Health Care Reform Reference Guide
The Patient Protection and Affordable Care Act (ACA) vs. American Health Care Act (AHCA)
May 11, 2017

On May 4, 2017, the House of Representatives voted 217-213 to pass H.R. 1628, the American Health Care Act (AHCA) as a plan to repeal and replace specific provisions of the Affordable Care Act (ACA) through the Fiscal Year 2017 budget reconciliation process. The legislation proposes to make major the Medicaid and the health insurance marketplace, and tax provisions under the ACA. NIHB encourages Tribal members to voice their concerns about the impact the legislation will have on the health care of American Indians and Alaska Natives (AI/ANs) to their Congressional delegation. The Congressional Budget Office (CBO) is expected to release an analysis of the House-passed American Health Care Act (AHCA) bill the week of May 22.

The House bill did not include repeal of the Indian Health Care Improvement Act (IHCIA), which was passed in 2010 as part of the ACA but remains unrelated to the main structure of the law's healthcare reforms. Other Indian-specific pieces of the ACA are also left intact. In addition, the following key Indian-specific provisions of the ACA will remain in place: Section 2901(b), which provides that the IHS and Tribal health programs are the payor of last resort; Section 2902, which permanently preserves the ability of the IHS and Tribal health programs to bill for Medicare Part B Services through a 5-year sunset provision; and Section 9021, which excludes health benefits provided by the IHS and Tribal health programs to eligible individuals from table gross income. Due to the vital role that Medicaid program plays in fulfilling the federal trust responsibility, NIHB is extremely concerned about the changes the legislation enacts to the Medicaid program.

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# Health Care Reform Reference Guide

## INDIAN HEALTH CARE IMPROVEMENT ACT (IHCIA):
First enacted in 1976, the Indian Health Care Improvement Act (IHCIA) is the legislative embodiment of the federal trust and treaty responsibilities to American Indian and Alaska Native people for healthcare. IHCIA was permanently enacted in 2010 as part of the ACA (Section 10221) in an effort to pass this long-stalled legislation, despite being unrelated to the overall ACA.

**PATIENT PROTECTION AND AFFORDABLE CARE ACT (ACA)**
- The Indian Health Care Improvement Act (IHCIA) is the foundational legislation governing the Indian health care system.
- IHCIA was permanently reauthorized in 2010 to improve and modernize the Indian health care system, as part of the Affordable Care Act (ACA).
- Sets to improve workforce development and recruitment of health professionals in Indian Country.
- Provides new authorities to fund facilities construction, maintenance, and improvement funds to address facility needs.
- Creates opportunities to improve access and financing of health care services for Indians.

**AMERICAN HEALTH CARE ACT (AHCA)**
- The Indian Health Care Improvement Act (IHCIA) is independent from the Affordable Care Act (ACA). IHCIA will remain fully intact through the AHCA, we must ensure that the Senate preserves IHCIA as well.

## MARKETPLACE:
The Marketplace is the one-stop shop for applying for health care coverage. It helps uninsured people find health coverage through a simple, single-streamlined application that will help find an affordable health insurance.

