A Crosswalk of ACA Provisions with Proposed Language Under the House American Health Care Act and the Senate Better Care Reconciliation Act.

This chart summarizes major provisions included in the 2010 Patient Protection and Affordable Care Act (ACA), provisions included in the American Health Care Act (AHCA) passed by the House on May 4, 2017, as well as preliminary analysis of the Senate Better Care Reconciliation Act (BCRA) discussion draft as amended on June 26, 2017, and the revised on July 13, 2017 and July 20, 2017. Provision changes included in the July 13 and July 20 versions are highlighted in yellow. On July 21, the Senate Parliamentarian ruled several provisions that could be stricken from BCRA under reconciliation rules. These provisions are highlighted in green. Sections still under review by the Parliamentarian are highlighted in blue.

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	Patient Protection and Affordable Care Act of 2010	American Health Care Act (as passed by the House on 5/4/2017)	Senate Draft Discussion Bill/Better Care Reconciliation Act (as of 6/26/17, with 7/13/17 changes/additions highlighted in yellow)
Enforcement to expand coverage			
Coverage Requirements			
Individual Mandate	Requires all U.S. citizens and legal residents to have health coverage. Assesses a tax penalty on those lacking coverage.	Effective elimination of mandate by setting penalty amount at $0. Retroactive to January 1, 2016.	Same as AHCA
Employer Mandate	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.	Effective elimination of mandate by setting penalty amount at $0. Retroactive to January 1, 2016.	Same as AHCA
Continuous Coverage		Institutes continuous coverage requirement. Assesses a 30 % late-enrollment surcharge on top of premiums for individuals that have more than 63 continuous days during which they did not have credible coverage over the prior 12 months. The	Institutes a mandatory 6 month waiting period on individuals who cannot demonstrate enrollment in continuous creditable coverage. Continuous coverage is defined for:

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		surcharge discontinues after the end of the plan year for which the person enrolled in coverage. Beginning in plan year 2018 for special enrollments, and plan year 2019 open enrollment.	a) enrollees enrolling during an open enrollment period: 12 months of continuous coverage without a significant break (>63 days) b) enrollees enrolling during a special enrollment period: 12 months of continuous coverage without a significant break or at least 1 day of coverage within the 60-day period preceding the date of submission of the application. [Added 7/13/17] Issuers would not be required to impose a waiting period on newborns who enroll within 30 days of birth or adopted children who enroll within 30 days of adoption. Extends the definition of creditable coverage to include a health care sharing ministry. [Added 7/13/17] Effective for plan year 2019

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Private Market Reforms and Assistance			
Affordability Assistance			
Advance, refundable, <u>income-based</u> 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 a qualified health plan (QHP) through a state or federal health insurance exchange. *Calculating tax credits* Credits are calculated on a sliding scale based upon a benchmark of the second-lowest cost silver plan available to the individual (actuarial value of 70%). Calculations also factor an "applicable percentage" of income individuals are required to contribute toward insurance. The applicable percentage is based on income and ranges from 2% for those up to 133% FPL to 9.5% for those up to 400% FPL. The percentage is adjusted yearly based on premium growth.	Repealed. Effective in 2020. Adds an age-rating factor to PTC credit calculations in 2019. ● Increases amount of PTC allocated to individuals up to age 39 that are between 150-400% FPL ● Increases amount of PTC allocated to individuals age 40-49 between 250-400% FPL ● Lowers PTC allocated to individuals age 50+ between 150-400% FPL Effective in 2019 *Flexibility over use of tax credits.* ● Credits can be used to purchase catastrophic coverage ● Credits can be used to purchase qualified health plans (i.e., covering essential health benefits) sold outside of the exchange, but are not advance-payable for such plans. ● Credits cannot be used to purchase short term	Advanceable premium tax credits available Eligibility changes: ● Income eligibility: 0% up to 350% FPL ● Lawfully present aliens are no longer eligible; qualified aliens (per the Personal Responsibility and Work Opportunity Reconciliation Act of '96) are eligible ● Individuals with access to employer-sponsored coverage are not eligible *Changes to calculating tax credits* Adjusted based on age, income and by rating area to accommodate geographic variation in prices. Benchmark for calculation of tax credit is based on the median premium for available plans with a rating area with an actuarial value (AV) of 58%. ~~If the Secretary of the Treasury and the Secretary of HHS determine no plan will be offered in a rating area that meets the standards of a second-lowest cost silver plan, the Secretary of the Treasury may~~

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		policies ● Credits cannot be used to purchase grandfathered or grandmothered individual health insurance policies sold outside of the exchange. ● Credits cannot be used for plans that cover abortion. Effective in 2018	~~increase the 58% AV threshold. [Added 7/13/17; Removed 7/20/17]~~ Adjusts the applicable percentage to include a factor for age. The total applicable percentage ranges from 2% up to 16.2%. ● Those with income up to 150% FPL the percentage does not change based on age ● For those with income 151%+ FPL, older individuals are required to contribute more than younger individuals (See Summary of Senate Funding Provisions for detailed chart) Effective in 2020
Advance, refundable <u>age-adjusted</u> premium tax credits		Institutes advanceable **r**efundable credits scaled, based on age, as follows: ● $2,000 <30 ● $2,500 30-39 ● $3,000 40-49 ● $3,500 50-59 ● $4,000 60+ *Income adjustment.* Credit amount phases down by 10% for every $1000 increase of income over $75,000 ($150,000 for couples). Credits are capped at $14,000 per year per family.	

