233 N. Michigan Ave.,21st Fl.
Chicago, IL 60601-5800

phone » (312) 233-1100
fax » (312) 233-1090
web » www.ahima.org

H.R. 1628, the American Health Care Act (AHCA) of 2017

Policy Proposal	Section
Patient Access to Public Health Programs	
Prevention and Public Health Fund	*Sec. 101* - Repeals the Prevention and Public Health Fund (PPHF) established under the Affordable Care Act (ACA) from fiscal year 2019 onwards. Unobligated PPHF funds remaining at the end of fiscal year 2018 will be rescinded.
Community Health Center Program	*Sec. 102* - Increases funding for the Community Health Center Fund which awards grants to Federally Qualified Health Centers (FQHCs).
Federal Payments to States	*Sec. 103* - Imposes a one-year freeze on mandatory funding to providers designated as prohibited entities. Funding includes Medicaid, the Children's Health Insurance Program (CHIP), Maternal and Child Health Services Block Grants, and Social Services Block Grants. - Defines a "prohibited entity" as one that meets the following criteria: (1) designated as a non-profit by the IRS, (2) is an essential community provider primarily engaged in family planning and reproductive health services, (3) provides abortions in cases that do not meet the Hyde amendment exception for federal payment, and (4) received over $350 million in federal and state Medicaid dollars in fiscal year 2014.

Updated: 5.5.17

Medicaid Program Enhancement	
Repeal of Medicaid Provisions	*Sec. 111* - Repeals states' expanded authority to make presumptive eligibility determinations. States will still be allowed to make presumptive eligibility determinations for children, pregnant women, and breast cancer and cervical cancer patients. - Reverts the mandatory Medicaid income eligibility level for poverty-related children back to 100 percent of federal poverty level (FPL). States will be allowed to cover this population in their State Children's Health Insurance Program (CHIP). - Repeals the 6 percentage point bonus in the federal match rate for community-based attendant services and supports, and returns to prior law.
Repeal of Medicaid Expansion	*Sec. 112* - Terminates the ACA's requirement for states to expand Medicaid coverage for certain childless, non-disabled, non-pregnant adults up to 133% of federal poverty level (FPL). Also sunsets the optional ability of a state to cover adults above 133% FPL effective December 31, 2017. - Allow states to cover Medicaid expansion enrollees (i.e.—childless, non-disabled, non-elderly, non-pregnant adults) at the state's regular Federal Medical Assistance Percentage (FMAP) by designating a new optional category in Section 1902(nn) of the *Social Security Act.* - Medicaid enrollees who were enrolled in Medicaid expansion prior to December 31, 2019, receive "grandfathered" status. States will receive the enhanced matching rate under current law (90% in 2020) for grandfathered enrollees as long as such individuals remain eligible and enrolled in the program. - Limits the enhanced FMAP under the ACA for Medicaid expansion states that have already expanded Medicaid to cover able-bodied adults as of March 1, 2017. Any state that might expand Medicaid to cover non-disabled, non-elderly, non-

	pregnant, able-bodied adults up to 133% FPL would receive its regular FMAP and not the enhanced FMAP. - Freezes the ACA's enhanced FMAP provided for certain states that covered low-income adults prior to ACA enactment at the state's regular FMAP.
Elimination of DSH Cuts	*Sec. 113* - Repeals the Medicaid Disproportionate Share Hospital (DSH) cuts for non-expansion states in 2018. States that have expanded Medicaid will have their DSH cuts repealed in 2020.
Reducing State Medicaid Costs	*Sec. 114* - Requires states, for purposes of determining MAGI for Medicaid and CHIP eligibility to consider monetary winnings from lotteries (and other lump sum payments) as if they were obtained over multiple months, even if obtained in a single month. Counts lottery winnings above $80,000 over multiple months. - Includes a hardship exemption by which states can continue to provide Medicaid coverage for an individual if the denial of coverage would cause undue medical or financial hardship based on criteria established by the Secretary of HHS. - For Medicaid applications made (or deemed to be made) on or after October 1, 2017, limits the effective data for retroactive coverage of Medicaid benefits to the month in which the applicant applied. - Repeals the authority of states to elect to substitute a higher home equity limit that is above the statutory minimum in law. Applies to Medicaid eligibility determinations made more than 180 days after enactment. Where the Secretary of HHS determines that state legislation is required to amend the state plan, additional time will be given to the state to comply with these requirements.
Safety Net Funding for Non-Expansion States	*Sec. 115* - Provides $10 billion over five years to non-expansion states for safety net funding. For FY2018 through FY2022, each state that

