

August 2017

## Summary of Graham-Cassidy-Heller Amendment

This summary describes key provisions of a proposal by Senators Graham, Cassidy, and Heller, drafted as an amendment in the nature of a substitute to HR 1628, the House-passed bill to repeal and replace the Affordable Care Act (ACA).

	<b>Graham-Cassidy-Heller Amendment Senate Amendment 586</b>
Date plan announced	July 27, 2017
Overall approach	<ul style="list-style-type: none"> <li>• <b>Repeal ACA mandates (2016), and premium and cost sharing subsidies (2020).</b></li> <li>• <b>Establish new state block grant program, appropriated at \$1.043 trillion over 7 years,</b> to fund state-designed health care reform programs. Block grant funding would be instead of current federal spending for marketplace subsidies and the Medicaid expansion</li> <li>• <b>Retain private market rules, with some changes.</b> Modify age rating limit to permit variation of 5:1, unless states adopt different ratios, effective 2019. Retain essential health benefits requirement, although bill makes it somewhat easier for states to waive it.</li> <li>• <b>Create new association health plan option for small employers and self-employed individuals</b> (called “small business health plans”) established in the large group market where community rating and essential health benefits requirements do not apply.</li> <li>• <b>Retain health insurance marketplaces, annual Open Enrollment periods (OE), and special enrollment periods (SEPs).</b></li> <li>• <b>Establish new short term federal reinsurance program</b> with federal funding of \$155 billion over 3 years (2018-2020).</li> <li>• <b>Encourage use of Health Savings Accounts</b> by increasing annual tax free contribution limit and through other changes.</li> <li>• <b>Repeal enhanced FMAP for Medicaid expansion effective January 1, 2020.</b></li> <li>• <b>Convert federal Medicaid funding to a per capita allotment</b> and limit growth in federal Medicaid spending beginning in 2020. State per-enrollee amounts for 5 groups would increase at a rate of medical CPI for children and adults and medical CPI plus one percentage point for the elderly and disabled adults for 2020 – 2024 and then by CPI-U for 2025 and beyond; provide state option to receive a block grant for nonelderly non-disabled adults and/or expansion adults.</li> <li>• <b>Add state option to require work as a condition of eligibility for nonelderly Medicaid adults who are not disabled or pregnant.</b></li> <li>• <b>Prohibit federal Medicaid funding for Planned Parenthood clinics for one year.</b></li> <li>• <b>Provide supplemental funding for community health centers of \$422 million for FY 2017.</b></li> <li>• <b>No change to Medicare benefit enhancements or provider/Medicare Advantage plan payment savings.</b></li> <li>• <b>Repeal several ACA revenue provisions.</b></li> </ul>
Individual mandate	<ul style="list-style-type: none"> <li>• Tax penalty for not having minimum essential coverage is eliminated effective January 1, 2016</li> </ul>

Premium subsidies to individuals	<ul style="list-style-type: none"> <li>For 2018-2019, ACA premium tax credit formula and eligibility standards are unchanged, except <ul style="list-style-type: none"> <li>For end of year reconciliation of advance credits, the cap on repayment of excess advance payments does not apply</li> <li>Tax credits cannot be used for plans that cover abortion, effective 2018.</li> </ul> </li> <li>Starting in 2019, anyone (not just young adults and certain others) can buy a catastrophic health plan. The ACA single risk pool rating requirement also applies to catastrophic policies starting in 2019, which may have the effect of increasing premiums somewhat for such policies.</li> <li>Starting in 2020, repeal ACA income-based premium tax credits</li> </ul>
Cost sharing subsidies to individuals	<ul style="list-style-type: none"> <li>Funds (such sums as necessary) are appropriated to reimburse health insurers for cost sharing reductions effective on the date of enactment through the end of 2019.</li> <li>ACA cost sharing subsidies are repealed effective January 1, 2020.</li> </ul>
Individual health insurance market rules	<ul style="list-style-type: none"> <li>ACA market rules are retained. Prohibition on turning applicants down based on health status is not changed</li> <li>Continue ACA rating rules, except age rating of 5:1 is permitted starting January 1, 2019, unless states adopt a different ratio. Short-term non-renewable policies can continue to set premiums based on health status.</li> <li>Prohibition on pre-existing condition exclusion periods is not changed. Short term non-renewable policies can continue to exclude pre-existing conditions</li> <li>Establish new federal short term reinsurance program for insurers in the individual market. Program is funded at \$55 billion over 3 years (\$20 billion in each of 2018 and 2019, \$15 billion in 2020.)</li> </ul>
Benefit design	<ul style="list-style-type: none"> <li>ACA requirement to cover 10 essential health benefit categories is not changed. The 1332 waiver authority is amended to make it somewhat easier for states to eliminate or change the essential health benefits standard for health insurance coverage offered in the individual or small group market.</li> <li>ACA requirement for maximum out-of-pocket limit on cost sharing is not changed; however, the 1332 waiver authority is amended to make it somewhat easier for states to eliminate or change the maximum out-of-pocket limit on cost sharing.</li> <li>ACA requirement for plans to be offered at specified actuarial values/metal levels is not changed, however, the 1332 waiver authority is amended to make it somewhat easier for states to eliminate or change this requirement.</li> <li>Prohibition on lifetime and annual dollar limits is not changed; however, the prohibition applies to limits on essential health benefits, which can be changed under 1332 waiver authority</li> <li>Requirement for group plans and individual market plans to cover preventive benefits with no cost sharing is not changed.</li> <li>Requirement for all plans to apply in-network level of cost sharing for out-of-network emergency services is not changed</li> <li>Redefine qualified health plans eligible for tax credits to exclude any plan that covers abortion services beyond those for saving the life of the woman or in cases of rape or incest (Hyde amendments), effective in 2018</li> </ul>
Women's health	<ul style="list-style-type: none"> <li>ACA essential health benefit requirement for individual and small group health insurance policies is not changed, including requirement to cover maternity care as an essential health benefit; however, the 1332 waiver authority is amended to make it easier for states to change this requirement.</li> <li>Requirement for individual and group plans to cover preventive benefits, such as contraception and cancer screenings, with no cost sharing is not changed.</li> <li>Prohibition on gender rating is not changed</li> <li>Prohibition on pre-existing conditions exclusions, including for pregnancy, prior C-section, and history of domestic violence, is not changed.</li> <li>Prohibit federal Medicaid funding for Planned Parenthood clinics for one year, effective upon date of enactment. Specifies that federal funds to states including</li> </ul>