**PATIENT PROTECTION AND AFFORDABLE CARE ACT (ACA)**
- Enacted in 2010 and became Public Law 111-148.

**AMERICAN HEALTH CARE ACT (AHCA)**
- On May 4, 2017, the House of Representatives voted 217-213 to pass H.R. 1628 the American Health Care Act (AHCA). It must now be considered by the Senate.
- $1 billion is appropriated for an American Health Care Implementation Fund to carry out certain provisions of the bill. There is no set-aside for Indian health programs from the fund.
<table>
<thead>
<tr>
<th>Individual-Shared Responsibility Payment (Individual Mandate)</th>
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<tbody>
<tr>
<td>Requires individuals to have qualifying health coverage. Individuals without coverage pay a tax penalty of the greater of $695 per year, indexed by inflation, or 2.5% of household income. Exemptions granted for affordability, financial hardship, religious objections, and other reasons.</td>
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<td>Members of federally recognized Tribes, ANCSA, and for those who use I/T/U services are exempt from the individual-shared responsibility payment.</td>
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<tr>
<td>Repeals the individual-shared responsibility payment and institutes a “continuous coverage” requirement that allows insurers to impose a 30% increase penalty in premiums for one year on individuals who have allowed their insurance coverage to lapse at least 63 continuous days. This does not pertain to those eligible for IHS services.</td>
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<tr>
<td>Repeals ACA mandates, cost-sharing subsidies, and standards for health plan actuarial values (AV) requiring issuers to label their plans at Bronze, Silver, Gold, or Platinum.</td>
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<td>As of January 1, 2020 Indian-specific cost-sharing protections eliminated.</td>
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<tr>
<td>Relaxes the variance of the actuarial value (AV) in premiums rates charged by insurance issuers to a ratio of 5 to 1 (currently it is 3 to 1), which could dramatically increase premiums to consumers aged 50-64.</td>
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<tr>
<td>Establishes a Patient and State Stability Fund to provide funding to States that submit an application to lower costs and stabilize State markets. For example, the funds could be used for high-risk individuals to enroll in the State market, reduce out-of-pocket costs, or promote preventative care.</td>
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<td>Permits the use of tax credits for the purchase of non-Exchange based health plans including catastrophic health plans.</td>
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<td>Increased use of Health Savings Accounts (HSAs), which are excluded from taxable gross income and may be used for qualifying medical expenses.</td>
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<td>Includes over-the-counter medications as a qualifying medical expenses.</td>
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<td>Essential health benefits (EHBs) determined by States.</td>
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<tr>
<td>Permits States to submit waivers in order to raise premiums for individuals with pre-existing conditions if the State establishes its own high-risk pool or participates in a federal high-risk pool.</td>
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</table>
Other Provisions

- Appropriation authority for the Prevention and Public Health Fund, which provides mandatory appropriations for prevention, wellness, and public health initiatives.
- Actuarial value (AV) standards require plan issuers to label their plans as Bronze, Silver, Gold, or Platinum depending on the AV.
- Requires the variance of the AV in premium rates charged by insurance issuers based on an age rating to a ratio of 3 to 1. Therefore an older consumer could not be charged a premium more than three times the amount charged to a younger consumer.
- Premium tax credits may only be used to purchase plans meeting the definition of “Qualified Health Plan” under the Marketplace.
- Increases funding for the Community Health Center Fund, which awards grants for Federally Qualified Health Centers (FQHCs). However, there are no funding increases or provisions regarding IHS or Tribal health programs.
- Convert federal Medicaid financing to a per capita cap beginning in FY 2020. The federal government will pay each State a per enrollee amount for each Medicaid enrollee.
- Implements similar refundable tax credit provisions to be put in place of the premium tax credits. Starting in 2020, income-based tax credits will be replaced with flat tax credit adjusted for age. The overall value of tax credits drops by 40%. The Senate is expected to make additional changes that would increase the tax credit for older, low-income individuals.
- Implementation of limited refundable tax credits based on age and household income. New refundable tax credits availability would be limited to individuals and families with lower incomes and utilized for the purchase of eligible health insurance.
- Refundable tax credit eligibility would exclude individuals eligible for government sponsored programs listed in Section 5000A(f)(1)(A) of the Internal Revenue Code, however the Indian Health Service is not listed in the Internal Revenue Code as a government sponsored program. Therefore, IHS beneficiaries would not be excluded from eligibility for the refundable tax credit.
- Implementation date of the Cadillac Tax is moved from 2025 to 2026.
- As of 2016, repeals the employer mandate by eliminating the tax penalties associated with it. But reporting requirements continue.
- Repeals the fee on each covered entity engaged in providing health insurance for U.S. health risks in 2017.
- Makes available $8 billion in funding for 5 years for State-run high-risk pools. The additional funding can only be used to reduce premiums or other out of pocket costs for high-risk pool individuals.
- Repeals the 2.3% tax on manufacturers and importers for sales of certain medical devices beginning 2017.
**INDIAN-SPECIFIC PROVISIONS:** Section 10221 of the Affordable Care Act incorporates and enacts the Senate IHCIA bill titled the Indian Health Care Improvement Reauthorization and Extension Act of 2009 (S.1790) as reported by the Senate Committee on Indian Affairs in December 2009.

