Social Security Act as a Medicaid state plan option that allows states to provide statewide home and community-based attendant services and supports to individuals who would otherwise require an institutional level of care. States taking up the option receive a 6 percent increase in their FMAP for CFC services. The AHCA would repeal the enhanced 6 percent FMAP associated with CFC services beginning January 1, 2020.

Optional "work requirement"

The March 20 Manager's Amendment would give states the option of instituting a work requirement in their Medicaid program for nondisabled, nonelderly, nonpregnant adults as a condition of receiving coverage under Medicaid. States could begin using this option on October 1, 2017. States that choose to implement the work requirement would receive a 5 percent administrative FMAP increase. There would be certain restrictions on how states could implement the work requirement, and certain populations would be exempt (e.g., pregnant women, children, students, primary caregivers).

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The Appendices below set up a side-by-side comparison of AHCA and ACA, and are organized according to the ACA Title impacted. Appendix A summarizes the provisions governing the private insurance markets (Title I of ACA). Appendix B summarizes the Medicaid provisions (Title II of ACA). Appendix C summarizes the revenue provisions (Title IX of ACA).

Appendix A – Private Coverage and Affordability Provisions

	ACA	AHCA
Individual Mandate	Absent an exemption, U.S. citizens and legal residents without coverage are assessed a tax penalty of the greater of $695 per year, indexed by inflation, or 2.5 percent of household income. That penalty grows over time, and, this current tax year, it can reach as high as $2,000 for some taxpayers.	It sets the penalty at $0, or 0 percent of household income, effective for the 2016 tax year. However, beginning in 2019, open enrollment periods (and special enrollment periods in 2018), the AHCA calls for a flat 30 percent late-enrollment surcharge that issuers would assess on applicants who went without coverage for longer than 63 days during a 12-month lookback period (the "continuous coverage incentive"). The late enrollment penalty would not apply in the small group market.
Employer Mandate	Employers with 50 or more full-time employees must offer coverage that meets standards for affordability and minimum value or face a penalty.	It sets the penalty at $0, retroactive to the 2016 tax year.
Cost-sharing Subsidies	Individuals with household incomes between 100 percent and 250 percent of FPL can receive cost-sharing subsidies to offset deductibles and co-pays. These amounts are paid directly to insurers.	Repeals cost-sharing subsidies for 2020 and beyond. Establishes a Patient and State Stability Fund through which the CMS will allocate funds to states from January 1, 2018 through December 31, 2026, for certain purposes, including: • Financial assistance to high-risk individuals seeking coverage in the individual market • premium stabilization incentives • reduction of cost-sharing for high utilizers in the

	ACA	AHCA
		individual and small-group markets • promotion of participation and increasing options in the individual and small-group markets • promotion of access to preventive, dental, vision, and/or mental health or substance abuse services • provision of payments to health care providers • provision of financial assistance for out-of-pocket costs • maternity coverage and newborn care. Total annual funding available is $15 billion for FY 2018 and FY 2019 and $10 billion for FY 2020 through FY 2026. The March 23 amendment to the Manager's Amendment added an additional $15 billion in 2020 for maternity coverage and newborn care and mental health/substance abuse services. The April 6 amendment would establish a federal "invisible" risk-sharing program under the AHCA. The CMS would provide payments to insurers for costs attributable to "eligible individuals," as defined by CMS (e.g., those with pre-existing conditions that the guaranteed issue rules require them to take). It

	ACA	AHCA
		appropriates $15 billion for calendar years 2018 through 2026, and, beginning in 2020, states could take over operation of the program. The May 3 amendment creates a fund of $8 billion for 2018 through 2023. The fund will be available to states that have waivers allowing insurers to charge higher premiums based on health status to certain high-cost individuals, and may be used to provide assistance to reduce premiums or other out-of-pocket costs for such individuals.
Premium Tax Credits	Individuals and families are eligible to receive refundable premium tax credits based on their income, ranging from 100 percent to 400 percent of the FPL, which can be used to purchase a qualified health plan (QHP) that is sold on an exchange and provides the essential health benefits package.	For 2018-2019, premium tax credits would be increased for young adults above 150 percent FPL and decreased for adults age 50 and over, and could be used to purchase off-exchange plans and catastrophic coverage. In 2020, the ACA income-based credits would be replaced with an age-adjusted annual credit (indexed annually at the CPI +1 percent). The per-individual amounts are as follows: • Under 30: $2,000 • 30-39: $2,500 • 40-49: $3,000 • 50-59: $3,500 • 60 and over: $4,000 Families could receive up to $14,000 in combined credits. Tax credits begin to phase out for individuals

