

March 8, 2017

## House Repeal and Replace Bill: American Health Care Act

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On March 6, two key committees (Ways & Means and Energy & Commerce) in the House of Representatives introduced legislation to repeal major provisions of the Affordable Care Act (ACA) and make the most significant changes to the financing structure for Medicaid since the program's inception in 1965 (the "proposed legislation").<sup>1</sup> Both Committees held markups on March 8; as of 5 PM no amendments have been added.

The proposed legislation, which combines the Ways & Means and Energy & Commerce bills, does not repeal the ACA in its entirety. It repeals the individual and employer mandates, actuarial value requirements, premium tax credits and cost sharing reductions, replacing these provisions with an alternative approach to tax credits, age rating, less generous benefit coverage, and penalties for those who fail to maintain continuous coverage. While the proposed legislation maintains authority for the ACA Medicaid expansion, it largely eliminates enhanced federal funding to states to cover expansion enrollees. There would be winners and losers under the coverage approach outlined in the proposed legislation. Individuals in states that did not expand Medicaid (those in the so-called "coverage gap") and those with incomes above 400% of the Federal Poverty Level (FPL) without insurance who do not currently qualify for tax credits would qualify under the proposed legislation. Younger adults with middle incomes (250-400% FPL) would potentially receive more generous tax credits than they do now. But most individuals who qualify for the Medicaid expansion or tax credits today, especially lower income and older Americans, would receive significantly less financial help to access affordable coverage.

The proposed legislation does not address President Trump's principles related to drug pricing, insurance sales across state lines, and medical malpractice reform. With a few exceptions, it appears to meet the budget reconciliation requirement that bill provisions have a primary budget purpose. However, the proposed legislation has not yet been publicly scored by the Congressional Budget Office (CBO) and absent scoring information, it is not possible to say whether the proposed legislation meets the President's principles to "increase access" and "lower costs".

### Key Takeaways

- The proposed legislation would convert financing for Medicaid from the current guaranteed matching rate structure to a new per capita cap applied to virtually all spending under the program. It establishes caps by eligibility group (children, seniors, people with disabilities and other adults). Those caps would grow at the rate of Medical-CPI, a trend factor that is unlikely to be "scored" as generating large federal savings by the Congressional Budget Office (CBO). This new structure would no longer

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<sup>1</sup> On March 7, each committee released updates to the legislation ("substitutes") with minor changes

accommodate unanticipated costs, creates a ready vehicle for future cuts and represents a fundamental shift away from the guaranteed nature of federal Medicaid funding.

- The proposed legislation would maintain authority for the Medicaid expansion but eliminate the enhanced federal Medicaid funding except for “grandfathered” individuals effective January 1, 2020. States would continue to receive enhanced federal Medicaid funding only for a grandfathered population of expansion adults who were enrolled as of December 31, 2019 and do not have a break in their eligibility of more than a month. Based on earlier experiences with enrollment freezes, the number of beneficiaries for whom states will receive enhanced federal funding will dwindle rapidly, especially because of a new requirement that expansion adults renew their coverage at least every six months.
- The proposed legislation also includes a number of additional, more targeted Medicaid cuts, such as elimination of retroactive eligibility for Medicaid beneficiaries, the “reasonable opportunity period” for Medicaid applicants to supply citizenship or immigration documents, hospital-based presumptive eligibility, and the requirement that expansion adults receive a benefit package that covers essential health benefits (EHB). It also prohibits states from using Medicaid funds for services provided by Planned Parenthood clinics.
- The individual mandate is eliminated retroactively to 2016, and replaced in part by a premium penalty that applies to people seeking to purchase coverage in the individual and small group coverage. This may mean less coverage overall, as the ACA mandate also has encouraged more people who are eligible for Medicaid, employer sponsored insurance and other sources of coverage to enroll.
- This proposal alters the tax credits (age rated between \$2,000 and \$4,000 for individuals, available to people with incomes below poverty and phased out for those with incomes between \$75,000 and \$115,000) and makes them available to those ineligible for other coverage; keeps the ACA requirements for annual and lifetime limits, the maximum out-of-pocket caps and the ten essential health benefits; but repeals the metal levels and cost sharing reductions which lower deductibles and cost sharing for most enrollees in the Marketplaces. For most individuals covered under the ACA today, the proposed legislation is likely to result in less generous subsidies to purchase coverage, and fewer comprehensive coverage options.
- The “Cadillac tax” is retained but delayed for additional five years. All of the other ACA taxes and provisions to raise revenue in the legislation are repealed, which leaves no clear source of revenue to fund the proposed legislation. The Joint Committee on Taxation estimates that these proposed changes<sup>2</sup> would increase federal spending by \$594 billion over 10 years.