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<td>• Section 2901(b) provides that the IHS and Tribal health programs are the payor of last resort.</td>
<td>• Section 2901(b) of the ACA provides IHS and Tribal health programs as the payor of last resort will remain intact. The Senate should preserve this.</td>
</tr>
<tr>
<td>• Section 2902, which permanently preserves the ability of the IHS and Tribal health programs to bill for Medicare Part B Services through a 5-year sunset provision.</td>
<td>• Section 2902 of the ACA, which preserves the ability of IHS and Tribal health programs to bill for Medicare Part B Services will remain intact. The Senate should preserve this.</td>
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<tr>
<td>• Section 9021, which excludes health benefits provided by the IHS and Tribal health programs to eligible individuals from being calculated as taxable gross income.</td>
<td>• Section 9021 of the ACA, which excludes health benefits provided by IHS and Tribal health programs to eligible individuals from being calculated as taxable gross income will remain intact. The Senate should preserve this.</td>
</tr>
<tr>
<td>• Special zero (100-300% FPL) or limited cost-sharing protections depending on income for American Indians and Alaska Natives</td>
<td>• There are no Indian-specific special cost-sharing or premium tax credit protections starting in 2020.</td>
</tr>
<tr>
<td>• Monthly special enrollment period (M-SEPs) for American Indians and Alaska Natives to enroll or change plans once per month.</td>
<td>• Credible coverage includes eligible IHS beneficiaries. Therefore, IHS beneficiaries would not be subject to the 30% penalty if there is a break in coverage for more than 63 continuous days (effective 2018).</td>
</tr>
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<td>• Members of federally recognized Tribes, ANCSA, and for those who use I/T/U services are exempt from the individual-shared responsibility payment.</td>
<td>• Tax credits will be calculated based on age and capped by income level.</td>
</tr>
<tr>
<td></td>
<td>• There are no monthly special enrollment periods (M-SEPs). The individual-shared responsibility payment will disappear in 2017.</td>
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**MEDICAID/CHIP:** Medicaid is a program created by the federal government, but administered by the individual States, to provide payment for medical services for low-income individuals and families. Children’s Health Insurance Program (CHIP) is a federal-State partnership that provides comprehensive health care coverage for children from families whose incomes are too low to afford private insurance but too high to qualify for Medicaid.

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<td>• In 1976, Congress amended Section 1905(b) of the Social Security Act to provide for a 100% Federal Medical Assistance Percentage (FMAP) for Medicaid. This ensures that the federal government pays 100% of the Medicaid costs for AI/ANs.</td>
<td>• Preserves 100% Federal Medical Assistance Percentage (FMAP) for Medicaid services received through the IHS and Tribal healthcare facilities. The Senate should preserve this.</td>
</tr>
<tr>
<td>• Medicaid is utilized to fulfill the federal government’s trust responsibility to provide Indian health care.</td>
<td>• American Indians and Alaska Natives are subject to State income and eligibility determinations for Medicaid. Therefore, IHS and Tribal health program funding will be significantly impacted if States are forced to reduce eligibility or control expenditures to remain within the cap.</td>
</tr>
<tr>
<td>• American Indians and Alaska Natives are subject to State income and eligibility determinations for Medicaid.</td>
<td>• In FY 2020, States will have the option to receive a flexible block grant of funds for providing health care in the per capita allotment. States can choose to provide care through a block grant of funds for a period of 10 years instead of providing</td>
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care through the per capita allotment. At the end of the 10 year period, if the block grant option is not renewed by the State it would revert to the per capita allotment.

- The caps will be increased annually by the percentage increase in the medical care component of the consumer price index, but would not be adjusted for population. There is also an increase to the annual inflation factor by 1% for the elderly, blind, and disabled enrollees.

- Exempts reimbursements to States for services received through IHS and Tribal health care facilities from per-capita allotment caps through Section 1903A, and from optional block-granting. The Senate should include a similar exemption and create a mechanism to exempt reimbursement for these services from any State limitations on eligibility or services that may result from Medicaid caps.

- Block grant funding shall be calculated by computing the per capita cost for the eligible population, multiplied by the number of enrollees in the year prior to adopting a block grant.

- Exempts reimbursements provided to States for services received through an IHS or Tribal health facility. States would continue to receive 100% FMAP for those services.

