

National Indian Health Board

Health Care Reform Reference Guide

Comparison of the Patient Protection and Affordable Care Act (ACA), to the newly proposed American Health Care Act (AHCA) and the Better Care Reconciliation Act (BCRA) Draft.

June 27, 2017

On Thursday, June 22, 2017, the Senate Republican leadership released a discussion draft of the Senate healthcare reform bill that would repeal large portion of the Patient Protection and Affordable Care Act (ACA) and reform Medicaid titled, “Better Care Reconciliation Act of 2017 (BCRA).” The Better Care Reconciliation Act (BCRA) is based on H.R. 1628, the American Health Care Act (AHCA), which was passed by the House of Representatives in May of this year. The legislation proposes to make major changes to the Medicaid program, the health insurance marketplace, and tax provisions under the ACA. In many ways the Senate bill is worse for Indian Country than the House of Representatives bill. NIHB encourages Tribal members to voice their concerns about the impact the legislation will have on the healthcare of American Indians and Alaska Natives (AI/ANs) to their Congressional delegation.

Fortunately, neither the House or Senate versions of healthcare reform included repeal of the Indian Health Care Improvement Act (IHCIA), which was passed in 2010 as part of the ACA. 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 and there is very little time to voice Tribal concerns to Senators. 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.

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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)	AMERICAN HEALTH CARE ACT (AHCA)	BETTER CARE RECONCILIATION ACT (BCRA) Draft
<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • The Indian Health Care Improvement Act (IHCIA) is independent from the Affordable Care Act (ACA). IHCIA will remain fully intact through the AHCA. 	<ul style="list-style-type: none"> • The Indian Health Care Improvement Act (IHCIA) is independent from the Affordable Care Act (ACA). Similar to the House bill, the Senate draft preserves the entire 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)	AMERICAN HEALTH CARE ACT (AHCA)	BETTER CARE RECONCILIATION ACT (BCRA) DRAFT
<ul style="list-style-type: none"> • Enacted in 2010 and became Public Law 111-148. • Major provisions took effect in 2014. 	<ul style="list-style-type: none"> • On May 4, 2017, the House of Representatives voted 217-213 to pass H.R. 1628 the American Health Care Act (AHCA). • The Congressional Budget Office (CBO) released their impact evaluation report on the draft legislation on March 13, 2017. The report can be accessed at https://www.cbo.gov/publication/52486. A CBO analysis of the House-passed AHCA bill is expected the week of May 22. • \$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. 	<ul style="list-style-type: none"> • On June 22, 2017, Senate GOP leadership released a healthcare reform bill discussion draft based on H.R. 1628, the American Health Care Act (AHCA) passed by the House of Representatives on May 4, 2017. • Senate Majority Leader Mitch McConnell announced that the Senate will be scheduling a vote on the bill before the July 4th recess. • The Congressional Budget Office (CBO) released their impact evaluation estimates on June 26, 2017. The CBO reports that the Senate health reform bill would increase the number of uninsured Americans by 22 million in 2026 compared to 28 million without insurance if the current law remained. • The CBO estimates that the Senate health bill would reduce the federal deficit over 2017-2026 by \$321 billion compared to the House bill’s reduction of \$119 billion.

Individual-Shared Responsibility Payment (Individual Mandate)

