NASHP Chart – An Overview of ACA Provisions and Their Repeal Implications for States

Note: This chart summarizes potential impact of ACA repeal on states. Issues identified here may be addressed by Congress, but the replacement bill(s) have not yet been made public for analysis.

Topic Area	ACA	Implications/questions for states to consider as a result of ACA repeal
Federal support/enforcement to expand coverage		
Increasing coverage (private and public markets discussed below)	**Coverage mandates:** ● **Individual Mandate:** Requires all U.S. citizens and legal residents to have health coverage. Assesses a tax penalty on those lacking coverage. ● **Employer Mandates:** Requires all employers with more than 200 employees to automatically enroll employees in health insurance plans (opt out is available for employees). All employers with more than 50 employees are assessed a fee if they have at least one employee who receives a premium tax credit **Individual Market Affordability Assistance:** ● **Advance Premium Tax Credits:** Refundable credits, which can be paid in advance, are given to individuals and families with incomes between 100-400% of the FPL to be used for the purchase of coverage through a state or federal health insurance exchange. ● **Cost Sharing Reduction:** Direct reimbursement is given to issuers; available for individuals with income between 100-250% FPL who enroll in a Silver level plan. These reimbursements increase the actuarial value of coverage so it is equal to a Gold or Platinum plan.	**How will states respond to an increase in the overall uninsured rates?** CBO's analysis of the Restoring Americans' Healthcare Freedom Reconciliation Act--a repeal bill passed by the Senate in December 2016—estimated 32 million will lose coverage: • 19 million projected to lose Medicaid and CHIP coverage; • 23 million projected to lose non-group insurance; and • 11 million projected to gain employer-sponsored insurance. **Loss of coverage mandate and affordability assistance could affect premium costs in the individual market** CBO has estimated elimination of the ACA's individual mandate could lead to a 20% - 25% increase in premiums immediately and as much as 50% once Medicaid expansion ends. Increases would vary based upon the resulting risk mix of individuals obtaining coverage post-repeal. Will uncertainty about the future of ACA cause increased health care utilization now? If so, how will that impact premiums in the non-group market? **Questions about availability and affordability of coverage could affect insurance market stability** Experts and stakeholders predict destabilization of the health insurance markets following a repeal, largely resulting from uncertainty over the number and risk mix of individuals that maintain coverage through repeal. **Safety-net providers are likely to see increased demand and require additional resources** The Urban Institute estimates state spending on uncompensated care to increase by $68.5 billion from 2017-2026. **Loss of insurance that funds health services could lead to loss of health care sector jobs** The increase in the number of uninsured is predicted to lead to lost revenue for most providers, which researchers at the George Washington University estimate could result in the loss of more than 900,000 healthcare sector jobs. **How will changes in coverage affect access to care? Will there be disruptions in care for individuals currently receiving treatment for chronic conditions who lose health insurance?**