	has not implemented the ACA Medicaid expansion as of July 1 of the preceding year may receive safety net funding to adjust payment amounts for Medicaid providers so long as the payment adjustment does not exceed the provider's costs in furnishing healthcare services to individuals either eligible for medical assistance under the state plan (or under a waiver of such plan) or have no health insurance or health plan coverage for such services before the period at the end. Non-expansion states using the safety net funding would receive an increased matching rate of 100% for FY2018 through FY2021 and 95% for FY2022. - Each non-expansion state's allotment from the $2 billion would be determined according to the number of individuals in the state with income below 138% of FPL in 2015 relative to the total number of individuals with income below 138% of FPL for all the non-expansion states in 2015. The 2015 American Community Survey 1-year estimates as published by the Bureau of Census would be used to determine the portion of each state's population that is below 138% of the FPL. - If a non-expansion state for a fiscal year implements the ACA Medicaid expansion during the fiscal year, the state will no longer be treated as a non-expansion state for safety net funding for subsequent fiscal years.
Providing Incentives for Increased Frequency of Eligibility Redeterminations	*Sec. 116* - Requires states with Medicaid expansion populations to re-determine expansion enrollees' eligibility every 6 months. - Provides a temporary 5% FMAP increase to states for activities directly related to complying with this section
Permitting States to Apply a Work Requirement For Nondisabled, Nonelderly, Non-pregnant Adults under Medicaid	*Sec. 117* - Provides states with the option of instituting a work requirement in Medicaid for nondisabled, nonelderly, non-pregnant adults as a condition of receiving coverage under Medicaid. States may begin to use this option beginning October 1, 2017.

	- "Work requirements" defined here uses the countable TANF (Temporary Assistance for Needy Families program) activities defined in section 407(d) of the *Social Security Act.* Includes, in addition to unsubsidized employment: subsidized private sector employment, work experience, on-the-job-training (OJT), community service programs, vocational educational training, job skills training related to employment, education directly related to employment in the case of a recipient who has not received a high school diploma or a certificate of high school equivalency, subsidized public sector employment, satisfactory attendance at a secondary school or in a course of study leading to a certificate of general equivalence, if a recipient has not completed secondary school or received such a certificate and providing childcare services to an individual who is participating in a community service program. - States cannot impose a work requirement as a condition of receiving Medicaid coverage if the individual is: pregnant, under the age of 19, the only parent or caretaker of a child under the age of 6 or the only parent or caretaker of a child with a disability or under the age of 20 who is married or is the head of the household and maintains satisfactory attendance at school or participates in education directly related to employment. - Provides a 5% administrative FMAP increase to states that choose to implement a work requirement.
Per Capita Allotment for Medical Assistance	
Per Capita Allotment for Medical Assistance	*Sec. 121* - Alters federal Medicaid financing by creating a per capita model (i.e.—per enrollee limits on federal payments to states) starting in 2020. Uses each state's spending in FY2016 as the base year to set targeted spending for each enrollee category (elderly, blind, and disabled, children, non-expansion adults, and expansion adults) in FY2019 and subsequent years for the state. Each state's targeted spending amount will increase by the applicable