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		Family composition. Credits can be claimed by up to the five oldest members of a household. Married individuals must file jointly to claim a credit. *Credit adjustment.* Credits are indexed annually based on 1% above the consumer price index (CPI +1%). Eligible individuals may not have access to government insurance or employer coverage. *HRA adjustment.* Individuals enrolled in a small employer health reimbursement account (HRA) will have credits reduced by the amount that is contributed to the HRA. *Flexibility over use of tax credits.* ● Credits cannot be used to purchase grandfathered or grandmothered plans ● Credits cannot be used to purchase short term policies ● Credits cannot be used for plans that cover abortion. ● Credits can be used to purchase major medical health insurance ● Credits can be used to purchase unsubsidized COBRA coverage. Effective in 2020	

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Cost Sharing Reduction (CSR)	Direct reimbursement given to issuers, available for individuals with income between 100-250% FPL who enroll in a Silver-level QHP. CSRs increase the actuarial value of coverage so it is equal to a Gold or Platinum plan.	Repealed. Effective in plan year 2020	Same as AHCA. Language added to fund through 2019.
Excess advance payments	Requires households who receive excess APTC to return excess funds. Limits the amount of excess payments to be returned in the case of households below 400% FPL.	Repeals payment limits for households below 400% FPL. Effective in 2018-2019	Repeals payment limit for households below 400% FPL Effective in 2018
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).	Repealed. Effective in 2020 Restricts small business tax credits so they cannot be used for plans that cover elective abortions. Effective 2018-19	Same as AHCA Restricts small business tax credits so that they cannot be used to for plans that cover abortions other than in cases necessary to save the life of the mother or due to rape or incest. Effective 2018-19 Creates Small Business Risk Sharing Pools regulated by Federal government
Issuer Requirements, Insurance Standards and Consumer Protections			
Issuer taxes and penalties	*Health insurance tax.* Imposes an annual fee on health insurance of a base rate, grown to reflect growth of premium rates. Fee is	Repealed Effective 2018.	Same as AHCA

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	reduced for non-profit issuers. *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.	Postpones effective date of the Cadillac tax until after December 31, 2024.	Postpones effective date until January 1, 2026. Establishes a penalty of $100 per day for any violations of abortion funding segregation for issuers established under law. [Added 7/13/17]
Qualified Health Plan (QHP)	Defines a QHP as a health insurance plan that meets certain parameters set forth by the ACA including limits on cost-sharing, provision of essential health benefits, and provides minimum essential coverage.	Repeals language associating QHPs with standards set by the health insurance exchanges including requirements that QHPs be certified or recognized by the exchange through which they are offered and regulations developed under section 1311(d) by the Secretary or exchanges. Repeals requirement that QHPs offer at least one QHP at the silver-level and one plan at the gold level in an exchange. Clarifies that a QHP does not have to be offered through an exchange. Mandates that QHPs cannot include coverage for	Allows states to waive essential health benefits, out of pocket maximums and coverage through the exchange. Mandates that QHPs cannot include coverage for abortions, other than when necessary to save the life of the mother or due to pregnancy as a result of rape or incest. Repeals prohibition on catastrophic coverage qualifying as a QHP. [Added 7/13/17] Effective in 2018 Eliminates restrictions limiting the availability of

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		abortions, other than when necessary to save the life of the mother. Prohibits grandmothered or grandfathered health plans from being considered QHPs. Repeals prohibition that catastrophic plans may qualify as QHPs.	catastrophic coverage to certain individuals (esp. individuals under the age of 30). [Added 7/13/17] Effective in 2019
Medical loss ratio	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.	No change.	Federal standard repealed and state option to set. Effective January 1, 2019
Limits to consumer spending	Institutes limits on out-of-pocket spending. Eliminates annual and lifetime limits on spending for services considered Essential Health Benefits (EHB) (see below). Eliminates of cost-sharing for preventive services defined by the U.S. Preventive Services Task Force.	No change. Annual and lifetime EHB limit may be affected by states that waive EHB requirements (see below).	Allows states to waive out of pocket maximums

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	Requires plans to charge in-network rates for emergency services rendered at out-of-network facilities.		
Extension of dependent coverage	Requires employer-sponsored insurance plans to offer employees' dependents health coverage up to age 26.	No change.	No change.
Guaranteed offerings	*Guaranteed issue.* Requires health plans to offer coverage to any eligible applicant regardless of health status, including those with pre-existing conditions.	No change.	No change
	Ban on rescissions. Prohibits issuers from revoking coverage other than in cases of fraud or intentional misrepresentation of facts.	No change.	No change
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.	No change.	No change

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Plan value/ design	*Essential Health Benefits.* 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. *Actuarial values.* Establishes four standard tiers of health insurance based on actuarial values (60%, 70%, 80% and 90% of expected costs). 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.	*Essential Health Benefits.* Allows states to apply for a waiver to define their own EHBs. Effective in 2020 Repealed. Effective in 2020	Same as AHCA. Establishes an actuarial value of 58% to receive tax credits. Effective in 2018
Rating bands	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).	*Age rating.* Widens age rating ratio to 5:1; provides state flexibility to set own ratios. States may submit a waiver application to set a wider age ratio. Effective in 2018 *Community rating.* States may apply to waive prohibitions on medical underwriting for individuals that do not maintain continuous coverage.	*Age rating:* Widens age rating to 5:1; states may vary. Effective in 2019

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	Prohibits issuers from charging different premiums to individuals based on gender or health status.	Effective for SEPs in 2018; otherwise, effective in 2019	
Rate review	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.	No change.	No change.
Network adequacy	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.	No change.	No change.