Insurance Standards and Consumer Protections** **Changing these provisions would require full repeal of ACA, not just the budget reconciliation vote that Congress is currently pursuing because they have no direct impact on the budget.	**Protections that limit consumer spending:** • Out-of-pocket spending limits • Elimination of annual and lifetime limits • Elimination of cost-sharing for preventive services defined by the U.S. Preventive Services Task Force **Standard benefits package (for qualified health plans (QHPs):** Requires QHPs to offer a package of essential health benefits (EHB) that cover a comprehensive set of services defined within 10 benefit categories, which include mental health and substance abuse services. **Preventive services without cost sharing:** People covered by private insurance and Medicaid expansion can receive recommended, in-network preventive services with no cost sharing. **Extension of dependent coverage:** Requires employer-sponsored insurance plans to offer employees' dependents health coverage up to age 26. **Guaranteed issue requirement:** Requires health plans to offer coverage to any eligible applicant regardless of health status, including those with pre-existing conditions. **Institution of rate review program:** Requires state/ federal review of any premium increases in excess of 10% over the prior year. Requires state to report on premium trends and offer recommendations for plans that should be excluded from the marketplace. Provides grants to states to support the rate review program. **Ban on rescissions:** Prohibits issuers from revoking coverage other than in cases of fraud or intentional misrepresentation of facts.	**States have enacted enabling legislation and regulations to implement these provisions. They would likely need to be repealed, assuming governors and state legislatures agree and take that action. Failure to enforce state-enacted legislation could lead to court challenges. Consider how loss of certain protections will affect consumers:** • Those with pre-existing conditions could either lose or be unable to purchase health coverage; • Women could be charged higher premiums then men for the same insurance plan; • Health plans could make changes to provider networks, which could affect consumers' access to care; • There could be changes to benefits offered through health plans. Without assurance that all plans include comprehensive benefits, consumers may experience challenges in purchasing plans that meet their health needs; • Some consumers may meet the lifetime cost limit available through their health plan and have trouble purchasing another one. Some states have relied on federal preemption to establish insurance standards and have repealed previous legal requirements. Without state legislative action following federal repeal, there might be no or incoherent market rules. **States will need to determine whether to retain this mandate or require Individuals to become responsible for paying toward their preventive services, which may lead to:** • Decreases in preventive care • Increases in preventable medical conditions **If states elect to continue ACA consumer protections, they will need to consider how issuers will respond and whether they will leave more regulated markets for less regulated ones.** • Making changes too quickly to state insurance market standards or to consumer protections could result in issuers being pulled away into nearby states they consider more favorable, reducing insurer competition in more tightly-regulated states. **Challenges in balancing consumer protections without the coverage mandate/** • Kaiser estimates 27% of individuals under the age of 65 have health conditions that would have excluded them from coverage prior to the ACA. • If network adequacy provisions are changed, consumers who are receiving treatment could lose current providers and could be subject to different drug formularies and out-of-pocket costs. How wills states protect consumers in the transition?

	Actuarial values: Establishes four standard tiers of health insurance based on actuarial values (60%, 70%, 80% and 90% of the expected costs the plan will cover). The tiered system sets the minimum amount of coverage individuals must purchase to receive tax credits and sets benchmarks for premium and cost sharing subsidies. **Limits on allowable rating factors:** Issuers offering health plans through the marketplaces may only rate (or price) their products based on age (3:1 ratio), tobacco use (1.5:1 ratio), geographic area, or family size. As described above, the law explicitly prohibits rating factors related to medical underwriting (i.e. a consumer's health condition.) **Ban on gender and health status rating:** Prohibits issuers from charging different premiums to individuals based on gender or health status. **Non-discrimination standards:** Prohibits discrimination on the basis of race, color, national origin, sex, age, or disability for health programs or activities funded by federal Health and Human Services Administration (HHS) and by issuers offering coverage in the health insurance marketplace. **Network adequacy requirements:** Requires marketplace plans to offer a sufficient choice of providers—meaning an adequate number and mix of provider types (including mental health and substance abuse providers) to assure accessibility of services without unreasonable delay. Networks must include essential community providers that serve predominantly low-income, medically-underserved individuals, such as federally qualified health centers. **Enables an appeal process:** Establishes an avenue for consumers to appeal coverage denials to the insurer and be guaranteed the right	

	to an independent external review.	
Easing purchasing and transparency	**Health insurance marketplaces:** • Establishes individual and small-group marketplaces, administered by a governmental agency or non-profit organizations, where individuals and businesses with up to 100 employees can purchase coverage. Exchanges are required to perform certain functions related to consumer outreach and service as well as provide health plan oversight. Tax-credits to purchase coverage are only available through the marketplaces. • Allows states to form regional exchanges and/or for multiple exchanges to exist in a state (the latter only if they serve distinct geographic regions). • Promotes greater transparency through a simplified approach to "shopping" for health insurance by providing tools that guide consumers through the process of obtaining health insurance, from plan search through enrollment. • Coordinates outreach and enrollment efforts with federal financial support for navigators and assisters to ensure individuals understand their plan options. **No-wrong door eligibility:** Requires states to develop a single form for consumers to use when applying for health insurance subsidies. Enables states to contract with Medicaid to determine eligibility for Medicaid coverage. **Maintenance of provider directories:** Mandates issuers to develop provider directories and to post accurate information about provider availability and networks.	**Elimination of marketplaces will result in the following:** • **Job loss**: Marketplace staff, navigators and other application assisters, and call center staff, insurance company staff, brokers and others. • **Elimination of one-stop shopping for health insurance: C**onsumers will lose the simplicity and ease of shopping for health insurance in one easy-to-use website that offers important details on cost, provider networks, etc. • **Terminate contracts:** In states that operate marketplaces, there could be a variety of vendors under contract with the state that are responsible for different aspects of related work, including operating or managing a call center, enrollment and eligibility systems, data sharing technology, and more. • **Statutory or regulatory changes:** States may need to change laws or regulations that established their marketplaces and created oversight Board of Directors, etc. • **Major systems changes:** The ACA required states to upgrade or build new Medicaid eligibility systems to integrate with the federal data hub and marketplace systems. The updated, integrated systems required substantial state and federal resources (money, staff, and time.) Dismantling the marketplace from the state's integrated eligibility and enrollment systems will require IT expertise (possibly requiring new expenditures/ contracts) and resources, such as Medicaid policy staff time and state funds. What should states do with their new eligibility and enrollment systems if ACA is repealed? Should they continue to use these systems once marketplaces are dismantled? Explore options for modifying systems – perhaps coordinating with other means-based programs? It is likely cost, which could be significant, will determine next steps.
Establishing coverage options	**Consumer-Operated and -Oriented Plan Program (CO-OPs):** Fosters the creation of qualified nonprofit health insurance issuers	**It is likely without the ACA's affordability assistance (APTCs and CSR), insurance regulators in the six states (MT, ID, WI, NM, MA and ME) with CO-Ops will need to review their long term viability**