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<sup>2</sup> This estimate excludes the tax credit modifications and repeal of the mandates.

**Timing.** Both House committees held hearings on Wednesday, March 8<sup>th</sup> to consider amendments to the proposed legislation. As of 5 PM, no amendments were added to the proposed legislation. House leadership has announced its intent to consider the House legislation the week of March 20<sup>th</sup> after the legislation is considered by the Budget and Rules Committees.

**Response.** Secretary Price sent a letter to the House leadership supporting the legislation as consistent with and an important first step toward the President's goal of repealing the ACA. The Administration has also signaled its intent to introduce a repeal and replace plan this week, which may be an attempt to secure support for the House leadership's proposals. Some Republican House members have already derided the proposed legislation as "Obamacare 2.0" and several prominent conservative groups (Heritage, Freedom Works, Americans for Prosperity) have also criticized the proposed legislation. On the other hand, Republican Senators Portman (OH), Gardner (CO), Murkowski (AK) and Capito (WV) issued a statement saying they would oppose any House plan that repeals the Medicaid expansion.

## Mandates

**Individual and Employer Mandate and Continuous Coverage.** The individual and employer mandate penalties are each repealed in the proposed legislation, retroactively to January 1, 2016. This would allow any taxpayers who have not yet filed their 2016 returns by the time the law is enacted to avoid penalties for lack of coverage, and permit others to seek a refund for penalties already paid. In the mandates' place, the proposed legislation includes a new provision intended to incentivize continuous coverage. Beginning in 2018 for special enrollment periods (SEPs) and in 2019 for open enrollment, insurers in the individual and small group markets must increase the premiums of any individual that was uninsured for 63 or more continuous days over the 12-month period prior to enrollment. Dependents aging out of family coverage are only subject to penalties if not enrolling during the first open enrollment period after losing coverage. The penalty is 30% of the monthly premium of the plan premium chosen by the individual, and applies for a plan year, or in the case of penalties imposed in 2018, for the remainder of that year. Because the penalty only applies to those in the individual and small group markets and only applies for one year, it may not have the same effect on coverage as the individual mandate, which applied to those in Medicaid and those with employer sponsored insurance. Because small group market and individual market premiums are calculated differently, it is somewhat unclear how this provision would be implemented in the small group market.

## Medicaid Proposals

**Medicaid Per Capita Based Caps.** The proposed legislation adopts sweeping changes to Medicaid's financing structure by establishing a cap on federal funding. It does not provide an option for a state to pursue a block grant or global waiver as articulated in the plan endorsed by House Republican leadership released on February 16, 2017.

At a high level, a cap would be set for each enrollee group based on state historical spending and an overall or aggregate cap would be set based on the number of people enrolled in each group multiplied by the cap for that group. For example, a state that enrolls 100,000 children and is subject to a per capita cap of \$3,000 per child would have \$30,000,000 counted toward its aggregate cap. States can use “savings” from one group to finance care for another; for example, if a state comes in below the amount attributable to people with disabilities, it can use the “room” this creates under the cap to finance care for seniors, children or other adults. Although it is a ready vehicle for reductions in federal support for the program, a per capita cap structure does not, in and of itself, result in substantial cuts to Medicaid. The magnitude of any reduction in federal funding will vary by state and depends on the per capita limit available for each enrollee group, how rapidly it increases over time, and the trajectory of health care costs in that state. The House has selected a trend factor of medical inflation, as measured by the medical care component of the consumer price index (CPI).

The details underlying the per capita cap are complex. Under the proposed legislation, there is a two-step process for establishing the per capita limits available for each enrollee group.