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Provider directories	Mandates issuers to develop provider directories and to post accurate information about provider availability and networks.	No change.	No change.
Merged markets	Permits states to merge individual and small group markets.	No change.	No change.
Single risk pool	Requires issuers to consider all plans sold in a state's individual market as part of a single risk pool, whether the plans exist on or off an exchange.	No change.	Requires inclusion of catastrophic plans in individual and small-group market risk pools. [Added 7/13/17] Effective in 2019
Coverage appeals	Establishes an avenue for consumers to appeal coverage denials to the insurer and be guaranteed the right to an independent external review.	No change.	No change.
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.	No change. States may apply for a waiver to redefine EHB, which could include a change in prescription drug inclusion as an EHB.	

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	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.	Repealed. Effective as of December 31, 2017.	Same as AHCA
	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.	No change.	No change.
Acquiring Coverage and Subsidies			
Health insurance exchanges	Establishes individual and small-group health insurance exchanges where individuals and businesses with up to 100 employees can purchase coverage. Exchanges may be run by a governmental or quasi-government agency, or a non-profit organization. Exchanges are required to perform certain functions related to consumer outreach and service as well as provide health plan oversight.	Exchanges are the only source through which consumers may procure an advanceable tax credit. Non-advanceable tax credits are available to purchase coverage off an exchange. Through 2019	States may eliminate use of exchanges through 1332 waivers

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	Exchanges intend to promote greater transparency through a simplified approach to "shopping" for health insurance. They are empowered to provide tools that guide consumers through the process of obtaining health insurance, from plan search through enrollment including coordination of outreach and enrollment support via health insurance navigators and assisters. *Regional exchanges:* States may form regional exchanges and/or for multiple exchanges may exist in a state (the latter only if the exchanges serve distinct geographic regions).		
Distribution of tax credits	Tax credits can be used to purchase QHPs only through established health insurance exchanges.	Empowers treasury to create a system to deliver age-adjusted tax-credits. Emphasizes the distribution system should, where possible, build upon what was established under the ACA. In cases where a plan is sold off an exchange, the provider of the eligible health insurance (or, if allowed by the Secretary, an agent or broker) shall be considered the proxy for conducting the responsibilities normally designated to an	No change.

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		exchange. System to be implemented in 2020.	
Eligibility determinations	*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.	Repeals requirements for eligibility determinations set forth in sections 1411, and 1412 of the ACA in the context of determinations made for tax credits. Effective in 2020	No change.
Establishing Coverage Options and Alternatives			
Consumer-Operated and -Oriented Plan Program (CO-OPs)	Fosters the creation of qualified nonprofit health insurance issuers to increase competition in the individual and small group markets.	No change.	No change.
Basic Health Plan	Option for states to create 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	No change.	No change.

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	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.		
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.	Repealed. Repealed. Repealed. HSAs may be used to pay for medical expenses incurred before the HSA was established, if the HSA was established within a 60-days of enrollment in a high deductible plan. *Increases HSA contribution.* Increases annual HSA contribution limit to the maximum sum of an annual deductible and out-of-pocket expenses	Repealed. Repealed. Same as AHCA. Same as AHCA.

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		permitted under a high-deductible plan (at least $6,550 in self-only coverage; $31,000 for family coverage). Additional "catch-up" contributions of up to $1,000 may be made by individuals over age 55. Allows both spouses to make catch-up contributions toward a single HSA. Effective in 2018	Allows HSA's to be used to pay for qualifying medical expenses for dependents up to age 27. [Added 7/13/17] Permits use of HSA funds to pay for premiums for high-deductible health plans other than employer sponsored plans in cases where health plan premiums exceed allowable tax credits. Plans that cover abortions (except in cases of rape, incest, or to preserve the life of the mother) are excluded from receipt of these premium payments. [Added 7/13/17] Effective in 2018
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.	No change.	No change.

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Small Business Health Plans			Establishes Small Business Health Plans (SBHP), an association health plan option for small businesses. Under ERISA, SBHPs would be identified as fully-insured group health plans offered by a large-insurer; ERISA would preempt state laws for any issuer wishing to offer coverage through a SBHP. SBHPs are required to ● Receive certification from the Department of Labor; ● Be permanently established for a purpose other than to provide health benefits (ex., a trade association, or franchise or certified professional employer organization.) [Added 7/13/17] ● not condition membership based on a minimum group size Participating employers are restricted from providing coverage for any employee excluded from the SBHP on the basis of health status through any other mechanism, including the individual market. [Added 7/13/17] Effective one year after enactment of the law.