	ACA	AHCA
		with incomes above $75,000 ($150,000 if filing jointly), with tax credits decreasing by $100 for each $1,000 of income above the thresholds.
Small Employer Tax Credits	Small businesses (fewer than 25 FTE employees) that purchase QHPs sold on the SHOP Marketplace and pay at least half of the cost of coverage for their employees can receive a tax credit of up to 50 percent of premiums paid.	It repeals ACA tax credits for small businesses in 2020.
EHBs	Individual and small-group plans must cover 10 categories of essential health benefits.	EHBs remain, but under the April 25 amendment, states can apply for a waiver to set their own EHBs. It repeals the EHB requirement for Medicaid expansion plans after December 31, 2019.
Actuarial Value (AV) Standards	Exchange plans must be offered at four cost-sharing levels based on AV categories and are labeled across four metal tiers: Bronze (60 percent AV), Silver (70 percent AV), Gold (80 percent AV), and Platinum (90 percent AV)	Repeals the AV standards for 2020 and beyond, allowing for more flexibility in benefit design.
Age Rating Rules	Individual and small group plans may not vary premiums based on age by more than 3 to 1.	It would amend age variation rules to allow a variation of 5 to 1 for plan years beginning on or after January 1, 2018. This means that plans could charge older enrollees up to five times as much as younger enrollees. Under the April 25 amendment, states can apply for waivers, beginning in 2018, to set a higher age ratio.

	ACA	AHCA
Community Rating Rules	Community rating rules prohibit insurers that offer nongrandfathered individual and small-group coverage from basing premiums on health status.	Under the April 25 amendment, states can apply for a waiver of the ACA's community rating requirements. States granted the waiver could allow insurers to health status underwrite for approximately one year for consumers who failed to maintain continuous coverage. However, states can waive these rules only if they establish a high-risk pool or reinsurance program, or participate in the federal invisible risk-sharing program.

Appendix B – Medicaid Provisions

	ACA	AHCA
Presumptive Eligibility	Hospitals are permitted to make presumptive eligibility determinations for all Medicaid-eligible populations.	Effective January 1, 2020, it repeals state authority to make presumptive Medicaid eligibility determinations, except in cases of children, pregnant women, and breast and cervical cancer patients. States with Medicaid expansion populations would also be required to redetermine the eligibility of those enrollees every six months beginning on October 1, 2017, and would receive additional federal funding in connection with such efforts.
Enhanced FMAP for Expansion Enrollees	States have the option to expand Medicaid to include nonpregnant, childless adults up to 138 percent of the FPL ("expansion enrollees"). States that expanded under the ACA received a 100 percent federal match for expansion enrollees between 2014 and 2016. This "enhanced FMAP" phases down after 2016 and remains fixed at 90 percent for 2020 and each year thereafter. States that had expanded coverage to adults prior to the ACA ("leader states") also receive enhanced funding under a different formula.	For states that have not expanded Medicaid by March 2017, it eliminates the option to expand at an enhanced FMAP. For states that did expand Medicaid, it eliminates the enhanced match for expansion enrollees after December 31, 2019, except for those enrolled as of that date who do not have a break in eligibility for more than one month. After January 1, 2020, the state could enroll only newly eligible individuals at the state's traditional FMAP. It eliminates the option to extend coverage to adults above 133 percent FPL as of December 31, 2017.

	ACA	AHCA
Per Capita Cap and Optional Block Grant		Beginning FY 2020, it implements per capita cap funding for Medicaid. The Per enrollee cap is based on state expenditures for five preset enrollment groups: (1) elderly (2) blind and disabled (3) children under 19 (4) expansion adults (5) other adults. The cap would use FY 2016 spending for each category as a baseline for each state's total per capita spending across all of the enrollee categories divided by full-year equivalent enrollees in each category and then trend the amount forward to FY 2019 using the CPI-M. States have the option to elect block grant funding for the "other adults" and children populations served under the per capita allotment beginning in 2020 and funded for a period of 10 years.
CHIP Eligibility	States were required to shift children ages 6 to 19 in families with incomes between 100 percent FPL and 138 percent FPL out of CHIP and into Medicaid. The rationale was that parents and children would be best served if they were covered by the same insurance plan, with the same doctors and hospitals and enrollment rules.	It reverts mandatory Medicaid income eligibility level for poverty-related children to pre-ACA level (100 percent FPL).