- **Step 1: Establish a projected spending level for FY 2019.** In the first step, using FY 2016 as a base year, the proposed legislation establishes a target amount for expenditures in FY 2019. It is based on average per capita expenditures in FY 2016 indexed by CPI-medical to FY 2019 and multiplied by the number of enrollees in FY 2019. The use of an average per capita limit – rather than a separate limit for each eligibility group – reflects that no current, audited data are available for all 50 states on per capita spending by eligibility group and such data are not expected to be available until January 2020.
- **Step 2: Establishing separate per capita spending limits for each enrollee group.** By January 2020, states are expected to provide audited data on per capita spending by enrollee group in FY 2019. Under the proposed legislation, these data will be used to establish a per capita limit for each enrollee group for FY 2020 and beyond. If the state’s actual FY 2019 spending is higher than its projected spending from Step 1, the state’s FY 2019 per capita limits for each enrollee group are adjusted downward. If the state’s actual FY 2019 spending is lower than its projected spending, the state’s FY 19 per capita limits for each enrollee group are adjusted upward. The FY 2019 per capita limits will be calculated for five different “enrollee groups”—(1) elderly; (2) blind/disabled; (3) children; (4) expansion adults, and (5) other non-elderly/non-disabled/non-expansion adults—using the following definitions and methods.
  - **Spending in FY 2019.** The spending used to determine the per capita amount for an enrollee group includes most medical assistance expenditures made on behalf of full benefit enrollees in the group.

- **Excluded Spending.** Medicaid payments for disproportionate share hospitals (DSH), Medicare cost sharing, and new provider payment adjustments in non-expansion states (described below) are explicitly excluded from the computation of the caps and are not subject to the new caps. Both of these payment streams are themselves subject to separate caps.
- **Adjustment for Supplemental Payments.** Upper Payment Limit (UPL) supplemental payments are built into the base of per capita expenditure limits. Specifically, a state's FY 2016 supplemental payments are calculated as a share of its total Medicaid expenditures and the state's FY 2019 per capita spending for each enrollee group (calculated without regard to supplemental payments in FY 2019) is then adjusted by this FY 2016 share. For example, if supplemental payments represented 10% of total Medicaid expenditures in FY 2016, the FY 2019 caps would be adjusted upward by 10%.
- **Spending under Waivers.** Waiver spending as part of a delivery system reform pool (commonly known as DSRIP waiver pools), uncompensated care pool, or designated state health program are excluded from consideration in a state's base spending. Waiver payments may continue, but the proposed legislation indicates that the aggregate cap applies to Medicaid waiver spending leaving a significant open question as the impact on states' current and new waiver spending.

Once calculated based on FY 2019 expenditures, the per capita amounts for each enrollee group would be trended forward by medical inflation each year. Beginning in FY 2020, the cap construct would be applied to states' expenditures, and, to the extent the state's spending exceeds the allowable amount, it would need to re-pay those excess expenditures to the federal government in the following year.

All Medicaid beneficiaries are included in the per capita cap except for beneficiaries who are eligible under the following categories:

- Individuals who are dually eligible for Medicaid and Medicare and for whom Medicaid pays only Medicare premiums and cost-sharing;
- Emergency services for individuals ineligible due to immigration status;
- Individuals eligible for family planning services only;
- Individuals eligible for tuberculosis treatment services only;
- Individuals eligible due to a Breast or Cervical Cancer diagnosis;
- Those enrolled in premium assistance programs for employer-sponsored coverage;
- Individuals who receive Medicaid coverage for care through the Indian Health Service; and
- Children enrolled in CHIP-financed Medicaid coverage.

**Medicaid Expansion.** The proposed legislation maintains authority for Medicaid expansion for adults with incomes up to 133% of the Federal Poverty Level (FPL) but eliminates the enhanced federal Medicaid funding except for “grandfathered” individuals effective January 1, 2020. Specifically, current expansion states and states that opt to expand between now and the end of calendar year 2019 would receive enhanced federal Medicaid funding through December 31, 2019. As of January 1, 2020, the enhanced funding is only available for a “grandfathered population”—expansion adults who were enrolled as of December 31, 2019 and do not have a break in their eligibility of one month or more after the December 31, 2019. The proposed legislation also requires that expansion adults undergo re-determination of eligibility every 6 months and imposes civil monetary penalties of \$20,000 on any person or entity that knew the individual’s income information was false and therefore not entitled to Medicaid but nevertheless participated in the process of seeking payment for healthcare services. This would likely include the individual who falsely certified his or her income, but could also include a provider if they were aware that the individual was not entitled to Medicaid but nevertheless sought to obtain federal funds. Based on states’ experiences with enrollment freezes and more frequent re-determinations, the number of beneficiaries for whom a state can receive enhanced matching funds can be expected to dwindle rapidly. Within a year, up to a half or more of the grandfathered beneficiaries are likely to have left Medicaid.<sup>3</sup>