and alternatives	to increase competition in the individual and small group markets. **Multi-state Program:** Directs the Office of Personnel Management to contract with at least two private health insurers per state to offer marketplace coverage options that [intend to] provide statewide or cross-state coverage. **Basic Health Plan: This o**ption for states creates an insurance product available to citizens or lawfully present non-citizens with income between 133-200% of the FPL who do not qualify for Medicaid, CHIP, or other minimum essential coverage. States receive 95% of the premium tax credits and cost-sharing reductions that would have otherwise been provided to (or on behalf of) eligible individuals if these individuals enrolled in QHPs through the marketplace. **Limitations on high-deductible plans and scope of Health Savings Accounts (HSAs), Health Reimbursement Accounts (HRAs), and Flexible Spending Accounts (FSAs)** ● Limits FSA and HRA flexibility: Excludes over-the-counter, non-prescribed drugs as reimbursable expenses. ● Increased tax on HSA funds: Imposes an increased tax on distributions to HSAs not spent on qualified medical expenses. ● Limits FSA contributions: Limits FSA contribution amounts to $2,500 per year, adjusted for cost of living. **1332 Waiver:** States can apply to CMS to pursue innovative strategies for providing health insurance that: • Are as comprehensive and affordable as they would be without the waiver; • Offers coverage to a comparable number of people; and • Does not increase the federal deficit.	**Only two states (MN and NY) implemented the ACA's Basic Health Plan. Without the ACA's affordability assistance, it is unclear how states will fund this coverage, which will require state expenditure to continue coverage or result in more individuals losing coverage.** **Only Hawaii has an approved 1332 waiver and three states (AK, CA, and VT) are actively pursuing approval for their waivers with CMS.** However, others are likely considering their options and may have initiated processes in their states to begin to develop coverage strategies. What will repeal mean for these efforts?

Market stabilization vehicles, and additional issuer requirements	**Medical loss rebates:** Requires most insurance companies that cover individuals and small businesses to spend at least 80% of their premium income on health care claims and quality improvement. The remaining 20% may be allocated to administrative and marketing costs and plan profits. **Reinsurance program:** Temporary program (2014-16) through which issuers are eligible for payments if enrollee costs exceed a specified threshold. All health insurance issuers and self-insured plans contribute funds to the program. **Risk Corridors program:** Temporary program (2014-16) through which marketplace issuers are required to spend 80% of premium dollars on healthcare and quality improvement. Issuers falling below 3% of the target are required to pay into the program. Funds collected are intended to be used to reimburse plans whose costs are 3% above the spending threshold. **Risk adjustment program:** Program through which HHS redistributes funds from plans with lower-risk enrollees to plans with higher-risk enrollees based on a risk calculation developed to evaluate the average financial risk of marketplace enrollees. States have the option to operate their own risk adjustment program, though to date all have defaulted to federal operation of the program. **Health issuer fees:** Imposes an annual fee on health insurance of a base rate, grown to reflect growth of premium rates. Fee is reduced for non-profit issuers. **Merged markets:** Permits states to merge individual and small group markets. **Single risk pool:** Requires issuers to consider all plans sold in a	**States have enacted laws and regulations to implement these provisions of the ACA. If repealed, states will need to consider what, if any, provisions they wish to continue, and revise laws and regulations accordingly. States will need to consider the impact of losing federal mechanisms for:** • Limiting how much insurers can retain for profit and administration; • Limiting how much insurance rates can be increased based on where consumers live, their age, or health condition; and • Supporting health plans by protecting them against large financial losses that could result in higher premiums for consumers. States will need to determine whether to retain fees on insurers to support state-based initiatives or repeal them. Without the ACA, states will make different decisions and issuers will make decisions about which states to do business in based on those choices.