- The overall decrease in Medicaid funding could have a significant impact on the IHS and Tribal health programs by forcing States to choose between allocating additional State funding to maintain coverage, or reduce eligibility, decrease covered services in future years.

- Effective October 1, 2017, establishes a new section to the Social Security Act to give States the ability to institute a work requirement for nondisabled, nonelderly, nonpregnant Medicaid enrollees, by participating in work activities as defined in the TANF program for a period of time determined by the state. Exempts pregnant individuals, individuals under 19 years, single parents, or caretaker relatives of children under 6 or children with disabilities, and individuals under 20 years who are married or head of household and participating in education. There is no exemption for AI/ANs from the optional work requirement. States who choose to implement this option would receive an additional 5% FMAP to reimburse for the administrative costs of implementing the requirement.

- Mandatory work requirements will not work in Indian country because unlike other Medicaid beneficiaries, AI/ANs have access to IHS services and will fall back on the underfunded IHS if work requirements are imposed. The Senate should exempt AI/ANs from any work requirements to the same as other exempt groups (ex. aged and disabled).

- Eliminates essential health benefit requirements for benchmark plans.

- Eliminates presumptive eligibility option.
### Medicaid Expansion to 138% FPL & 100% Federal Medical Assistance Percentage (FMAP)

- Medicaid expansion has provided critical third-party revenues to the Indian health systems, expanding the care available to AI/ANs. Medicaid expansion has increased Medicaid revenues at IHS and Tribal health programs by approximately 20%.
- Medicaid eligibility expansion was mandatory to all non-elderly adults with household incomes up to 138% FPL based on a modified adjusted gross income.
- Availability of an enhanced federal financial medical assistance percentage (FMAP) rate covering 100% of Medicaid spending on health care services for newly eligible adults in expansion States through 2016, decreasing to 90% in 2020.

- Defunds Medicaid expansion beginning in 2020, by ending the enhanced FMAP rates for new enrollees or enrollees that experienced a gap in coverage for more than a month. Additionally, it caps Medicaid funding going forward using a per capita allocation funding formula.
- Medicaid expansion would become a State option, but at regular FMAP rates. No new enrollments under Medicaid expansion coverage to adults above 138% FPL (childless non-elderly, non-pregnant, non-disabled adults) effective December 31, 2017. The Senate should preserve Medicaid expansion as an options for States.
- Medicaid expansion enrollees enrolled prior to December 31, 2019 receive a “grandfathered” status and States will be able to receive the enhanced matching rate as long as such individuals remain eligible and enrolled in the program.
- States can choose to provide health care to non-expansion adults and children, or just non-expansion adults. However, the Manager’s Amendments restricts the enhanced FMAP rate (including grandfathered individuals beginning 2020) to States that expanded Medicaid as of March 1, 2017.
- States have the option to cover adults in the expansion population (newly enrolled or existing) after 2020, but the enhanced FMAP rate for non-grandfathered individuals (new enrollees or those with a break in coverage for more than 30 days) will end in 2020.
- Payments for individuals who received medical assistance through an IHS or Tribal health facility that currently qualify for 100% FMAP would not count towards the total per capita allotment.
- Includes the 100% FMAP for services to eligible beneficiaries receiving services through IHS and Tribal health facilities.
- Beginning in 2020, 90% FMAP applies only to persons enrolled as of January 2020 with no break in coverage greater than 30 days.
- States can continue Medicaid eligibility expansion, but at regular federal medical assistance percentage (FMAP) rates.
- The States will be required to re-determine the eligibility of expansion enrollees every 6 months, beginning October 1, 2017. This will likely result in a greater number of expansion enrollees losing coverage. Once an expansion enrollee experiences a break in coverage for more than one month, the expanded FMAP would no longer be available if they re-enroll after December 31, 2019.
- States would receive a temporary 5% FMAP increase for activities related to the State increased eligibility determination requirements.
- States who choose to implement a work requirement will receive a 5% administrative FMAP increase.
- Return the mandatory Medicaid income eligibility level for poverty-related children back to 100% FPL.
- For non-expansion States, $10 billion over 5 years would be provided in safety-net funding to adjust payment amounts to Medicaid providers. States that did not expand Medicaid would receive 100% FMAP for the payment adjustments in 2018-2021 and 95% FMAP in 2022.