<ul style="list-style-type: none"> • Established Exchanges for individuals and small employers to buy insurance. • 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. • Income-based subsidies provided to help individuals afford insurance. • Plans must cover 10 essential health benefits. • Risk programs created to stem insurer losses and stabilize market. 	<ul style="list-style-type: none"> • 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. • 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. • As of January 1, 2020 Indian-specific cost-sharing protections eliminated. 	<ul style="list-style-type: none"> • 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. Starting in 2019, people who try to buy a healthcare insurance policy during open enrollment, or because of a life-qualifying event, will not be able to do so for 6 months if they have had a break in coverage of 63 days or longer during the prior year. This does not pertain to those eligible for IHS services. • Health insurers are still banned from charging more or denying coverage based on pre-existing medical
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<ul style="list-style-type: none"> • Members of federally recognized Tribes, ANCSA, and for those who use I/T/U services are exempt from the individual-shared responsibility payment. • Imposed a Medical Loss Ratio (MLR) of 85% for the large group market and 80% for the small group market, so insurance companies had to spend at least that percentage of what they received in premiums on the cost of care. • Ban on use of federal funding to pay for abortions (with certain exceptions). • Marketplace plans not required to cover abortions. • Marketplace plans covering abortions (if allowed by State law) must take steps to ensure no use of federal funding to pay for abortions. • Beginning in 2017, allowed States to submit a Section 1332 waiver application to HHS or the Department of Treasury to exempt them from certain health insurance market requirements related to the following: establishment of qualified health plans (QHPs); Marketplace consumer choices and insurance competition; cost-sharing reductions; and premium tax credits and individual/employer mandates. 	<ul style="list-style-type: none"> • 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. • 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. • Permits the use of tax credits for the purchase of non-Exchange based health plans including catastrophic health plans. • Increased use of Health Savings Accounts (HSAs), which are excluded from taxable gross income and may be used for qualifying medical expenses. • Includes over-the-counter medications as a qualifying medical expenses. • Essential health benefits (EHBs) determined by States. • 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. • Ban on use of federal funding to pay for abortions (with certain exceptions). • Prohibits using premium tax credits on health plans that cover abortion services. • Bars Medicaid funding for Planned Parenthood. • 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. • Allows States to waive the ACA prohibition of health insurance underwriting based on health status. • Allows States to submit a waiver application to HHS in order to: <ul style="list-style-type: none"> ○ Increase the age rating ratio above the 5:1 ratio ○ Specify their own essential health benefits ○ Replace the 30% penalty for not maintaining continuous coverage with the ability to charge 	<p>conditions, but states can create waivers to change other rules such as what benefits insurers must cover and the minimum payments insurers must make toward medical bills - effectively weakening the protections in place for pre-existing conditions.</p> <ul style="list-style-type: none"> • Cost sharing subsidies will be funded for 2018 and 2019 then repealed thereafter. Beginning in 2020, eliminates Indian-specific cost-sharing protections. • Effective January 2016, the ACA tax penalty for not having minimum essential coverage is repealed. • ACA premium tax credit formula and eligibility standards are unchanged EXCEPT: <ul style="list-style-type: none"> ○ End of year reconciliation of advance credit, the cap on repayment of excess advance payments does not apply and penalty for erroneous claim of premium tax credit is increased to 25%. ○ Tax Credits cannot be used for plans that cover abortions effective 2018. • In 2020, a new premium tax credit would reduce income eligibility from 100%-400% FPL to 100%-350% FPL. • The new premium tax credit amounts will be based on percentages of income and age with a new benchmark plan actuarial value of 58%. • Effective 2019, premium rates charged by insurance issuers will be based on an age ratio set at 5 to 1; States have the ability to set an alternative ratio. • Beginning in 2018, increases allowable HAS tax-deductible contribution to amount of deductible/out-of-pocket maximum. Includes other provisions to promote the use of HSAs. • Does not address a high-risk pool. • State authority to set their own Medical Loss Ratios (MLR) for insurance companies operating in their States (Section 205), beginning in January 2019.
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	<p>individual premiums based on health status or subsidize insurers for high-risk individuals.</p>	<ul style="list-style-type: none"> • Beginning in 2018, revises the definition of "QHP" to exclude any plan that includes coverage for abortions (with certain exceptions) • Prohibits Medicaid funding for Planned Parenthood for 1 year. • Amends the ACA section 1332 state innovation waiver program to require States seeking a waiver to describe plans to provide for alternative means of increasing access to comprehensive coverage. • Allow States to waive ACA requirements related to essential health benefits, out-of-pocket maximums, premium tax credits, qualified health plan requirements, Exchange provisions, and actuarial value. • Permits States to receive premium tax credits and cost-sharing subsidies as "pass-through payments" to States. • Provides \$2 billion in additional funding in 2017 for grants to States for seeking and implementing waivers • Increases the duration of waivers from 5 years to 8 years with an option for States to renew waivers for an additional 8 years. • Allows States to waive the ACA prohibition of health insurance underwriting based on health status.
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Other Provisions

<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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%. • Implementation of limited refundable tax credits based on age and household income. New refundable tax credits availability would be limited to individuals and 	<ul style="list-style-type: none"> • As of 2016, repeals the employer mandate by eliminating the tax penalties associated with it. But reporting requirements continue. • Increases funding for the Community Health Center Fund, which awards grants to Federally Qualified Health Centers by \$422,000,000 for FY 2017. It does not include any funding increases or other provisions regarding the IHS or Tribal health programs. • Delays implementation of the so-called "Cadillac Tax" on high value employer plans until January 2026 (Section 108).
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	<p>families with lower incomes and utilized for the purchase of eligible health insurance.</p> <ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • Repeals the fee on each covered entity engaged in providing health insurance for U.S. health risks in 2017.
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INDIAN-SPECIFIC PROVISIONS: Section 10221 of the Affordable Care Act incorporates and enacts the Senate IHCA 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.