In addition, the proposed legislation modifies other ACA provisions related to expansion of Medicaid coverage:

- **Enhanced Match for Coverage “Leader States.”** The proposed legislation similarly eliminates enhanced federal Medicaid funding for states that had expanded coverage to adults prior to the ACA except for “grandfathered” individuals effective January 1, 2020, and also reduces the level of enhanced match in FY 2018 and FY 2019 and for the grandfathered individuals.
- **Coverage for Adults above 133% FPL.** The proposed legislation removes the option for states to expand Medicaid coverage to adults above 133% FPL after December 31, 2019.
- **Coverage for Children Ages 6-19 up to 133% FPL.** The proposed legislation lowers the minimum income eligibility level for children ages 6 and older from 133% FPL to 100% FPL, the level required pre-ACA. The repeal provision would require states to move these children to CHIP, if CHIP is reauthorized (CHIP is set to expire October 1, 2017), or allow states to cover them under Medicaid.

**Disproportionate Share Hospital (DSH) Cuts.** The proposed legislation maintains the ACA’s cuts to Medicaid DSH allotments for expansion states in FY 2018 and FY 2019 but exempts non-expansion states from these reductions. The proposed legislation then eliminates Medicaid DSH cuts to all states starting in FY 2020.

<sup>3</sup> Manatt analysis of enrollment data in Arizona, Maine and Wisconsin after enrollment freezes were instituted.

**Additional Medicaid Provisions.** The proposed legislation would also make additional changes to the Medicaid program including:

- Prohibiting states from using Medicaid funds to pay for services provided by Planned Parenthood clinics;
- Ending the requirement that alternative benefit designs for Medicaid meet the EHB standard as of January 1, 2020;
- Ending the requirement for states to provide beneficiaries with retroactive coverage (the law now requires up to 90 days of coverage prior to the date of application if otherwise eligible), effective October 1, 2017;
- Ending the requirement that otherwise eligible Medicaid applicants who report they are citizens or in a satisfactory immigration status be covered for up to 90 days while they produce citizenship or immigration documents, effective six months after enactment;
- Ending two provisions that provide people with temporary coverage pending a full review of their application, effective January 1, 2020; and
- Allowing states to disenroll high dollar lottery winners, effective January 1, 2020.

**Selected ACA Medicaid Provisions Not Included in the Proposed Legislation.** The following ACA provisions are not addressed in the proposed legislation:

- Modified Adjusted Gross Income (MAGI);
- Single, streamlined application process;
- Health Home option, with enhanced federal match; and
- Medicaid coverage for former foster care children up to age 26

## Individual Market/ Marketplace Proposals

**Transition Period: 2017 through 2019.** The proposed legislation eliminates the ACA's cost-sharing reductions and substantially modifies the premium tax credits, beginning in 2020. The proposed legislation also repeals the small group tax credit beginning in 2020.

Prior to 2020, consumers will still have access to the current premium tax credits offered to purchasers of Qualified Health Plans (QHPs) on the individual market. But the proposed legislation makes a few notable changes to the ACA tax credit structure and other features of the individual insurance market.

Beginning in plan year 2018, the proposed legislation institutes changes to the definition of a QHP for which consumers can receive tax credits. Any coverage sold in the individual market will count as a QHP, except for grandfathered, grandmothed, or excepted benefit plans,<sup>4</sup> or plans that cover abortion. Marketplaces will continue to operate, but individuals will be able to purchase QHPs off the Marketplace. However, such consumers would not receive advance payment of the premium tax credit (the taxpayer would receive the credit only when the tax

<sup>4</sup> Grandfathered plans are those that have been in effect since the ACA passed in 2010 and grandmothed plans are those that have been in effect since 2013. Both types are exempt from most ACA requirements. Excepted benefit plans are typically limited benefit plans, like dental only, vision, long-term care, or fixed indemnity.



return is filed). The proposed legislation does create an option for the purchase of separate abortion coverage, not funded with tax credits.