	<p>those used by managed care organizations under state contract are prohibited from going to such entity. (CBO estimates at least one other provider may also be affected.)</p> <ul style="list-style-type: none"> <li>• Redefine qualified health plans eligible for tax credits to exclude any plan that covers abortion services, beyond those for saving the life of the woman or in cases of rape or incest (Hyde amendment), effective in 2018</li> <li>• Disqualify small employers from receiving tax credits if their plans include abortion coverage beyond Hyde limitations, effective in 2018.</li> <li>• Allows tax favored health savings accounts (HSAs) to be used to pay premiums for qualified high-deductible health plans that do not include abortion coverage beyond Hyde limitations</li> <li>• Clarifies that state 1332 waivers will not affect the authority of the Secretary of HHS to enforce requirement that premiums for plans covering abortion include a separate, segregated payment for the abortion benefits</li> </ul>
Health Savings Accounts (HSAs)	<ul style="list-style-type: none"> <li>• Modify certain rules for HSAs, changes take effect January 1, 2018 unless otherwise noted: <ul style="list-style-type: none"> <li>– Increase annual tax free contribution limit to equal the limit on out-of-pocket cost sharing under qualified high deductible health plans (\$6,550 for self only coverage, \$13,100 for family coverage in 2017, indexed for inflation).</li> <li>– Additional catch up contribution of up to \$1,000 may be made by persons over age 55. Both spouses can make catch up contributions to the same HSA.</li> <li>– Amounts withdrawn for qualified medical expenses are not subject to income tax. Qualified medical expense definition expanded to include over-the-counter medications and expenses incurred up to 60 days prior to date HSA was established</li> <li>– Tax penalty for HSA withdrawals used for non-qualified expenses is reduced from 20% to 10%, effective January 1, 2017.</li> <li>– Provide that qualified medical expenses include expenses for premiums for qualified high deductible health plans; qualified premium expenses must be net of any otherwise applicable ACA premium tax credit. In addition, premium expenses claimed as deduction by self-employed individuals, or premium contribution by employees excluded from gross income cannot be paid with HSA funds</li> <li>– Also, provide that qualified medical expenses include fees paid to private concierge physician practices</li> <li>– Expenses paid with HSA funds cannot be used to pay premiums for plans that cover abortion beyond Hyde limitations</li> </ul> </li> </ul>
High-risk pools	<ul style="list-style-type: none"> <li>• States may use Market-based Health Care Grant Program funds to establish mechanisms for high-risk individuals to purchase non-group coverage, and for other purposes</li> </ul>
Selling insurance across state lines	<ul style="list-style-type: none"> <li>• No provision</li> </ul>
Exchanges/ Insurance through associations	<ul style="list-style-type: none"> <li>• State exchanges continue. Under Section 1332 waiver authority, states can waive requirements or operations of exchanges, including to allow premium tax credits to be applied to plans sold outside of exchanges.</li> <li>• Single risk pool rating requirement for plans first sold on or after January 1, 2014 is retained, though requirement can be changed or waived under Section 1332 waivers. In addition, starting in 2019 the single risk pool rating requirement applies to catastrophic plans</li> <li>• The bill authorizes establishment and federal certification of association health plans, called “small business health plans” that can offer coverage to employer groups and to self-employed individuals. (see employer section below)</li> </ul>
Dependent coverage to age 26	<ul style="list-style-type: none"> <li>• Requirement to provide dependent coverage for children up to age 26 for all individual and group policies is not changed.</li> </ul>