PATIENT PROTECTION AND AFFORDABLE CARE ACT(ACA)	AMERICAN HEALTH CARE ACT (AHCA)	BETTER CAR RECONCILIATION ACT (BCRA) DRAFT
<ul style="list-style-type: none"> • Section 2901(b) 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. • Section 9021, which excludes health benefits provided by the IHS and Tribal health programs to eligible individuals from being calculated as taxable gross income. • Special zero (100-300% FPL) or limited cost-sharing protections depending on income for American Indians and Alaska Natives 	<ul style="list-style-type: none"> • Section 2901(b) of the ACA provides IHS and Tribal health programs as the payor of last resort will remain intact. • 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. • 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. • There are no Indian-specific special cost-sharing or premium tax credit protections starting in 2020. • 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). 	<ul style="list-style-type: none"> • Does not affect or amend the key Indian-specific provisions of the ACA. • The monthly special enrollment period (M-SEPs) for American Indians and Alaska Natives to enroll or change plans once per month is retained.

<ul style="list-style-type: none"> • Monthly special enrollment period (M-SEPs) for American Indians and Alaska Natives to enroll or change plans once per month. • Members of federally recognized Tribes, ANCSA, and for those who use I/T/U services are exempt from the individual-shared responsibility payment. 	<ul style="list-style-type: none"> • Tax credits will be calculated based on age and capped by income level. • The monthly special enrollment period (M-SEPs) for American Indians and Alaska Natives to enroll or change plans once per month is retained. • The individual-shared responsibility payment will disappear in 2017. 	
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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.

PATIENT PROTECTION AND AFFORDABLE CARE ACT(ACA)	AMERICAN HEALTH CARE ACT (AHCA)	BETTER CARE RECONCILIATION ACT (BCRA) DRAFT
<ul style="list-style-type: none"> • Medicaid funding: federal match rate averages 57% of State spending on beneficiaries’ medical costs; traditionally covers low-income, children, pregnant women, elderly and disabled. • 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. • Medicaid is utilized to fulfill the federal government’s trust responsibility to provide Indian health care. • 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%. • American Indians and Alaska Natives are subject to State income and eligibility determinations for Medicaid. • Coverage is extended retroactively for 3 months provided the newly covered individual would 	<ul style="list-style-type: none"> • According to the Congressional Budget Office (CBO), this bill would result in \$834 billion in cuts to Medicaid funding over 10 years, with 14 million fewer people enrolled in the program. • Preserves 100% Federal Medical Assistance Percentage (FMAP) for Medicaid services received through the IHS and Tribal healthcare facilities. • 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. • 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 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. • Sets an initial per capita cap amount based on 2016 reimbursements. • The caps will be increased annually by the percentage increase in the medical care component of the consumer 	<ul style="list-style-type: none"> • Greater cuts to Medicaid by tying the annual increase to the consumer price index (CPI), which is lower than the medical consumer price index (CPI-M). The CPI-M would be used until 2025 (Section 133). • The reduction in Medicaid funding could force States to choose between allocating additional State funding to maintain coverage; decrease covered services; or reduce eligibility. • Transforms the Medicaid program from an entitlement program by imposing a cap on the federal funds States receive to run their State exchanges. The caps lead to further cuts to Medicaid compared to the AHCA. • A per capita allotment approach will begin in 2020 with the creation of a new Section 1903A of the Social Security Act. Medicaid spending will be capped according to a formula that results in a set amount provided to the States for each individual enrolled in Medicaid. The per capita allotment will measure the total amount the State will receive from the federal government each year (Section 133). • States will have the option to receive a capped block grant of funding to run their Medicaid programs each year. States would be given the ability to design