	annual inflation factor for that succeeding fiscal year. Starting in FY2020, any state with spending higher that their specified targeted aggregate amount would receive reductions to their Medicaid funding for the following fiscal year. - Increases the annual inflation factor for the elderly and disabled from CPI-U Medical (medical care component of the consumer price index for all urban consumers) to CPI-U Medical plus one percentage point. - For states that in 2016 had a DSH allotment that was more than six times the national average and requires political subdivision within the state to contribute funds to Medicaid, the amount of allowable medical assistance expenditures under the per capita allotment reform is reduced by the amount required to be raised from the political subdivisions. A state with a population that exceeds 5 million and that imposes a local income tax upon its residents and that receive funds from such political subdivisions are exempt. - Modernizes Medicaid's data and reporting systems and requires additional reporting requirements including data on medical assistance expenditures within categories of services and categories of all enrollees on Medicaid. - Provides a temporary increase to the federal matching percentage to improve data reporting systems. Impacts expenditures on or after October 1, 2017 and before October 1, 2019. - Exempts DSH payments and administration payments from the caps. - Exempts certain populations from the caps including: (1) individuals covered under a CHIP Medicaid expansion program, (2) individuals who receive medical assistance through an Indian Health Service facility, (3) individuals entitled to medical assistance coverage of breast or cervical cancer treatment due to screening under the Breast and Cervical Cancer Early Detection program, (4) partial-benefit enrollees that are unauthorized aliens eligible for Medicaid emergency medical care, individuals

	eligible for Medicaid family planning options, dual-eligible individuals eligible for coverage of Medicare cost sharing, individuals eligible for premium assistance, or coverage of tuberculosis-related services for individuals infected with TB. - Requires the Secretary of HHS to conduct audits of each state's enrollment and expenditures reported on the Form CMS-64 for FY2016, FY2019 and subsequent years. - Creates a new option for states, for a period of 10 years and beginning in FY2020, to receive a block grant of funds for providing healthcare to their traditional adult and children populations served in the per capita allotment. States choosing the block grant will be required to outline the types of items and services, the amount, duration and scope of such services, the cost-sharing with respect to such services; and the method for delivering care. These items and services are in lieu of the requirements under current law except, the block grant must provide medical assistance for: hospital care, surgical care and treatment, medical care and treatment, obstetrical and prenatal care and treatment; prescribed drugs; medicines and prosthetics; other medical supplies and services; and healthcare for children under 18 years of age. A plan shall be deemed approved by the Secretary of HHS unless the Secretary finds within 30 days that the plan is inaccurate or actuarially unsound. - Funding for the block grant will 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. Funding will increase by the growth of the consumer price index but will not adjust for changes in the population. Unused funds will rollover and remain available for expenditure so long as a state has a block grant. - Under the block grant, states may determine to provide healthcare to either non-expansion adults and children or just non-expansion adults. - States adopting a block grant are required to contract with an independent entity to ensure the state is in compliance with the

	requirements of the block grant. Audit reports are required to be made available to HHS on request.
Patient Relief and Health Insurance Market Stability	
Repeal of Cost-Sharing Subsidy	*Sec. 131* - Repeals the cost-sharing subsidy program of the ACA by 2020.
Patient and State Stability Fund	*Sec. 132* - Establishes a fund designed to lower patient costs and stabilize state markets. Under the use of funds, a state may use the resources for any of the following purposes: (1) helping, through the provision of financial assistance, high-risk individuals (who do not have access to health insurance coverage offered through an employer) enroll in health insurance coverage in the individual market in the state, as such market is defined by the state (whether through the establishment of a new mechanism or maintenance of an existing mechanism for such purpose), (2) providing incentives to appropriate entities to enter into arrangements with the state to help stabilize premiums for health insurance coverage in the individual market, as such markets are defined by the state, (3) reducing the cost of providing health insurance coverage in the individual market and small group market, as such markets are defined by the state, to individuals who have, or are projected to have, a high rate of utilization of health services (as measured by cost) (4) promoting participation in the individual market and small group market in the state and increasing health insurance options available through such market, (5) promoting access to preventive services, dental care services (whether preventive or medically necessary), vision care services (whether preventive or medically necessary), or any combination of such services, (6) maternity coverage and newborn care, (7) prevention, treatment or recovery support services for individuals with mental or substance use disorders focused on either or both of the