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Strategies to support market stabilization			
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.	No change.	No change.
Strategies to support innovation, flexibility, and affordability			
State Innovation Waiver (1332)	*Waiver "Guardrails".* Waivers must satisfy four criteria in relation to the ACA. 1. **Coverage:** Coverage must be "at least as comprehensive." 2. **Affordability:** Coverage must be "at least as affordable" (inclusive of all ACA cost-sharing protections). 3. **Number:** Coverage must be provided to "a comparable number of residents."	No change.	1332 waiver provisions altered and $2B provided to support states (2017-2019) Changes criteria for 1332 waiver: • increase access to comprehensive coverage • reduce average premiums • increase enrollment • provide consumers with freedom to purchase the health insurance of their choice [Added 7/13/17]

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	4. **Budget:** Provisions included in the waiver may not increase the federal deficit. *What may be waived?* The ACA specifies which types of provisions may be waived. These include rules and legislation governing: ● Benefits ● Subsidies ● Health insurance marketplaces ● Qualified Health Plan certification ● The individual and employer mandates		● does not increase the federal deficit ● requires certification from Governor and Insurance department, not legislative authorization May apply funds from Stabilization Fund and, if so, those funds will not be considered when determining impact on federal deficit Approvals up to 8 years with potential 8 year renewals; Secretary may not cancel a waiver before completion Authorizes expedited review and approval process by the Secretary
Patient and State Stability Fund		Establishes $138 in funding for states to be used to establish market stabilization programs. ● $100 billion from 2018-2026 can be used to establish any of 8 types of programs ● $15 billion from 2018-2026 to establish an invisible risk-sharing program ● $8 billion from 2018-2023 to provide financial assistance to consumers in states that opt to engage in medical underwriting	Establishes the State Stability and Innovation Program comprised of two funds - one directly for issuers and another for states to administer *Issuer Stability Fund* ● $15 billion in CY 2018 & 2019 ● $10 billion in CY 2020 & 2021 CMS pays directly to issuers to address coverage and access disruptions and respond to urgent health care needs. Issuers required to submit notice of intent to participate within 30 days of

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		• $15 billion in 2020 for the purpose of maternity coverage, newborn care, or prevention, treatment, or recovery support for individuals with mental and or substance use disorders. *Funding allocation.* 85% of funding allotted in 2018 and 2019, will be based on claims incurred during benefit year 2015 and 2016, respectively (the most recent years of medical loss ratio data). To receive the remaining 15%, states must have fewer than three plans that offer coverage on-exchange in 2017 or total uninsured rate must have increased from 2013-2015. In 2020, the Administration will set an allocation methodology based on cost, risk, low-income uninsured, and issuer competition. CMS may use the resources available to help stabilize premiums in states that opt not to use this funding to institute their own programs *State match.* A state match will be phased in beginning in 2020.	enactment. CMS to determine procedure for providing and distributing funds. No match required *Long term state stability and innovation fund* • $8 billion in CY 2019 • $14 billion in CY 2020 & 2021 • ~~$6 billion in CY 2022 & 2023~~ • ~~$5 billion in CY 2024 & 2025~~ • ~~$4 billion in CY 2026~~ [Revised 7/13/17] • $19.2 billion in CY 2022-2026 [Added 7/13/17] This program would be established under title XXI (the statute governing CHIP) and requires CMS to determine a methodology to provide states that apply for funds with allotments that if not spent in 3 years can be redistributed among the states. This program requires state match: • 0% match in 2019-2021 • 7% match in 2022 and rising incrementally to 35% in 2026 Requires that 1% of funding in each calendar year must be directed toward issuers in states where the cost of insurance premiums are at least 75% higher than the national average. [Added 7/13/17]

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		State flexibility. Allows states flexibility to define certain parameters around which they will establish or maintain mechanisms through which they provide assistance related to the Stability Fund. More details available here.	For each of FY 2019 - FY 2021, at $5 billion would be required to be used by states to make arrangements with issuers to stabilize premiums and promote market participation. Additionally, states may use funds to: ● Establish a program or mechanism to help high risk individuals without access to employer sponsored coverage enroll in the individual market (e.g. reduce premiums); ● Establish arrangements with issuers to help stabilize premiums, promote market participation and plan choice; ● Pay providers directly; ● Provide out of pocket assistance Limits what states can use for revenues to provide match- no intergovernmental transfers, public expenditures Once CMS approves an application it is valid through 2026.
State waiver process (applicable to waivers for insurance		Waivers are considered automatically approved unless the Secretary responds within 60 days of waiver submission.	