<p>have been eligible for coverage during that period.</p>	<p>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.</p> <ul style="list-style-type: none"> • 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. • 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. 	<p>their programs without having to meet applicable Medicaid requirements (Section 133).</p> <ul style="list-style-type: none"> • Allows a State to set its cap amount by using any 8 consecutive quarters between 2014 and 2017. The caps would increase annually due to an inflation provision, the amount of the increase is not estimated to come close to the rising cost of care (Section 133). • Beginning in 2020, allows States flexibility in designing and operating their Medicaid programs under a block grant approach. The State is simply granted a block sum of federal funding (Section 134). • In the block grant option, States would be required to cover a list of basic services and would be required to cover categorically needy individuals (Section 134). • In the block grant option, States would also be required to cover mental health services and substance abuse disorders (Section 134). • States may impose cost-sharing requirements of up to 5 percent of income (Section 134). • Section 134 excludes American Indians and Alaska Natives (Section 134). • Authorizes States to conduct a Medicaid Flexibility Program to provide targeted health assistance to program enrollees including Section 1903A enrollees. American Indians and Alaska Natives are excluded from the definition of Section 1903A enrollees. Therefore, a State could not include American Indians and Alaska Natives in a block grant proposal. • Tribes and Tribal organizations advocated for payments for services received through the IHS or Tribal health programs not be included in any caps to the Medicaid program. This bill maintains the exclusion of reimbursements for services received through the IHS and Tribal health programs. • Individuals who receive services through an IHS or Tribal healthcare facility remain eligible for 100% FMAP for services.
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	<ul style="list-style-type: none"> • Eliminates essential health benefit requirements for benchmark plans after December 31, 2019. • Eliminates presumptive eligibility option. • Repeals the Medicaid Disproportionate Share Hospital (DSH) cuts in 2018 for non-expansion States and in 2020 for expansion States. • Eliminates 3-month retroactive coverage requirement (start eligibility “in or after” the month of application) beginning October 1, 2017. • States will be required to include lottery winnings for purposes of determining Medicaid and CHIP eligibility. 	<ul style="list-style-type: none"> • States will likely be forced to reduce eligibility or services when faced with the caps. American Indians and Alaska Natives are still subject to State income and eligibility determinations for Medicaid, therefore could see cuts even though the funding for the services does not count against the cap. • Beginning in October 2017, Section 131 grants States the option of imposing mandatory work requirements on all non-disabled, non-elderly, non-pregnant individuals (Section 131). • Several States including Wisconsin and Indiana are currently seeking to impose mandatory work requirements through a waiver. Work activities are defined under the TANF program (Section 407(d) of the Social Security Act). • It is unclear if participation in Tribally operated work requirements would meet these requirements. Section 131 includes a number of excluded individuals from work requirements, such as pregnant women and children. Tribes are not exempt (Section 131). • Grants States a 5% increase in FMAP as an incentive for imposing mandatory work requirements. • Section 136 would allow States to easily renew any managed care waiver they had in place as of January 2017. States would be authorized to renew such waivers by submitting a State Plan Amendment instead of a waiver renewal request (Section 136). • Section 136 allows for the HHS Secretary to implement procedures to encourage States to adopt or extend waivers to provide home and community based services (HCBS) (Section 136). • Effective October 2017, Section 128 limits the effective date for retroactive coverage of Medicaid benefits to the month in which the applicant applied. • Section 135 would establish new Medicaid and CHIP quality performance bonuses for FY 2023 through 2026. Payments would be made to States who could demonstrate they had lower than expected aggregate medical assistance expenditures. \$8 billion in funding would be made available between 2023 and 2026 (Section 135).
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Medicaid Expansion to 138% FPL & 100% Federal Medical Assistance Percentage (FMAP)