Upton amendment to Section 132	following—direct inpatient or outpatient clinical care for treatment of addition and mental illness and/or early identification and intervention for children and young adults with serious mental illness, (8) providing payments, directly or indirectly, to healthcare providers for the provision of such healthcare services as are specified by the Administrator of CMS, (9) providing assistance to reduce out-of-pocket costs, such as copayments, coinsurance, premiums, and deductibles, of individuals enrolled in health insurance coverage in the state. - Authorizes $15 billion for the fund for 2018 – 2019 ($10 billion for 2020 – 2026.) A state match is phased-in beginning 2020 at a different schedule, depending on if a state chooses to use the money for their own program or utilizes the federal default program administered through CMS. - Authorizes an additional $15 billion to be used for maternity coverage and newborn care as well as mental health and substance use disorders. - *Authorizes an additional $8 billion for the fund from 2018 – 2023 to states that have applied and been granted a waiver from community rating as specified by the MacArthur Amendment. (see Sec. 136). Directs the additional funds to be used in providing assistance to reduce premiums or other out-of-pocket costs for individuals who may be subject to an increase in their monthly premium rates because they: (1) reside in a state with an approved waiver, (2) have a preexisting condition, (3) are uninsured because they have not maintained continuous coverage and (4) purchase health insurance in the individual market.* - Should a state not use the funding, resources will be available to the Administrator of the Centers for Medicare & Medicaid Services (CMS) to stabilize premiums for patients. - The formula used to calculate a state's allotment for years 2018 and 2019 uses two following criteria: (1) 85 percent of the annual funding is based off of incurred claims for benefit year 2015, and subsequently 2016, which provides for the latest medical loss

	ratio (MLR) data available that reflects total costs for the on-exchange individual market, (2) for states to access a proportion of the remaining 15 percent, a state must meet one of two triggers: their uninsured population for individuals below 100 percent of federal poverty level (FPL) increased from 2013-2015; or, fewer than three plans are offering coverage on the exchange in the individual market in 2017. - Beginning in 2020, the Administrator will set an allocation methodology to reflect the cost, risk, low-income uninsured population, and issuer competition. To determine this methodology, the Administrator will consult with healthcare consumers, health insurance issuers, state insurance commissioners, and other stakeholders and after taking into consideration additional cost and risk factors that may inhibit healthcare consumer and health insurance issuer participation. - Establishes a Federal Invisible Risk Sharing Program to provide payments to health insurance issuers for claims of eligible individuals for the purpose of lowering premiums for health insurance coverage offered in the individual market. - CMS Administrator will establish, after consultation with stakeholders, parameters for the Federal Invisible Risk Sharing program no later than 60 days after date of enactment of the bill. Details of the program must include: definition of an eligible individual, the development and use of health status statements, standards for qualification (including both automatic and voluntary qualifications), the percentage of premiums paid to health insurance issuers for coverage that shall be collected, deposited and credited for use by the program, the dollar amount of claims that the program will provide payments to as well as the proportion of claims above such dollar amount that the program will pay. - Authorizes $15 billion for the Federal Invisible Risk Sharing Program for 2018 – 2026. Unallocated funds from the Patient and State Stability Fund would be available for carrying out the Federal Invisible Risk Sharing Program.

	- Beginning in 2020, states can take over operation of the Federal Invisible Risk Sharing Program.
Continuous Health Insurance Coverage Incentive	*Sec. 133* - Beginning in open enrollment for benefit year 2019, there will be a 12-month look back period to determine if the applicant went longer than 63 days without continuous health insurance coverage. If the applicant had a lapse in coverage for greater than 63 days, issuers will assess a flat 30 percent late-enrollment surcharge on top of their base premium based on their decision to forgo coverage. This late-enrollment surcharge would be the same for all market entrants, regardless of health status, and discontinued after 12 months, incentivizing enrollees to remain covered. This process would begin for special enrollment period applicants in benefit year 2018.
Increasing Coverage Options	*Sec.134* - Repeals the actuarial value standards contained in the ACA.
Change in Permissible Age Variation in Health Insurance Premium Rates	*Sec.135* - The ACA limits the cost of the most generous plan for older Americans to three times the cost of the least generous plan for younger Americans. This section changes the ratio to five to one.
Permitting States to Waiver Certain ACA Requirements (MacArthur Amendment)	*Sec. 136* - Allows a state to submit a waiver application to the Secretary of HHS to: increase the age ratio above H.R. 1628's 5:1 ratio beginning in 2018, specify their own essential health benefits beginning in 2020 and replace H.R. 1628's continuous coverage incentives' late-enrollment penalty with health status rating beginning in 2019, conditional upon a state operating a risk mitigation program or participating in the Federal Invisible Risk Sharing Program. Health status rating may not be waived for individuals who maintain continuous coverage. - Provides a default approval process for states, making all