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requirements)		Waivers must indicate how the request will: ● reduce average premiums; ● increase enrollment; ● stabilize health insurance markets; ● stabilize premiums for individuals with pre-existing conditions; ● increase plan choice. Waivers are not applicable toward: ● Section 1332 programs ● BHP or CO-OPs ● Interstate compacts or multi-state plans ● Insurance benefits provided to Congress	
Individual Market fund			~~[Tentative Title III, included in brackets in version released on 7/13/17]~~ ~~Appropriates $70 billion from Title XXI from 2020-2026 to fund individual market plans covering high-risk individuals in specified rating areas.~~ ~~Plans funded through this fund are exempt from meeting the following requirements:~~ ● ~~Essential Health Benefits~~ ● ~~Rating limitations on age, family size, geography, or tobacco~~ ● ~~guaranteed issue~~

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			~~● pre-existing condition exclusions~~ ~~● Waiting periods for group health plans~~ ~~● coverage of preventive services~~ ~~● provision of medical loss ratio rebates to consumers~~ ~~Issuers may qualify for funds if on or before May 3 of the calendar year of the applicable plan year the plan:~~ ~~● notifies the HHS Secretary and State insurance commissioner of its intent to apply for funds~~ ~~● certifies that it will make one gold and one silver plan available through the exchange in the applicable rating areas~~ ~~● certifies that one health plan that provides the same level of coverage as the second lowest cost silver plan offered in the exchange~~ ~~Premium tax credits may not be used for purchase of these plans. Funds available through an HSA may be used to pay for plan premiums.~~ ~~Plans developed under this fund may not:~~ ~~● exempt requirements outlined under state law~~ ~~● be considered as creditable coverage for~~

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			~~the purpose of meeting continuous coverage requirements~~ ~~● offer coverage for abortion except in the case of rape, incest, or to save the life of the mother~~ ~~● be purchased with premium tax credit dollars, however may be purchased through funds available in an HSA~~ ~~● receive funding under the risk adjustment program~~ ~~1332 funding may not be used to provide assistance to individuals who enroll in plans established under this fund.~~ ~~$2 billion is appropriated to states from Title XXI for regulation and oversight of plans established under this fund.~~ ~~Effective January 1, 2020~~ [Added 7/13/17, removed 7/20/2017]

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Medicaid			
Medicaid expansion			
Revised FPL limits for Medicaid	Expands 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).	Codifies Medicaid expansion as a state option. Effective as of January 1, 2020 Repeals state option to expand Medicaid to adults above 138% FPL. Effective as of December 31, 2017.	Codifies Medicaid expansion as a state option; specifies ACA Medicaid expansion end date of 12/31/19 and adds a new Medicaid optional eligibility group that incorporates the existing ACA expansion enrollee definition. Effective January 1, 2020 Same as AHCA/no change
State match for Medicaid expansion	States expanding Medicaid for the newly eligible population received 100% federal match for 2014-2016, gradually phasing down to 90% federal match in 2020.	Enhanced match for the Medicaid expansion population is only provided to states that expanded Medicaid as of 3/1/2017. This enhanced match for the expansion population is eliminated as of 1/1/20, but the bill grandfathers the enhanced match for individuals who were enrolled as of 12/31/19, so long as they remain enrolled and do not have a lapse in coverage for more than one month. After 1/1/20 states can enroll newly eligible individuals at the state's traditional FMAP.	Enhanced match for the Medicaid expansion population is only provided to states that expanded Medicaid as of 3/1/17. Enhanced match rate will remain through CY2020, and then is phased down at the following rate in subsequent years: -85% in 2021 -80% in 2022 -75% in 2023 State's traditional match rate beginning in 2024 (If a state's regular match rate in any year is higher than the newly eligible match rate, the regular

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		For states that expanded Medicaid prior to March 23, 2010, halts the phase up of matching rate; percentage would remain at 2017 levels of 80% for future years. Matching rate only applies for expenditures on behalf of individuals eligible for the matching rate and who remain enrolled in Medicaid without a gap of more than a month.	match rate would apply.) For states that expanded Medicaid prior to March 23, 2010, halts the phase up of matching rate; percentage would remain at 2017 levels of 80% for future years. (If a state's regular match rate in any year is higher than the newly eligible match rate, the regular match rate would apply, and the expansion match rate would not be available after 2023.)
Medicaid Safety-Net Fund		Provides $10 billion over 5 years (FY2018-FY2022) for states that have not implemented Medicaid expansion under the ACA as of July 1 of the preceding year. Further details under "provider payments." Spending does not count for calculating per capita caps (below).	Same as AHCA/no changes
Medicaid Global Budget Financing (per capita cap and block grants)			
Per capita cap		Uses FY2016 as the base year to establish a per capita limit for spending for each of the following groups: ● Elderly ● Blind and disabled ● Children ● ACA expansion adults ● Other eligible people not included in the first	Same as AHCA except that for states that adopted ACA expansion adults after February 2017, those adults are assigned to the "other eligible people" category for purposes of the PCC calculation. Reporting on Children with Complex Needs. The CMS 64 form is to be revised to call out CHIP and Medicaid children who have a chronic condition