<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • State option to continue to expand Medicaid through December 31, 2019. It will be optional after 2019 by adding a new Medicaid eligibility group beginning January 2020. • The State option to expand Medicaid beyond 133% FPL is eliminated after December 31, 2017. • Beginning on October 1, 2017, Section 130 would amend Section 1902(e)(14) of the Social Security Act to require States to re-determine the eligibility of expansion enrollees every 6 months (Section 130). This will likely result in a greater number of
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<p>covering 100% of Medicaid spending on health care services for newly eligible adults in expansion States through 2016, decreasing to 90% in 2020.</p>	<ul style="list-style-type: none"> • 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. 	<p>Medicaid expansion individuals losing coverage quickly after the funding is repealed.</p> <ul style="list-style-type: none"> • States would receive a temporary 5% FMAP increase for activities directly related to State compliance with the increased eligibility determination requirements (Section 130). • Phases out enhanced federal funding for Medicaid expansion to 75% in 2023, then to State’s regular Medicaid match rate (Section 126). • Phasing out the enhanced FMAP for Medicaid expansion will likely lead States to phase out Medicaid expansion and/or reduce covered services in future years. • The new FMAP for Medicaid expansion enrollees will be 90% in 2020, 85% in 2021, 80% in 2022, and 75% in 2023. • Provides new safety net funding for non-expansion States. Allows non-expansion States to receive 100% FMAP in FY 2018-2021 and 95% FMAP in 2022 to provide reimbursements to providers. Payments would be allocated according to a formula and capped at \$2 billion each year, with a total of \$10 billion from 2018-2022 (Section 129).
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	<ul style="list-style-type: none"> • 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. • Provides a temporary increase to the federal matching percentage between October 2017 and October 2019 for States to improve data reporting systems. • Repeals the 6% bonus point in the federal matching rate for community-based attendant services and supports. 	
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Other Provisions

	<ul style="list-style-type: none"> • Impose new reporting requirements relating to medical assistance expenditures. 	
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MEDICARE: Changes will affect individuals who are 65 and older, children and adults with disabilities.

PATIENT PROTECTION AND AFFORDABLE CARE ACT(ACA)	AMERICAN HEALTH CARE ACT (AHCA)	BETTER CARE RECONCILIATION ACT (BCRA) DRAFT
<ul style="list-style-type: none"> • Phase-out of the Medicare Part D coverage gap (“donut hole”) by 2020. • Increased financial assistance for individuals in the Part D coverage gap. • Elimination of copays for certain preventive services. • 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; Medicare Shared Savings Accountable Care Organizations; and penalty programs for hospital readmissions and hospital acquired conditions. 	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • Retains phase-out of the Part D coverage gap. • Reinstates the tax deduction for employers who receive Part D retiree drug subsidy payments to provide creditable prescription drug coverage to Medicare beneficiaries, beginning after December 31, 2016. • Repeal the Medicare payroll tax (HI) on high earners, beginning after December 31, 2022. • Repeal the annual fee paid by branded prescription drug manufacturers, beginning after December 31, 2017. • Repeals ACA taxes dedicated to funding Part A Trust fund. • Increase Medicare premiums (Parts B and D) for higher income beneficiaries (\$85,000/\$170,000 (individual/couple)).

		<ul style="list-style-type: none"> • 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.
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PUBLIC HEALTH PROVISIONS: The impact the legislation will have on public health and preventative care.

PATIENT PROTECTION AND AFFORDABLE CARE ACT(ACA)	AMERICAN HEALTH CARE ACT (AHCA)	BETTER CARE RECONCILIATION ACT (BCRA) DRAFT
<ul style="list-style-type: none"> • Mandated that all health insurance options cover the same set of essential health benefits (EHBs); including mental health and substance use disorder services, preventive and wellness services, and chronic disease management. • Establish the Prevention and Public Health Fund in the amount of \$1.25 billion annually. The PPHF was created to provide expanded and sustained national investments in prevention and public health, to improve health outcomes and to enhance health care quality. The funding was invested in programs throughout the U.S. Department of Health and Human Services – primarily the Centers for Disease Control and Prevention. Tribes accessed these funds where possible to build community and clinical prevention initiatives; research, surveillance, and public health infrastructure. • Established a major supplementary funding of \$11 billion for the Community Health Center Fund over a 5 year period for the expansion, operation, and construction of health centers. • Requirement for individual and group plans to cover preventive benefits with no cost sharing. • Health insurers were banned from charging more or denying coverage based on pre-existing medical conditions. 	<ul style="list-style-type: none"> • Would allow state waivers to set their own essential health benefits (EHBs) starting in 2020 • Repeals the Prevention and Public Health Fund in FY 2019. • Increases funding for the Community Health Center Fund, which awards grants for Federally Qualified Health Centers (FQHCs). However, there are not funding increases or provisions regarding IHS or Tribal health programs. • States can opt-out of the requirement that insurers must charge everyone the same regardless of pre-existing medical conditions. 	<ul style="list-style-type: none"> • States could waive essential health benefits (EHBs) and provides \$2 billion to help states implement these waivers. • Repeals all of the funding for the Prevention and Public Health Fund immediately in FY 2018 (Section 201). • Authorizes the HHS Secretary to provide \$2 billion for FY 2018 in grants to the States to support substance use disorder treatment and recovery support services in response to the opioid crisis for individuals with mental or substance abuse disorders (Section 202). • Increases funding for the Community Health Center Fund, which awards grants to Federally Qualified Health Centers by \$422,000,000 for FY 2017. There are no funding increases or other provisions regarding the Indian Health Service or Tribal health programs (Section 203). • Requirement for individual and group plans to cover preventive benefits with no cost sharing remains intact. • Health insurers are still banned from charging more or denying coverage based on pre-existing medical conditions, but states can create waivers to change other rules such as what benefits insurers must cover and the minimum payments insurers must make toward medical bills -