	ACA	AHCA
FMAP for Home and Community-Based Services	It increased FMAP for states implementing coverage for home- and community-based services by 6 percent.	It repeals the 6 percent increase in FMAP.
EHB	Coverage offered to expansion enrollees may differ from coverage offered to traditional enrollees, but it must include EHBs.	It repeals the EHB requirement for Medicaid expansion enrollees after December 31, 2019.
Medicaid DSH Payments	It reduced federal DSH allotments to account for the decrease in uncompensated care anticipated under the health insurance coverage expansion. As enacted in the ACA, the DSH allotment reductions would have ended after FY 2020, and allotments would have reverted to their pre-ACA levels. However, several pieces of legislation have been enacted since 2010 that have altered theACA's Medicaid DSH reduction schedule.	It repeals Medicaid DSH cuts in nonexpansion states in 2018 and repeals the Medicaid DSH cuts in expansion states in 2020.
Work Requirements		Per the March 20 Manager's Amendment, states would have the option of conditioning Medicaid eligibility on satisfaction of a work requirement. The option would extend to only certain nondisabled, nonpregnant, nonelderly adults.
New York State-specific Provision		Per the March 20 Manager's Amendment, the AHCA would reduce the per capita allotment in Medicaid for the state of New York in proportion to any financing the state receives from county governments (reportedly added to secure support of key Republicans in the New York delegation).

Appendix C – Tax Provisions

	ACA	AHCA
Cadillac Tax	Beginning in 2020, it would apply a 40 percent excise tax on "high-cost" employer-sponsored health coverage; certain limited scope excepted benefits are excluded.	It keeps the tax, but pushes back the effective date to January 1, 2026.
Health Insurance Tax	An annual fee is assessed on health insurance providers based on the pro rata share of premiums sold during a prior year. Previous legislation had placed a moratorium on the tax for 2017.	It repeals tax, effective after December 31, 2016.
Medical Device Tax	There is a tax of 2.3 percent on the sale price of a taxable medical device.	It repeals tax, effective after December 31, 2016.
Medicare Hospital Insurance Surtax	There is a surtax increase of 0.9 percent on an employee's wages over $250,000 of annual income.	It repeals the tax, effective after December 31, 2022 (the original bill would have repealed the tax for the 2017 tax year, but the March 23 amendment to the Manager's Amendment delayed the repeal).
Pharmaceutical Manufacturer Tax	Annual fee on branded prescription pharmaceutical manufacturers and importers.	It repeals tax, effective after December 31, 2016.
Deduction for Expenses Allocable to Medicare Part D	It eliminated the retiree drug subsidy for employers to help cover prescription drug costs.	It reinstates the tax deduction for employers who receive Part D retiree drug subsidy payments beginning after December 31, 2016.

	ACA	AHCA
Medical Expense Deduction	It increased the adjusted gross income threshold from 7.5 percent to 10 percent for medical expense deductions that can be claimed as itemized tax deductions for qualifying medical expenses that exceed the threshold.	It decreases the adjusted gross income threshold to 5.8 percent and becomes effective in 2017.
Flexible Spending Accounts (FSA)	It limited the amount that an employer or individual could contribute to FSAs to $2,500.	It repeals the limitation, effective after December 31, 2016.
HSAs	It increased tax on HSA distributions to 20 percent and limited contribution levels. It excludes cost for over-the-counter drugs from being reimbursed through a tax-preferred HSA.	It returns the tax on HSA distributions to pre-ACA rate of 10 percent, effective after December 31, 2017. Increases the limit on yearly contributions to $6,550 (self-only coverage) and $13,100 (family coverage), effective after December 31, 2017. Repeals the exclusion, effective after December 31, 2017.
Health Insurance CEO Deduction	Limits the amount of allowable deduction for insurance company executive compensation for amounts more than $500,000.	It repeals the tax, effective after December 31, 2016.
Tanning Tax	There is an excise tax of 10 percent on indoor tanning services.	It repeals the tax, effective after June 30, 2017.