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		four groups *Allocation determination.* Trends 2016 amounts through to 2019 using CPI-M. After 2019, spending targets would increase yearly, based on the medical care component of the consumer price index for urban consumers (CPI-M) for adults and children, and by CPI-M+1 for elderly and disabled groups. The base for the per capita cap excludes DSH spending, Medicare premiums and other cost sharing, and safety net provider payment, supplemental payments, and the Part D clawback (states will continue to receive these payments outside of the cap). Any state exceeding their cap will receive reductions to their Medicaid funding in the following fiscal year. The per capita cap capped funding does not apply to the following eligibility groups: ● CHIP Medicaid expansion ● Individuals receiving assistance through Indian Health Service Facilities ● Individuals entitled to coverage under the Breast and Cervical Cancer Early Detection Program ● Unauthorized aliens eligible for Medicaid emergency medical care	affecting 2 or more body parts or that affects cognitive ability requiring intensive health interventions or meets criteria for complexity under risk adjustment methodologies. Allocation determination: States chose base period -- any 8 consecutive quarters between 1Q2014 and 3Q2017. Base period trended to 2019 and indexed until 2025 by CPI-M. Elderly and disabled group indexed to CPI-M + 1 percentage point. Index changes to CPI in FY 2025 and thereafter. Base year excludes DSH, Medicare cost sharing, temporary safety net provider payment. Non-DSH supplemental payments are included in base year. The bill appears to be silent on how the Part D clawback is addressed. Per Capita Cap does not apply to certain eligibility groups. Same as AHCA with the addition of the exclusion of children eligible on the basis of disability. Drive State Per Capita Caps (PCC) to the National Average. For each eligibility group PCC in each state, when a PCC is at least 25% lower than national average, the PCC for that eligibility group is increased at least .5% but not more than 2%. For each eligibility group PCC in each state, when a PCC

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		• Individuals eligible solely for Medicaid family planning • Partial benefit dual-eligibles • Individuals eligible for premium assistance • Tuberculosis-related services	is at least 25% higher than national average the PCC for that eligibility group is decreased at least .5% but not more than 2%. Very rural states are removed from the calculation. Effective FY 2020 Spending on public health emergencies not counted toward per-capita cap spending from January 2020 until January 2025 [Added 7/13/17]
Block grant option		Starts in FY 2020, available for 10 years (afterward reverts to per capita cap). State plan amendment is approved unless HHS Secretary determines it incomplete or actuarially unsound within 30 days Applies only to traditional adult and child Medicaid populations (excluding elderly and disabled individuals). *Allocation determination.* Funding would be determined using the same base year and formula as under the per capita cap approach, indexed to CPI (not CPI-M). Federal portion of block grant funds are based on enhanced CHIP FMAP. Unused block grant funds can be rolled into the next fiscal year if the state maintains the block grant. *Program flexibility.* The only required services are	Medicaid Flexibility Program for which states makes application providing detail on eligibility categories, amount duration and scope of services, and notification of current enrollees. Approvals last 5 years. Potential new reporting requirements such as birth certificate and clinical data. State must hold a public comment period and meaningful opportunities for public input. There would be a similar federal process. *Allocation determination:* Allocation would be calculated on a per capita basis as under the PCC approach (above) for the "other, non-elderly adult" group multiplied by the number of people in that

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		the following: hospital care; surgical care and treatment; medical care and treatment; obstetrical and prenatal care and treatment; prescribed drugs and medicines, and prosthetic devices; other medical supplies and services; health care for children with the exception of Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) services. State discretion on cost sharing, delivery system model, and eligibility determination methodology.	group. The PCC amount is indexed to CPI and the total budget is the PCC multiplied by the size of the "other adult" eligibility group in 2016, indexed forward to the first year of the block grant by percentage growth in total state population since 2016 + 3 percentage points. Spending on public health emergencies not counted toward block grant spending from January 2020 until January 2025 [Added 7/13/17] At state option, the ACA adult expansion population can be included in the block grant together with, or instead of, 'other non-elderly adults' and the allocation formula would change to reflect the state choice. [Added 7/13/17] States can keep excess funds from year to year if they meet maintenance of effort requirements: uses a specified portion of federal allotment (allotment x CHIP FMAP rate) each year. ~~States can spend excess funding with few limitations.~~ [Removed 7/13/17] States must ● use MAGI eligibility, ● provide a minimum set of specified services to enrollees who would be

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			otherwise categorically eligible under current law, ● provide a benefit package that has an actuarial value at least 95% of the Sec 1937 benchmark plan. ● provide mental health/substance abuse services in amount compliant with parity laws ● limit premiums and cost sharing to 5% of family income. Effective 2020
Eligibility and enrollment			
Eligibility threshold for children	This raises Medicaid eligibility levels for all children to 138% FPL. Required some states to transition children from separate CHIP to Medicaid coverage. *Maintenance of effort (MOE).* 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.	Reverts mandatory Medicaid income eligibility for children ages 6-19 to 100% FPL. No change.	~~Same as AHCA/no change [Removed 7/13/17]~~ No change.
Redetermination of expansion population		Requires states with Medicaid expansion populations to re-determine eligibility of expansion enrollees every 6 months. Provides a temporary 5%	Same as AHCA, except that it is a state option rather than requirement, and allows states to opt to conduct redeterminations more frequently than