effectively weakening the protections in place for pre-existing conditions.

STATE ROLE: The role States play in the respective pieces of the health care legislation.

PATIENT PROTECTION AND AFFORDABLE CARE ACT(ACA)	AMERICAN HEALTH CARE ACT (AHCA)	BETTER CARE RECONCILIATION ACT (BCRA) DRAFT
<ul style="list-style-type: none"> • 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. • 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. • Under current law, State may apply to waive the following requirements: (1) standards for qualified health plans, including requirements to cover essential health benefits, to apply a maximum out-of-pocket limit on cost sharing, to offer plans at different metal levels; (2) standards for State health insurance exchanges, including requirements to establish individual and SHOP exchanges, offer open enrollment periods, and other exchange requirements; (3) requirement to provide cost sharing subsidies; and (4) requirement to provide premium tax credits. • Section 1332 gives States broad authority to seek waivers of certain Marketplace rules. Such waivers have to comply with certain minimum requirements to ensure minimum levels of coverage, cost-protection and affordability requirements, and comparability of coverage requirements. • Imposed a Medical Loss Ratio of 85% for the large group market and 80% for the small group market, so insurance companies had to spend at 	<ul style="list-style-type: none"> • State option to establish a State based health insurance exchange is not changed. • 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. • 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. • States may determine age rating ratio; otherwise federal standard of 5:1 applies. • 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. • 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. • 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. 	<ul style="list-style-type: none"> • State option to determinate age rating ratio; otherwise federal standard of 5:1 applies beginning in 2019. • Establishment of State Stability and Innovation Program within Title XXI of the Social Security Act. • Repeals the following for granting 1332 waivers: (1) requirement that coverage under the waiver program will be at least as comprehensive as the ACA would otherwise provide; (2) requirement that coverage and cost sharing protections are at least as affordable as the ACA would otherwise provide; and (3) requirement that at least as many State residents will be insured. • Appropriates \$2 billion in FY 2018 for grants to States to support substance use disorder treatment and recovery support services. • State consumer assistance/ombudsman program is not changed, and is not funded. • State option to establish a Basic Health Program (BHP) is retained, though federal subsidy funding would be reduced. • States continue to administer Medicaid program with Federal matching funds available up to the federal per capita cap with the option of a block grant for certain populations. • Eliminates the need for States to comply with the minimum requirements imposed by the ACA, and eliminates the need for States to demonstrate that a waiver is budget neutral (Section 206). Provides authority for HHS Secretary to fast track approval of any waiver proposal. Section 1332 waivers will remain in place for 8 years and may be perpetually renewed.

<p>least that percentage of what they received in premiums on the cost of care.</p>	<ul style="list-style-type: none"> • State option to obtain a five-year waiver of certain new health insurance requirements (Section 1332 waiver) is not changed. • States continue to administer the Medicaid program with Federal matching funds available up to the federal cap. • 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. 	<ul style="list-style-type: none"> • States only need to show that the waiver will not increase the federal deficit. Section 2016 provides States with an additional \$2 billion to offset such impacts. • State authority to set their own Medical Loss Ratios for insurance companies operating in their States (Section 205), beginning in January 2019.
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FINANCING: The expenses and taxes of the health care legislation.