### Children’s Health Insurance Program (CHIP)

- Require States to maintain current income eligibility levels for children in Medicaid and the Children’s Health Insurance Program (CHIP) until 2019 and extend funding for CHIP through 2015. Beginning in 2015, increase CHIP match rate by 23 percentage points up to a cap of 100%.

### Other Provisions

- Impose new reporting requirements relating to medical assistance expenditures.
- Provides a temporary increase to the federal matching percentage between October 2017 and October 2019 for States to improve data reporting systems.
- Eliminates 3-month retroactive coverage requirement (start eligibility “in or after” the month of application) beginning October 1, 2017.
- Repeals the 6% bonus point in the federal matching rate for community-based attendant services and supports.
- Repeals the Medicaid Disproportionate Share Hospital (DSH) cuts in 2018 for non-expansion States and in 2020 for expansion States.
- States will be required to include lottery winnings for purposes of determining Medicaid and CHIP eligibility.

**MEDICARE:** Changes will affect individuals who are 65 and older, children and adults with disabilities.

### PATIENT PROTECTION AND AFFORDABLE CARE ACT (ACA)

- Gradually close the Medicare Part D coverage gap (“donut hole”) by 2020.
- Reduce Medicare Disproportionate Share Hospital (DSH) payments.
- Establish various quality, payment and delivery system changes, including a new Center for Medicare and Medicaid Innovation to test, evaluate, and expand methods to control costs and promote quality of care.

### AMERICAN HEALTH CARE ACT (AHCA)

- Repeal of elimination of deduction for expenses allocated to the Medicare Part D Subsidy beginning 2017.
- Reduces qualifying adjusted gross income threshold from 10% to 5.8% providing additional support for Americans with high health costs.
- Establish various quality, payment and delivery system changes, including a new Center for Medicare and Medicaid Innovation to test, evaluate, and expand methods to control costs and promote quality of care; Medicare Shared Savings Accountable Care Organizations; and penalty programs for hospital readmissions and hospital-acquired conditions.
**STATE ROLE:** The role States play in the respective pieces of health care legislation.

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<td>• Establish a State based health insurance exchange and provide oversight of health plans with regard to the new insurance market regulations, consumer protections, rate reviews, solvency, reserve fund requirements, premium taxes, and to define rating areas.</td>
<td>• State option to establish a State based health insurance exchange is not changed.</td>
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<tr>
<td>• Permit States to create a Basic Health Plan for uninsured individuals with incomes between 138% and 200% FPL in lieu of these individuals receiving premium subsidies to purchase coverage in the exchanges.</td>
<td>• States can choose to utilize the block grant funding or a per capita allotment. States would be required to submit a State Plan for administering the block grant for approval by the Secretary of Health and Human Services (HHS). The State Plan will be deemed approved unless the Secretary rejects the plan in 30 days.</td>
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<tr>
<td>• States who choose the block grant must submit a report that identifies eligibility, except for low-income pregnant women and children. States must also outline the services, cost-sharing for such services, and duration in lieu of required services in current law.</td>
<td>• States may determine age rating ratio; otherwise federal standard of 5:1 applies.</td>
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<tr>
<td>• Establish new Patient and State Stability Fund. Funds can be used by States for financial help for high-risk individuals, to stabilize private insurance premiums, promote access to preventive services, provide cost sharing subsidies, and for other purposes. Allows States to use the funds for maternity and newborn care and for prevention, treatment, or recovery support services for individuals with mental illness or substance abuse disorders.</td>
<td>• Establishes a Federal Invisible Risk Sharing Program (FIRSP), administered by HHS to provide payments to health insurance issuers for high-cost individual claims to lower individual market premiums. States takeover operation in 2020.</td>
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<td>• States can allow insurers to use health status as a rating factor for applicants in the individual market who have not maintained continuous coverage or States can apply a 30% late enrollment penalty. It is unclear if States could apply these to AI/ANs.</td>
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<td>• State option to obtain a five-year waiver of certain new health insurance requirements (Section 1332 waiver) is not changed.</td>
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<td>• States continue to administer the Medicaid program with Federal matching funds available up to the federal cap.</td>
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<td>• Beginning in 2020, States may apply for waivers to redefine essential health benefits for health insurance coverage offered in the individual and small group market.</td>
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