The size of the tax credit available for purchasers of individual coverage is also changed in the proposed legislation starting in 2018. The ACA requires individuals to contribute between 2% and 9.5% of income to insurance, depending on income level. Under this proposal, the percentages are now age-banded, with lower contributions expected from younger individuals, and the oldest, those ages 60-64 paying up to 11.5%. Further, individuals must repay the full amount of any excess advanced tax credits, beginning in tax year 2018.

As in the individual market, plans covering abortion are ineligible for the small business tax credit, but abortions may be covered under a separate policy.

**Cost-Sharing Reductions.** The ACA's cost-sharing reductions, which reduce out of pocket costs for enrollees with incomes below 250% of FPL, are repealed beginning in 2020. However, the reductions may terminate sooner as Congress has not specifically appropriated funds for the cost-sharing reductions. The House of Representatives has sued the Department of Health and Human Services (HHS) to stop these payments absent an appropriation and that case is pending before a federal appeals court. Because the proposed legislation does not appropriate funds for the payments, that litigation might decide whether the payments can continue, unless Congress appropriates funds in some other legislative vehicle.

**Tax Credits.** Beginning in 2020, new refundable tax credits will be available to consumers buying "eligible health insurance" in the individual market, as long as they are not eligible for other specified coverage and the coverage meets other state and federal requirements detailed below.

The new tax credits will be refundable. They are age-based, with the maximum yearly amounts as follows for 2020 (thereafter, adjusted by CPI plus 1%) and phase out at higher incomes:

- Younger than 30 years old: \$2,000 (\$167/month)
- 30-39 years old: \$2,500 (\$208/month)
- 40-49 years old: \$3,000 (\$ 250/month)
- 50-59 years old: \$3,500 (\$292/month)
- 60+ years old: \$4,000 (\$333/month)

The federal government will pay the new tax credits on an advanced monthly basis to the insurance company providing coverage. The proposed language requires the Secretary to use similar methods to those used under the current ACA for making and tracking advance payments with references to ACA exchanges, agents and brokers.

The tax credits may be used for any coverage that an individual state certifies meets the requirement of the statute—that it is offered in the individual market within a state or is unsubsidized COBRA coverage; is not grandfathered or grandmothers coverage; is not



substantially all excepted benefits such as cancer policies; and does not include abortion coverage. If a high deductible plan's premiums are less than the allowable tax credit amount, the difference may be deposited into a health savings account (HSA), at the consumer's request.

Spouses and families will receive an aggregate cap, not to exceed \$14,000 per year, which takes into account the oldest of the five family members (spouses and dependent children through age 26) with eligible coverage. Family members do not need to purchase the same coverage. The credits are income-sensitive, and phase out by 10% of the excess of Modified Adjusted Gross Income over \$75,000 (\$150,000 for joint filers). For example, a single 60 year-old receiving a \$4,000 tax credit at a \$75,000 income would see that credit gradually reduced to zero at a \$115,000 income. Unlike the ACA premium tax credits, which were generally not available to individuals below the FPL, these credits would be available to individuals with incomes below poverty. This is consequential in states that have not expanded Medicaid, where individuals below the FPL and above Medicaid eligibility levels have no federally-subsidized health coverage option today. That said, these subsidies may not be sufficient to enable low income individuals to afford coverage in the individual market.

Tax credits are not available for individuals with subsidized COBRA or state continuation coverage, group coverage (other than of excepted benefits), Medicare, Medicaid, CHIP, TRICARE or Veterans, Peace Corps, or Department of Defense non-appropriated fund coverage, and are reduced by the amounts paid by an employer in a qualified small-employer Health Reimbursement Arrangement.

The tax credits are advanceable, whether coverage is purchased on or off the Marketplace, but subject to new documentation requirements, and an increased penalty of 25% for erroneous claims of credit not due to reasonable cause.

Insurers and employers are subject to reporting requirements to facilitate the administration of the credits.

**Basic Health Plan (BHP).** Even though BHP is not specifically repealed, since the ACA tax credit and cost-sharing reductions are repealed in 2020, BHP funding would also be repealed.