PATIENT PROTECTION AND AFFORDABLE CARE ACT(ACA)	AMERICAN HEALTH CARE ACT (AHCA)	BETTER CARE RECONCILIATION ACT (BCRA) DRAFT
<ul style="list-style-type: none"> • Payments to disproportionate share hospital reduced. • Medicare payments reduced. • Taxes and fees imposed on individuals, employers and industries. • Included Stabilization programs - temporary high-risk pool, reinsurance and other programs to assist insurers. • Annual fee on health insurance providers (\$14.3 billion in 2018; suspended in 2017). • Annual fee on prescription drug manufacturers (\$4 billion in 2017). • 2.3% tax on medical devices; suspended in 2017. • 40% Cadillac tax on plans costing more than \$10,200 (individual) in 2018; takes effect in 2020. • Deduction for Medicare Part D subsidy expenses eliminated. • 10% tax on indoor tanning services. • 3.8% tax on investment income above \$200,000/\$250,000 (single/joint filer). • Floor for medical expense deduction increased to 10% from 7.5%. • 0.9% increase in Medicare payroll tax above \$200,000/\$250,000 (single/joint filer). 	<ul style="list-style-type: none"> • Patient and State Stability Fund: \$100 billion to assist high-risk individuals, stabilize premiums, among other options from 2018 to 2026; \$15 billion for invisible risk-sharing program from 2018 to 2026; \$8 billion for states with health rating waivers from 2018 to 2023; and \$15 billion for maternity care, mental and substance use in 2020. • Repeals annual fee on health insurance providers (\$14.3 billion) in 2017. • Repeals annual fee on prescription drug manufacturers (\$4 billion) in 2017. • Repeals 2.3% tax on medical devices in 2017. • 40% Cadillac tax on plans costing more than \$10,200 (individual) in 2018 delayed until 2026. • Deduction for Medicare Part D subsidy expenses reinstated in 2017. • 10% tax on indoor tanning services repealed July 2017. • 3.8% tax on investment income above \$200,000/\$250,000 (single/joint filer) repealed in 2017. • Floor for medical expense deduction reduced from 10% to 5.8%. • Repeals 0.9% increase in Medicare payroll tax above \$200,000/\$250,000 (single/joint filer) in 2023. • Repeals annual limit on FSA contributions (\$2,600 in 2017) in 2017. 	<ul style="list-style-type: none"> • Increase in Medicare payroll tax (HI) rate on wages for high-wage individuals effective 2023. • Tax penalties associated with individual and large employer mandate, reduced to zero effective January 2016. • Establishes State Stability and Innovation Funds: Short-term is \$50 billion to assist insurers from 2018 to 2021; Long-term is \$62 billion to assist high-risk individuals, stabilize premiums and other options from 2019 to 2026; and \$5 billion toward premium stabilization from 2019 to 2021. • Provides \$2 billion for substance use treatment and recovery for fiscal year 2018. • Repeals annual fee on health insurance providers (\$14.3 billion) in 2017. • Repeals annual fee on prescription drug manufacturers (\$4 billion) in 2018. • Repeals 2.3% tax on medical devices in 2018. • 40% Cadillac tax on plans costing more than \$10,200 (individual) in 2018 delayed until 2026. • Deduction for Medicare Part D subsidy expenses reinstated in 2017. • 10% tax on indoor tanning services repealed October 2017. • 3.8% tax on investment income above \$200,000/\$250,000 (single/joint filer) repealed in 2017.

<ul style="list-style-type: none"> • Annual limit on FSA contributions (\$2,600 in 2017). • Tax on prescription medications. • Planned Parenthood receives federal funding mostly through Medicaid. • Prevention and Public Health Fund: \$1.25 billion in 2018. • Community Health Center Fund: \$3.6 billion in 2017. 	<ul style="list-style-type: none"> • Repeals over-the-counter drugs not qualified savings account expenses in 2017. • Prohibits federal funding to Planned Parenthood for one year from bill's enactment. • Repeals Prevention and Public Health Fund in fiscal year 2018. • \$422 million more provided for the Community Health Center Fund in fiscal year 2017. 	<ul style="list-style-type: none"> • Floor for medical expense deduction reduced from 10% to 7.5%. • Repeals 0.9% increase in Medicare payroll tax above \$200,000/\$250,000 (single/joint filer) in 2023. • Repeals annual limit on FSA contributions (\$2,600 in 2017) in 2018. • Repeals tax on prescription medications in 2017. • Caps federal Medicaid funding, effective FY 2020; enhanced match for Medicaid expansion population phased out beginning January 2020. • Appropriate \$500 million for federal administration of the premium tax credit changes, State Stability and Innovation Program, Medicaid changes, and other implementation responsibilities. • Prohibits federal funding to Planned Parenthood for one year from bill's enactment. • Repeals Prevention and Public Health Fund in fiscal year 2018. • \$422 million more provided for the Community Health Center Fund in fiscal year 2017.
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