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		FMAP for states to comply. Effective October 1, 2017-December 31, 2019.	every 6 months.
Systems enhancements	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.	• Provides a temporary 100% FMAP for state MMIS and eligibility systems • Provides increase in other administrative matching to 60% for implementation of new data requirements. Available FY2018-FY2019	Provides a 10% and 25% increase in administrative FMAP for MSIS/TMSIS claims and other systems so that FMAP for IT is 100%. Provides a 10% (to 60%) increase in the basic administrative match rate to implement the per capita cap. Effective for expenditures in FY 2018
Enrollment simplification	Provides a new presumptive eligibility (PE) authority for hospitals.	Repealed; also eliminates PE for expansion population. Effective January 1, 2020	Same as AHCA/no change.
Retroactive coverage date		Limits the effective date of retroactive coverage of Medicaid benefits to the month in which the applicant applied. As of applications made on and after October 1, 2017	Same as AHCA/no change States would need to continue to provide up to 3 months retroactive Medicaid coverage for services provided to individuals age 65 or older or who are eligible based on blindness or disability. [Added 7/13/17]
Accounting for lottery / lump sum payments		Requires states to count monetary winnings from lotteries and other lump sum income in the month received if less than $80,000, or over two months if	Not included

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		amount is less than $90,000, over 3 months if the amount is less than $100,000, and adding 1 additional month for every additional increment of $10,000. Allows states to define a hardship exemption, within parameters established by HHS. Effective January 1, 2020	
State flexibility on home equity limits		Repeals state authority to elect a home equity limit above the statutory minimum for Medicaid eligibility determinations. Effective 180 days after enactment except where state legislation would be required to amend the state plan.	Not included
State option to institute work requirements		States can create work requirements as a condition of receipt of Medicaid coverage for non-disabled, non-elderly and non-pregnant adults. States that implement a work requirement would receive a 5% administrative FMAP increase for administrative costs associated with implementation of a work requirement. Option available beginning October 1, 2017	Same as AHCA/no change
Medicaid programmatic design			
Benchmark	Benefits for newly-eligible individuals based	Repeals requirement that Medicaid benchmark	Same as AHCA/no change

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benefits	on a Medicaid benchmark plan that includes the ACA's essential health benefits.	plans (Sec 1931 plans) provide the essential health benefits. Effective as of December 31, 2019	
Enhanced match for community-based attendant services and supports	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.	Repeals enhanced federal match (6 percent) available for community-based attendant services and supports. Effective January 1, 2020	Same as AHCA/no change
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.		Establishes a four-year home- and community-based services demonstration project that will give priority to the 15 least-populous states. Aggregate amount provided to eligible states for all years of the demonstration cannot exceed $8 billion. [Added 7/13/17] Effective January 1, 2020-December 31 2023
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.		
Medicaid health home	Established a Medicaid state plan option under Section 2703 to coordinate care through a health home model for	No change.	No change.

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	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.		
Penalty for fraud		Increases monetary penalty that may be imposed for intentional Medicaid fraud to $20,000.	Not included.
Money follows the Person	Allocated an additional $2.25 billion to the program and expanded eligibility criteria.		
Institutions for Mental Disease			Establishes a new state plan option, "Qualified Inpatient Psychiatric Hospital Services" for individuals over 21 and under 65: ● Coverage is limited to 30 consecutive days/90 days annually; ● Requires state to maintain at least the same number of beds as were owned, operated, or contracted by the state as of the day of enactment or, if higher, the date of application; ● Requires state to maintain the same annual level of funding for inpatient and outpatient psychiatric services apart from

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			new state plan option; ● Federal match rate for Qualified Inpatient Psychiatric Hospital Services is 50%. Effective October 1, 2018
Grandfathering managed care waivers			Allows states with existing managed care waivers to maintain these services under a state plan amendment, provided that the waiver provisions do not change. Secretary encourages states to adopt HCBS waivers Effective for waivers approved less than once and in place prior to January 1, 2017
Medicaid and CHIP Quality Performance Bonus Payments			Establishes quality performance bonus payments in Medicaid and CHIP beginning FY2023-FY2026. States that meet certain aggregate medical assistance expenditure targets and submit information on applicable quality measures defined by the HHS Secretary.
Enhanced FMAP for Medical Assistance to Eligible Indians			Provides 100% FMAP rate for Medicaid services for an individual who is a member of an Indian tribe or an Alaskan Native and is eligible under a Medicaid state plan. [Added 7/13/17]
Children's Health Insurance Program (CHIP)			
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	No change.	No change.

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	certain conditions were met).		
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.	No change.	No change.
Maintenance of effort (MOE)	Requires states to maintain Medicaid and CHIP eligibility levels, standards, methodologies and procedures for children that were in place in 2010 through FFY 2019.	No change.	No change.
Medicaid and CHIP Quality Performance Bonus Payments			Establishes quality performance bonus payments in Medicaid and CHIP beginning FY2023-FY2026. States that meet certain aggregate medical assistance expenditure targets and submit information on applicable quality measures defined by the HHS Secretary.
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.	No change.	No change.