**Health Insurance Coverage Reforms.** The proposed legislation repeals the ACA requirement that individual and small group health insurance coverage be offered only at fixed actuarial values (called metal levels), beginning in 2020. The proposed legislation would not repeal the EHB coverage requirements (including requirements that individual and small group coverage cover behavioral health, maternity, and habilitative benefits, and not discriminate on the basis of health status), though without the metal level requirements, plans might offer less generous benefits within the required benefit categories. Further, HHS has significant administrative flexibility to modify requirements within ten benefit categories, but also will face issues, such as mental health parity and the opioid crisis, in cutting EHBs back by regulation. The Administration and states could also relax their enforcement of this provision.

The proposed legislation expands the permissible age variation in premium rates from 3:1 to 5:1, with the option for states to authorize a broader or narrower age band, for coverage beginning in 2018. The proposed legislation does not alter most regulation of health insurance coverage and group health plans, preserving the ACA rules prohibiting pre-existing condition exclusions, medical underwriting, rescissions, maximum out-of-pocket caps, and annual or lifetime dollar limits on benefits. The proposed legislation also does not disturb the requirements for plans to cover dependent children to age 26 and to cover preventive services without cost-sharing. The proposed legislation keeps the premium rating rules in the individual and small group markets: community rating, single risk pools, and risk adjustment, as well as rate review and medical loss ratio rebate requirements.

**Health Savings Accounts.** The proposed legislation includes provisions to further incentivize health savings accounts, all beginning in 2018. The first provision increases the HSA maximum limit, tying the new maximum to the annual limit on cost sharing for high-deductible health plans (Flexible Spending Arrangements are similarly no longer subject to a \$2,550 contribution limit). Another expands the ways that spouses can allocate catch-up contributions if one spouse has family coverage. The third allows HSAs to cover expenses incurred prior to establishing the HSA, as long as the HSA is set up within 60 days of high deductible health plan (HDHP) coverage beginning. Under the proposed legislation, HSA owners may buy over-the-counter medications with HSA dollars without a prescription, repealing the ACA's limitations. And early withdrawals from an HSA, increased to 20% under the ACA, will revert to their pre-ACA amount of 10%.

## Revenue-Raising Taxes

**Tax on Excess Health Benefits.** The ACA's "Cadillac tax" on excess health coverage currently scheduled to take effect on January 1, 2020, is further delayed until 2025. Prior versions of the proposed legislation had replaced the Cadillac tax with a cap on the exclusion of employer-provided coverage from employee income beginning in 2020.

**Part D Provision.** The proposed legislation repeals an ACA Part D provision that discouraged employers from directly providing prescription drugs as part of their retiree plans in return for federal payments. Known as the Retiree Drug Subsidy, pre-ACA employers could deduct the cost of drug coverage and get a subsidy. Post-ACA, they had to reduce their deduction by the amount of the subsidy. This led employers to provide less coverage or use Employer Group Waiver Plans (EGWPs).

**Additional Taxes Repealed.** The proposed legislation repeals or rolls back numerous taxes imposed or expanded under the ACA, effective in 2018. The tax on prescription medications; the medical device tax; the health insurance tax; and the tanning tax are each eliminated. The \$500,000 cap on the deductibility by insurers of employee compensation is eliminated.

Taxes imposed on individuals by the ACA are also repealed or rolled back, and also effective in 2018. The two Medicare supplemental taxes imposed on higher-income taxpayers, the 0.9% additional Medicare tax on wages and the 3.8% net investment tax are each sunset. And the

threshold for deducting medical expenses from income tax is returned to 7.5% from the 10% level imposed by the ACA. While the latter change takes effect for all taxpayers in 2018, those 65 or older will benefit under the proposed legislation from the 7.5% rate in 2017.

## Funding Opportunities

**State Innovation Grants and Stability Program.** The proposed legislation established a new grant program for states, available from 2018 through 2026. The program, which will be administered by the Center for Medicare and Medicaid Services (CMS), can be used by states to support their individual and small group markets in a wide variety of ways:

- Provide financial assistance to any “high risk individuals” who do not have an offer of group insurance through a new or existing mechanism (e.g., high-risk pool);
- Provide “incentives to appropriate entities to enter into arrangements” to help stabilize premiums (e.g., reinsurance in traditional or new forms);
- Help pay for the costs incurred by high-utilizers in the individual and small group markets;
- Encourage take-up of health insurance coverage;
- Promote access to preventive care and vision and dental services;
- Provide payments “directly or indirectly” to health care providers, or
- Provide financial relief to consumers by assisting with out-of-pocket health care costs.