	state's individual market as part of a single risk pool, whether the plans exist on or off an exchange.	
Employer market reforms	**Small employer tax credit:** Provides small employers (up to 25 employees) with a temporary tax credit for purchase of health insurance (up to 50% of employer contribution if employer contributes at least 50% of premium costs). **Small business Health Options Program (SHOP):** Creates the SHOP marketplace to enable purchase of health coverage by small-employers (up to 50 employees, with a state option to expand the definition to up to 100 employees). **Cadillac tax:** Imposes an excise tax on insurers of employer-sponsored health plans with aggregate values that exceed $10,200 for individual coverage and $27,500 for family coverage (indexed based on the consumer price index for urban consumers). Implementation of the tax has been repeatedly delayed, with implementation now slated for 2020.	**Loss of the small employer tax credit, while temporary and limited, could result in some small employers dropping coverage for employees due to cost, especially true if ACA repeal creates overall insurance market destabilization as noted above.**
Prescription drug benefits	Prescription drugs are included as one of the 10 EHBs. The ACA requires private plans and plans covering the Medicaid expansion population to cover all 10. A tax on drug manufacturers and importers is created as part of the ACA funding mechanism, and the ACA gives manufacturers 12 years of exclusive use before generics can be developed. The ACA includes provisions to close the Medicare Part D coverage gap (the "donut hole") by phasing down the copayments for drugs until it is at the standard 25% in 2020 and stepping up the percent discount that manufacturers provide.	**Without the EHB requirement and increasing costs for pharmaceuticals, will health plans begin limiting or simply not covering some drugs? Will plans provide catastrophic care only?** **In some states, the non-discrimination requirements (noted above) have had an impact on formulary design. For example, ensuring individuals with HIV have coverage for antiretroviral drugs.** **How will the re-introduction of the Medicare Part D pharmacy coverage gap impact state retiree health plans and Medicaid budgets? For individuals who are eligible for both Medicare and Medicaid, might some spend down income on drug costs and become Medicaid eligible?** **Will consumers experiencing the coverage gap for their prescription drugs go without necessary medications and ultimately require expensive care at emergency departments or other safety net providers? How will such care be funded?**
Medicaid		