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Accountable care organizations (ACOs)	The ACA defines ACOs and establishes a Medicare Shared Savings ACO program.	No change.	No change.
Medicare-Medicaid Coordination Office	Created to address issues for individuals dually-enrolled in Medicare and Medicaid.	No change.	No change.
Hospital Provider Payments			
Hospital readmissions reduction program	Penalizes hospitals for excess readmissions within 30 days of discharge. (Medicare)	No change.	No change.
Hospital-Acquired Condition (HAC) reduction program	Penalizes the worst performing quarter of hospitals. (Medicare)	No change.	No change.
Medicaid coverage for tobacco cessation for pregnant women	Medicaid must cover counseling and medication for tobacco cessation without cost sharing.		
Disproportionate Share Hospital (DSH) and other	• Reduces Medicare DSH payments and aggregates Medicaid DSH allotments.	**Repeals Medicaid DSH cuts** • In 2018 for non-expansion states. • In 2020 for expansion states.	Non-Medicaid expansion states would be exempt from Medicaid DSH reductions beginning for the remainder of FY2017 through FY2019. States with

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hospital payments	● Reduces Medicare payments to certain hospitals for hospital-acquired conditions by 1%.		below national average DSH spending would have their allotments increased each year FY2020 - FY2024 and scheduled reductions after 2024 would occur without regard to any allotment increase in non-expansion states. Reductions in expansion states continue with current law schedule. The number of uninsured—not the number of Medicaid enrollees—would be considered when calculating which non-expansion states have below national average DSH spending. [Added 7/13/17] The definition of "non-expansion state" would be broadened to include former expansion states for the quarters beginning on or after the month during which the state stops expanding Medicaid eligibility. [Added 7/13/17]
Medicaid Safety-net Fund		Provides $10 billion over 5 years (FY2018-FY2022) for states that have not implemented Medicaid expansion under the ACA as of July 1 of the preceding year. Funding may only be used to adjust payment amounts made to **safety net** providers. ● **Federal match rate for the payment adjustment amounts** is 100% for CY 2018-2021 and 95% in CY 2022. ● State allotments would be determined	Same as AHCA/no change

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		according to the number of individuals in the state below 138% FPL as published in the 2015 American Community Survey (ACS) relative to other states eligible for funding.	
Funding freeze on prohibited entities (Planned Parenthood)		Imposes a one-year freeze on mandatory funding to prohibited entities which include non-profit, essential community providers primarily engaged in family planning and reproductive health services, that provide abortions in cases that do not meet the Hyde amendment exception for federal payment and received over $350 million in federal and state Medicaid dollars in fiscal year 2014. Effective upon enactment.	Same as AHCA/no change
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).	No change.	No change.
Additional	Increased federally supported medical	No change.	No change.

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federal support for medical education	student loans, increased loan rates/amounts for nursing students. Established pediatric specialty and public health loan repayment programs.		
Community Health Center Fund		Increases funding to the Community Health Center Fund to support FQHCs for FY 2017.	Same as AHCA/no change
Quality Improvement			
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, coverage, or treatment or used to deny coverage."	No change.	No change.
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	No change.	No change.

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	quality priorities. Measure alignment is done with an eye toward minimizing provider burden.		
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	Repeals Prevention and Public Health Fund appropriations from fiscal year 2019 onward. Unobligated fund remaining at the end of FY 2018 will be rescinded.	Repeals Prevention and Public Health Fund appropriations from fiscal year 2018 onward.

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	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.		
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.	No change.	No change.
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.	No change.	No change.
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	No change.	No change.

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	and consider input from a governmental public health department.		
Other taxes to fund the law			
	Prescription Drug Tax	Repealed	Repealed Effective January 1, 2018
	Medical device tax.	Repealed.	Repealed Effective January 1, 2018
	Tanning tax.	Repealed.	Repealed Effective October 1, 2017
	Net investment tax.	Repealed.	Retained [Added 7/13/17]
	Caps remunerations to health insurance executives at $500,000.	Repealed. Effective January 1, 2017.	Retained [Added 7/13/17]
	3.8% tax on unearned income for high-income taxpayers.	Repealed. Effective January 1, 2023.	Retained[Added 7/13/17]
	Increases Medicare payroll tax rate on wages for high-wage individuals.	Repealed Effective January 1, 2017	Repealed Effective January 1, 2017
	Eliminates employer retiree drug benefit tax deduction		
	Increases to 10% the medical expense tax deduction threshold	Restores pre-ACA threshold for tax deductions based on medical-expenses (from 10% to 7.5%). Reduces threshold for tax deductions to 5.8%.	Repealed and former 7.5% threshold restated Effective January 1, 2017

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Miscellaneous			
Support for State Response to Opioid Crisis			Authorizes and appropriates $2 billion to HHS for state grants to provide individuals with mental or substance use disorders with substance use disorder treatment and recovery support services. For each of FY2018-FY2026, authorizes and appropriates $4,972,000,000 to HHS for state grants to provide individuals with mental or substance use disorders with substance use disorder treatment and recovery support services. [Added 7/13/17] For each of FY2018-FY2022, authorizes and appropriates $50.4 million for "research on addiction and pain related to the substance abuse crisis."[Added 7/13/17] Effective FY 2018

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Additional rulemaking procedures for HHS Secretary			Requires HHS Secretary to establish processes to seek input from state Medicaid agencies and directors prior to finalizing proposed rules related to Medicaid. HHS must also accept and consider written and oral comments from state Medicaid agencies or an organization that represents state Medicaid directors and incorporate these comments in the preamble to the proposed rule.
Provider Taxes			Reduces the Medicaid provider tax threshold each fiscal year by .2 percentage points, from 6% to 5% in FY2025, remaining at that level in subsequent years. Effective FY 2021

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