There will be \$15 billion per fiscal year available in 2018 and 2019, to be distributed to all states and the District of Columbia. These funds will be allocated based on a state’s relative incurred claims amount compared to other states’, and relative uninsured and issuer participation. For the first two years, the funds will be used for a reinsurance program unless a state chooses a different option. The program will pay insurers for 75% of claims costs between \$50,000 and \$350,00.

For 2020 through 2026, there will be \$10 billion available annually, which will be allocated among eligible states based on the adjusted incurred claims in a state, the percent of uninsured residents in a state below 100% of FPL, and the number of participating insurers in a state’s insurance market. The allocation methodology will be informed by conversations with health care consumers, providers, insurers, and other stakeholders.

States must apply for 2018 funds within 45 days of the passage of the bill, and for 2019 through 2026 by June 30 of the year previous, though approved applications for one year are deemed approved for each year that follows. Beginning in 2020, states must agree to make matching payments, in annually-increasing percentages. In 2020, the states are required to match 7% of the funding; by 2026, they are required to match 50% of the funding. If a state does not make non-federal funds available, only a portion of the funding will be allocated to market stabilization measures in the state; 10% will be forfeited in 2020, climbing to 50% in 2026.

If a state does not apply for funding, or has an application that is denied, the state's allocated funding will instead be distributed to insurers participating in the individual market or other "appropriate entities" to stabilize the individual market with the allocation methodology to be determined through the stakeholder process described above for years after 2019. Each year, excess undistributed funds are awarded proportionately to states with approved applications for the purposes described in the applications, and to states without applications for payments to appropriate entities for claims over \$1,000,000.

Any program that receives grant funding through this program would be subject to the federal antikickback statute (AKS). Thus, if these funds are used for reinsurance or another mechanism to support the individual market, coverage in the individual market would be subject to the AKS, which would limit the ability of healthcare providers or pharmaceutical manufacturers to provide premium or cost-sharing assistance to enrollees. Individual health insurance coverage that receives ACA subsidies is not currently subject to the AKS.

**Funding for Non-Medicaid Expansion States.** The proposed legislation establishes a "supplemental payment allotment" that provides additional funds of \$2 billion annually from CY 2018 through 2022 for states that have not expanded Medicaid to increase payments to Medicaid providers. The amount each eligible state receives is based on its share of individuals residing in non-expansion states with income below 138% FPL in 2015. The federal government will provide an enhanced matching rate for payments made out of the allotment set at 100% for 2018, 2019, 2020 and 2021 and 95% in 2022. Unlike DSH payments, states can use the supplemental payment allotment to make payments to all types of Medicaid providers, not just hospitals. And the proposed legislation does not define standards under which providers are eligible for these payments. However, as with DSH, they must ensure that the payment for any individual provider does not exceed the Medicaid provider's uncompensated care costs for Medicaid beneficiaries and uninsured or underinsured individuals.

Funding is available to a state that does not provide Medicaid expansion coverage as of July 1 of the prior year, meaning a state that has expanded Medicaid coverage could drop the expansion and then qualify for the supplemental payment allotment.

**Federally Qualified Health Centers (FQHCs).** Funding for FQHCs is increased by \$422 million in FY 2017.

**Prevention and Public Health Fund.** The proposed legislation repeals the Prevention and Public Health Fund, established by the ACA, after FY 2018. Currently, it is set to continue indefinitely. Repeal of this provision removes \$9.1 billion through 2025 and \$2 billion annually thereafter.

## Planned Parenthood and Abortion-Related Proposals

**Abortion Coverage.** Under the proposed legislation, individual tax credits and small business tax credits may not be used to purchase plans that cover abortions in cases other than abortions necessary to save the life of the mother or abortions with respect to a pregnancy that is the result of an act of rape or incest. Individuals may purchase a separate plan covering abortion services.

**Funding of Planned Parenthood.** The proposed legislation would prohibit for one year any federal funding for Planned Parenthood through Medicaid, CHIP, the Maternal and Child Health Services Block Grant, and the Social Services Block Grant.

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