Medicaid expansion	**Coverage expansion:** Expanded Medicaid to all non-Medicare-eligible individuals under age 65 with incomes up to 138% FPL, based on modified adjusted gross income (Supreme Court ruling resulted in expansion being optional for states) **Increased funding to states:** States expanding Medicaid for the newly-eligible population received 100% federal match for 2014-2016, gradually phasing down to 90% federal match in 2020 **Benchmark benefits:** Benefits for newly-eligible individuals based on a Medicaid benchmark plan that includes the ACA's essential health benefits	**Increases in uninsured:** The Congressional Budget Office has estimated that the repeal of the ACA would result in approximately 19 million individuals losing Medicaid or CHIP coverage. **States will lose money:** A recent analysis found that the expansion provided an estimated $73 billion in federal funding in calendar year 2016 to states that expanded Medicaid. Other analyses found that many of these states have experienced budget savings as a result of spending less on uncompensated care and behavioral health programs previously funded by state dollars, as well as revenue gains from hospital and issuer taxes. **The 32 states that expanded Medicaid will need to pick up costs with all state dollars or shut down part of their Medicaid program. They may be forced to:** • **Disenroll individuals from Medicaid;** • **Review and address contracts that need to be modified or terminated;** • **Collect, process, and pay providers of expansion beneficiaries; and/or** • **Make eligibility and enrollment system changes that will be dependent upon repeal language. Will states need to change eligibility methodology from MAGI? States need to dismantle integration with marketplaces, which will likely be costly.** **With individuals losing Medicaid coverage, what would be the magnitude of the increase in uncompensated care costs, as well as the financial impact on providers in states that expanded Medicaid, such as rural hospitals and community health centers? What would be the impact on individuals' ability to access care?**
Other Medicaid changes (not including LTSS delivery system changes and DSH reductions)	**Systems changes:** States were required to implement a number of changes to their Medicaid programs (related to eligibility and enrollment, operations, etc.), regardless of whether they opted to implement the Medicaid expansion **Maintenance of effort (MOE)**: This provision requires states to maintain the Medicaid and CHIP eligibility levels, standards, methodologies, and procedures for children that were in place in 2010 through FFY 2019 **New eligibility floor** -This raises Medicaid eligibility levels for all children to 138% FPL, which required some states to transition children from separate CHIP to Medicaid coverage **Enrollment simplification:** Provides a new presumptive eligibility (PE) authority for hospitals	**ACA repeal could include a shift from using MAGI to determine Medicaid eligibility**. As identified by the National Association of Medicaid Directors, states invested significant resources to implement this standard and changes would be costly. Changing eligibility methodology could also: • Increase administrative burden for eligibility staff; • Require new eligibility, enrollment, renewal and data systems, policies and practices, as well as new applications – online and paper; and • Necessitate new income data sources. **ACA repeal could eliminate the MOE provision**, which would allow states more flexibility to determine eligibility levels, but could likely result in increases in uninsured children. **Would it create state savings?** **ACA repeal could revert Medicaid eligibility levels for children ages 6-18 to lower levels required pre-ACA.** States would need to determine whether or not to maintain higher eligibility. States may have to transition children within certain income ranges from Medicaid to CHIP, which could result in disruptions to care or unintended loss of coverage and additional systems changes.

		Hospitals may have to stop presumptive eligibility determinations, which may: • Delay needed care for uninsured individuals; • Result in hospitals not receiving payment for care delivered; and/or • Increase demand on states to render fast eligibility determinations for people in need of medical services.
Medicaid demonstrations and state options for long-term services and supports	**Money follows the Person**: The rebalancing demonstration program -- through September 2016 -- allocated an additional $2.25 billion to the program and expanded eligibility criteria. **Home and community-based services: P**rovided states with additional options for providing home and community based services (HCBS) through Medicaid state plans instead of waivers for certain individuals. **Community First Choice:** Created an option in Medicaid to allow states to provide community-based supports for individuals with disabilities who need institutional-level care. States were provided with an enhanced federal match rate. **Balancing Incentive Program**: Provided qualifying states with an enhanced federal match rate from 10/1/11 to 9/30/15 to increase access to non-institutional LTSS options for individuals	**Repealing ACA could remove state flexibility for implementing HCBS services as a Medicaid option in their state plans.** **Would states have flexibility to promote home- and community-based, long-term care services in Medicaid? If so, through what authority? Would there be an enhanced federal match rate to support states' efforts to provide community-based, long-term services and supports? If so, how would they be funded and how would states access those enhanced funds? What are the implications, if any, for Medicaid managed care contracting if changes are made to states' options for promoting HCBS?** **Would states see an increase in demand for nursing home services?**
Medicaid health home	Established a Medicaid state plan option to coordinate care through a health home model for individuals with two or more chronic conditions, or who have one chronic condition and are at risk for developing another, or who have one serious mental illness. States receive enhanced federal funding (a 90% match) for the first eight quarters of implementation.	**Would these types of care coordination initiatives remain in place even if ACA is repealed?** States may no longer receive enhanced funding matches for these services, so there could be additional costs to states.
Children's Health Insurance Program (CHIP)		
CHIP financing and policy changes	**Reauthorized CHIP: E**xtended funding for CHIP through FFY 2015 **Enhanced funding to states: I**ntroduced a 23% point increase in the federal CHIP match rate (not to exceed 100%) beginning in FFY 2016 through FFY 2019 **Maintenance of effort (MOE**): Requires states to maintain Medicaid	**ACA repeal could eliminate the MOE provision**, which would allow states more flexibility to determine eligibility levels, but could also result in an increase in uninsured children. Could result in a cost **savings to states.** **States may lose enhanced CHIP funding bump**, which would require more state spending to maintain children's coverage or a decision to disenroll children from CHIP. **Regardless of ACA future, CHIP funding is currently limited**