	applications automatically approved within 60 days unless the Secretary of HHS notifies a state of the reasons for denial within the 60-day time frame. - As part of its waiver application, a state must explain how the waiver will provide one or more of the following: (1) reduce average premiums for health insurance coverage in the state, (2) increase enrollment in health insurance coverage in the state, (3) stabilize the market for health insurance coverage in the state, (4) stabilize premiums for individuals with pre-existing conditions, or (5) increase the choice of health plans in the state. - Waivers may be in effect for up to 10 years but can become void if a state ends its risk-sharing program.
Constructions **(MacArthur Amendment)**	*Sec. 137* - Nothing in this Act shall be construed as permitting health insurance issuers to discriminate in rates for health insurance coverage based on gender or limit access to health coverage for individuals with preexisting conditions.
American Health Care Implementation Fund	*Sec. 141* - Authorizes a fund of $1 billion within HHS to carry out*: Sec. 121, Sec. 132, Sec. 202 and Sec. 214.*
Repeal and Replace of Health-Related Tax Policy	
Recapture Excess Advance Payments of Premium Tax Credits	*Sec. 201* - For tax years 2018 and 2019, requires any individual who was overpaid in premium tax credits to repay the entire excess amount, regardless of income.
Additional Modifications to Premium Tax Credit	*Sec. 202* - Amends current law to make available premium tax credits for the purchase of “catastrophic-only” qualified health plans and certain qualified plans not offered through an exchange. - Prohibits premium tax credits from being used to purchase plans

	that offer elective abortion coverage. - Revises the schedule under which an individual's or family's share of premiums is determined by adjusting for household income and the age of the individual or family members.
Small Business Tax Credit	*Sec. 203* - Repeals the ACA's small business tax credit beginning in 2020. Between 2018 and 2020, the small business tax credit will generally not be available with respect to a qualified health plan that provides coverage relating to elective abortions.
Individual Mandate	*Sec.204* - Reduces the penalty to zero for failure to maintain minimum essential coverage; effectively repealing the individual mandate. Effective date would apply beginning after December 31, 2015.
Employer Mandate	*Sec.205* - Reduces the penalty to zero for failure to provide minimum essential coverage; effectively repealing the employer mandate. Effective date would apply beginning after December 31, 2015.
Employee Health Insurance Premiums and Health Plan Benefits	*Sec.206* - Under current law, the tax will go into effect in 2020. This section changes the effective date of the tax. It will not apply for any taxable period beginning after December 31, 2019, and before January 1, 2026.
Over-the-Counter Medications	*Sec.207* - Under current law, taxpayers may use several different types of tax-advantaged health savings accounts to pay or be reimbursed for qualified medical expenses. Over-the-counter medications are currently excluded from the definition of qualified medical expenses. This section repeals the exclusion effective 2017.
Health Savings Accounts	*Sec.208* - Distributions from an HSA or Archer MSA that are used for

	qualified medical expenses are excludible from gross income. Distributions that are not used for qualified medical expenses are includible in income and are generally subject to taxation. Under the ACA, the percentage of the tax on distributions that are not used for qualified medical expenses was increased to 20 percent. This section lowers the rate to pre-ACA percentages for distributions made after December 31, 2016.
Contributions to Flexible Savings Accounts	*Sec. 209* - The ACA limited the amount an employer or individual may contribute to a Flexible Spending Account (FSA) to $2,500, indexed for cost-of-living adjustments. This section repeals the limitation on FSA contributions for taxable years beginning after December 31, 2016.
Medical Device Tax	*Sec. 210* - Repeals the 2.3 percent excise tax on the sale of certain medical devices beginning after December 31, 2016.
Deduction for Expenses Allocable to Medicare Part D Subsidy	*Sec. 211* - Prior to the ACA, employers who offered sufficient prescription drug coverage to their employees qualified for the Retiree Drug Subsidy to cover actual spending for prescription drug costs. This deduction was eliminated under the ACA. This section repeals this change and re-instates the business-expense deduction for retiree prescription drug costs without reduction by the amount of any federal subsidy. This section applies to taxable years beginning after December 31, 2016.
Income Threshold for Medical Expense Deduction	*Sec. 212* - Taxpayers who itemize their deductions may deduct qualifying medical expenses. The medical-expense deduction may be claimed only for expenses that exceed a certain percentage of the taxpayer's adjusted gross income (AGI). The ACA increased the AGI percentage threshold from 7.5 percent to 10. This section reduces the AGI percentage threshold to 5.8 percent