	and CHIP eligibility levels, standards, methodologies and procedures for children that were in place in 2010 through FFY 2019 **Option to extend CHIP coverage:** Provided states an option to offer CHIP coverage to children of state employees who were eligible for health benefits (if certain conditions were met)	• Federal CHIP funding would be maintained through FFY 2017 because funding was extended by the passage of the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015; MACRA also funds the ACA's 23% point increase in the CHIP match rate through FFY 2017 • With CHIP funding currently set to expire 9/30/17, Congress will need to address the issue of whether to extend funding for the program • If federal funding for CHIP is not available, states operating separate CHIP programs can limit enrollment; states operating Medicaid expansion CHIP programs would be required by the MOE provision to maintain current eligibility levels but would receive the Medicaid match rate (unless MOE provision is repealed in an ACA repeal bill) • States operating separate CHIP programs need to begin planning early in 2017 for the possibility of CHIP funding not being extended. Planning efforts include budgetary, legislative, policy, and operational changes as well as communicating with families and medical providers about potential changes in children's coverage
Delivery System Reforms		
Center for Medicare and Medicaid Innovation (CMMI) within CMS	CMMI demonstration programs reward providers and systems for value over volume. CMMI funds a number of initiatives (such as the State innovation Model - SIM)) that address payment and delivery system reform and population health and prevention. CMMI also has a prevention and population health group that provides national leadership.	**As of December 2016, CMMI was on track to award all of its appropriated $10 billion by 2019 to states to support health system reforms, but ACA repeal puts that plan at risk.** • **SIM efforts:** o **Round 1:** Of the six states originally awarded a total of $250 million, only Arkansas has completed its efforts; five states currently still have efforts funded with federal dollars underway, but most are scheduled to wrap up within the current fiscal year. o **Round 2:** All 11 states awarded a total of $620 million are actively engaged in their federally-funded supported efforts – at least until 2019. It may be possible for states to lose portions of their SIM grants. Individual state awards range from $20 million to $100 million.
Accountable care organizations (ACOs)	The ACA defines ACOs and establishes a Medicare Shared Savings ACO program.	• Without the Medicare Shared Savings ACO program, will all payers be incentivized to participate in ACOs?
Medicare-Medicaid Coordination Office	Created to address issues for individuals dually-enrolled in Medicare and Medicaid	**Thirteen states participate in the MMCO Financial Alignment Initiative demonstration and could lose:** • **Federal funds that help support efforts to achieve costs savings by better coordinating care.** Loss of these funds could mean job loss for care coordinators and others established to support demonstration efforts**.** • **Cost savings achieved through these efforts.**
Provider Payments		
Hospital readmissions reduction program	Penalizes hospitals for excess readmissions within 30 days of discharge.	As result of this program, hospitals have an incentive to: • Improve care transitions; • Focus on discharge planning; and • Engage in other supports for the homeless and marginally-housed so they don't return within 30 days. **Without this program, will hospitals continue their efforts? If not, what costs will states and Medicaid MCOs**