	beginning in 2017.
Medicare Tax	*Sec. 213* - Beginning in 2022, repeals the Medicare Hospital Insurance (HI) surtax based on income at a rate equal to 0.9 percent of an employee's wages or a self-employed individual's self-employment income.
Refundable Tax Credit for Health Insurance Coverage	*Sec. 215* - Creates an advanceable, refundable tax credit for the purchase of state-approved, major medical health insurance and unsubsidized COBRA coverage. - To be eligible, an individual must not have access to government health insurance programs or an offer from any employer; and is a citizen, national or qualified alien of the United States, and not incarcerated. - The credits are adjusted by age: (1) if under age 30 the credit is $2,000, (2) between 30 and 39 the credit is $2,500, (3) between 40 and 49 the credit is $3,000, (4) between 50 and 59 the credit is $3,500, (5) over age 60 the credit is $4,000 - Credits are additive for a family and capped at $14,000. - Credits grow over time by CPI+1. - Credits are available in full to those making $75,000 per year ($150,000 for joint filers). The credit phases out by $100 for every $1,000 in income higher than those thresholds. - Allows the Secretary of the Treasury to create a system, built upon previous developed systems, to deliver the credit. - Eligibility determinations will continue to be conducted by the federal government. - Requires simplified reporting of an offer of coverage on the W-2 by employers and allows the Secretary of the Treasury to stop enforcing reporting not needed from taxable purposes once the current system is replaced by the reporting mechanism called for in this section

Maximum Contribution Limit to Health Savings Account Increased to Amount of Deductible and Out-of-pocket Limitation	*Sec. 216* - Increases the basic limit on aggregate Health Savings Account (HSA) contributions for a year to equal the maximum on the sum of the annual deductible and out-of-pocket expenses permitted under a high deductible health plan. Thus, the basic limit will be at least $6,550 in the case of self-only coverage and $13,100 in the case of family coverage beginning in 2018.
Spousal Catch-up Contributions	*Sec. 217* - Allows both spouses to make catch-up contributions to one HSA beginning in 2018.
Special Rule for Certain Medical Expenses Incurred Before Establishment of HSA	*Sec. 218* - Sets forth circumstances under which HSA withdrawals can be used to pay qualified medical expenses incurred before the HSA was established. Starting in 2018, if a HSA is established during the 60-day period beginning on the date that an individual's coverage under a high deductible health plan begins, then the HSA is treated as having been established on the date coverage under the high deductible health plan begins for purposes of determining if an expense incurred is a qualified medical expense.
Prescription Medications	*Sec. 221* - Repeals an annual fee on certain brand manufacturers such that it would not apply for years beginning after December 31, 2016.
Annual Fee on Health Insurance	*Sec. 222* - Repeals an annual fee on certain health insurers beginning after December 31, 2016.
Tanning Tax	*Sec. 231* - Repeals the tanning tax effective June 30, 2017.

Remuneration from Certain Insurers	*Sec. 241* - Generally, employers may deduct the remuneration paid to employees as "ordinary and necessary" business expenses. The ACA added a limitation for certain health insurance providers that exceeds $500,000 paid to an officer, director, or employee. - Repeals the limit on the deduction of a covered health insurance provider for compensation attributable to services performed by an applicable individual starting in 2017.
Net Investment Tax	*Sec. 251* - Repeals the 3.8 percent tax of certain net investment income of individuals, estates and trusts with income above certain amounts beginning in 2017.