		shoulder to reduce readmissions, particularly for homeless beneficiaries?
Hospital-Acquired Condition (HAC) reduction program	Penalizes the worst-performing quarter of hospitals.	**The removal of incentives could result in increased hospital-acquired infections that require state reporting and surveillance.** Prior to the ACA, CMS encouraged states to adopt non-payment policies for never events, in line with federal policy.
Medicaid coverage for tobacco cessation for pregnant women	Medicaid must cover counseling and medication for tobacco cessation without cost sharing.	**Federal funds for these services would end and as a result the services will either cease or become 100% state-funded.**
Disproportionate Share Hospital (DSH) and other hospital payments	• Reduces Medicare DSH payments and aggregates Medicaid DSH allotments. • Reduces Medicare payments to certain hospitals for hospital-acquired conditions by 1%	**If repealing the ACA results in a higher rate of uninsured, would repealing the DSH cuts scheduled to begin in FY 2018 be adequate to cover the higher uncompensated care costs?** **How would repealing DSH cuts, coupled with the changing numbers of the uninsured and Medicaid beneficiaries, impact Medicaid payment adequacy in different states?**
Provider Workforce		
National Healthcare Workforce Commission	Reauthorized funding for existing grant programs under the Public Health Services Act (PHSA) including federal health workforce programs administered by Health Resources and Services Administration (HRSA) National Health Service Corps (NHSC) funding reauthorized through Community Health Center Fund (CHCF)	Has not met since its creation because no appropriation has been made. MACRA extended funding for NHSC through FY17.
Additional federal support for medical education	• Increased federally-supported medical student loans, increased loan rates/amounts for nursing students. • Established pediatric specialty and public health loan repayment programs	**Will reducing available federal loans and loan repayments have an adverse effect on individuals choosing certain medical specialties? If so, how will that affect access to care?**
Quality Improvement		
National Quality Strategy (NQS)	NQS works with stakeholders to align clinical quality measures around shared aims and priorities. It identifies and prioritizes areas of focus for quality improvement nationwide. It developed measure sets for nine topics aligned with six quality priorities. Measure alignment is done with an eye toward minimizing provider burden.	**Removing this alignment could increase burden on states.** Aligning measures across federal programs helps states focus resources and reduce administrative burden. In 2015, the Agency for Healthcare Research and Quality (AHRQ) aligned the NQS with the National Healthcare Quality and Disparities report, in order to focus on health disparities. **Would dismantling these initiatives impact state efforts to reduce disparities?**
Patient-Centered Outcomes Research Institute (PCORI)	PCORI funds comparative effectiveness research (CER) to help policymakers and others make informed decisions based on evidence-based information; however, CER may not be, "construed as mandates, guidelines, or recommendations for payment,	States will have less robust resources for decision-making.

	coverage, or treatment or used to deny coverage."	
Population Health		
Prevention and Public Health Fund	The Epidemiology and Laboratory Capacity for Infectious Diseases (ELC) Cooperative Agreement, which awards funds to all 50 state health departments, receives nearly half its funding from the fund (see ASTHO, Prevention and Public Health Fund). ELC awards to states and localities totaled $245 million in 2016. According to the CDC, "Funds provided through the ELC mechanism help pay for more than 1,000 full- and part-time positions in the state, territorial, local, and tribal health departments. These positions include epidemiologists, laboratorians, and health information systems staff," in 2013. Trust for America's Health estimates that states would lose more than $3 billion over five years if the fund were repealed. The fund supports the Preventive Health and Health Services (PHHS) Block Grant to states, which supports rapid responses to emerging health issues. The CDC allocated $160 million in PHHS Block Grant funding 2015, aligned with Healthy People 2020 goals. The ELC also gave states and cities $60 million in July 2016 to fight Zika.	**Without the Prevention and Public Health Fund, states and localities could lose the 1,000 jobs in state, local and tribal departments that the fund currently helps to support, and lose funding to fight Zika and other emerging threats to public health.** If the CDC diminishes its support for state vaccination, chronic disease prevention, and other public health programs, will state governments and hospitals face rising costs for treating and monitoring preventable diseases and conditions?
Tax-exempt hospital community needs assessment/ community benefits	The ACA requires nonprofit hospitals seeking to retain their tax-exempt status to conduct community health needs assessments and develop a plan for addressing those needs. Final rules specify that the community needs addressed by hospitals may include the need to, "ensure adequate nutrition, or to address social, behavioral, and environmental factors that influence health in the community." The rule requires each hospital to obtain and consider input from a governmental public health department.	**If community health needs assessments are no longer required of tax-exempt hospitals, what are the implications for aligning activities with state public health priorities?**
Office of Minority Health	The ACA reauthorized the Office of Minority Health and moved it to the Office of the Secretary. It also created individual offices of minority health within each agency: CDC, HRSA, SAMHSA, AHRQ, FDA, and CMS.	**Will investments in community health worker initiatives, as a strategy to increase health equity, be adequate to address the needs of minority health without additional federal support to the Office Minority Health?**
Enhanced demographic data collection to monitor disparities	The ACA called for enhanced data collection for federal programs, including Medicaid and CHIP, to help address disparities.	**Without enhanced national data collection, will states have the information required to address health disparities in their own states? To effectively measure disparities, will states need to invest their own resources or not be able to measure disparities at all?**