Other private insurance standards	<ul style="list-style-type: none"> <li>• Minimum medical loss ratio standards for all health plans are not changed</li> <li>• Requirement for all health plans to offer independent external review is not changed.</li> <li>• Requirements for all plans to report transparency data, and to provide standard, easy-to-read summary of benefits and coverage are not changed.</li> </ul>
Employer requirements and provisions	<ul style="list-style-type: none"> <li>• Tax penalty for large employers that do not provide health benefits is reduced to zero, retroactive to January 1, 2016</li> <li>• Wellness incentives permitted under the ACA are not changed</li> <li>• Repeal tax credits for low-wage small employers, effective January 1, 2020. Prohibit small business tax credits from being used to purchase plans that cover abortions beyond Hyde limitations, effective in 2018</li> <li>• Establish authority for new association plans, called “small business health plans” (SBHP). SBHPs must be fully insured health plans offered in the large group market, where modified community rating and essential health benefits are not required. Employers and self-employed individuals with no employees can obtain coverage through SBHPs. The Secretary of Labor will certify sponsors of SBHPs, under an expedited process of 90 days or less, and state laws precluding insurers from offering SBHPs are preempted. Federal certification requirements for SBHP sponsors will be determined through regulation. Secretary of Labor may conduct oversight of SBHPs. Standards prohibiting discrimination against employees and employers eligible to participate in SBHPs are satisfied if the SBHP provides appropriate notice of all coverage options it offers. A SBHP must be domiciled in a single state but can offer coverage to employers in other states</li> </ul>
Medicaid	<p><i>Financing</i></p> <ul style="list-style-type: none"> <li>• Repeal the enhanced match rate for the Medicaid expansion for states that adopted the expansion as of January 1, 2020. <ul style="list-style-type: none"> <li>– Converts coverage group for adults up to 138% FPL from mandatory to optional in the statute, as of January 1, 2020.</li> <li>– Eliminate option to extend coverage to adults above 133% FPL effective either January 1, 2017 or January 1, 2020 (two conflicting provisions in the bill)</li> <li>– Limit the “expansion state” enhanced match rate transition percentage to CY 2017 levels of 80% for 2018 and 2019.</li> </ul> </li> <li>• Convert federal Medicaid financing to a per capita cap beginning in FY 2020. <ul style="list-style-type: none"> <li>– Set total medical assistance expenditures for a state as the sum of the per-enrollee amounts for 5 groups - elderly, blind and disabled adults, children, expansion adults, and other adults - multiplied by the number of enrollees in each group. (For states opting to adopt the Medicaid expansion after FY 2016, the per-enrollee amount for this group would be the same as the other adult group under the per capita cap).</li> <li>– The base year for per-enrollee amounts is determined using state-selected 8 consecutive quarters of expenditure data from FY 2014 through the third quarter of FY 2017 for enrollees subject to the per capita caps. States implementing the expansion after in FY 2015 can use fewer than 8 but at least 4 consecutive quarters of data to determine the base amount for that group. Secretary has discretion to adjust data as deemed appropriate. Base year amounts are inflated to 2019 by medical CPI. The target expenditures in 2020 are calculated based on the 2019 per-enrollee amounts for each enrollment group adjusted to maintain the ratio of non-DSH supplemental payments to total payments and multiplied by the number of enrollees in each group. Expenditures exclude administrative costs, DSH, Medicare cost-sharing, and safety net provider payment adjustments in non-expansion states. Certain categories of individuals, including CHIP, those receiving services through Indian Health Services, those eligible for Breast and Cervical Cancer services, partial-benefit enrollees (including partial duals), and children who qualify on the basis of being blind or disabled are excluded.</li> </ul> </li> </ul>

- Increase per-enrollee amounts by medical CPI for adults and children and medical CPI plus one percentage point for the elderly and disabled for 2020 through 2024. For FY 2025 and beyond, increase per-enrollee amounts by CPI-U.
- Direct the Secretary to calculate and apply per capita cap payment provisions for categories that were not satisfactorily submitted as if they were a single 1903A enrollee category and the growth factor otherwise applied shall be decreased by one percentage point.
- Direct the Secretary to adjust target per-enrollee amounts by .5% to 2% for states spending 25% or more above and below the mean per capita expenditures to be closer to the mean beginning in 2020. (Adjustments applied in aggregate and not for each enrollee group in 2020 and 2021). Adjustments are to be budget neutral to the federal government and excludes adjustments to certain low-density states (Alaska, Montana, North Dakota, South Dakota and Wyoming). Any adjustment made will be disregarded when determining the target medical assistance expenditures for state and category for the succeeding year.
- States with medical assistance expenditures exceeding the target amount for a fiscal year will have payments in the following fiscal year reduced by the amount of the excess payments.
- Add state option to elect Medicaid block grant instead of per capita cap for nonelderly non-disabled adults and / or expansion adults for a period of 5 fiscal years, beginning in FY 2020, through the Medicaid Flexibility Program.
  - States are required to provide for eligibility for mandatory adults (including adults receiving cash assistance, pregnant women with incomes up to 133% FPL and foster care children up to age 26).
  - States must provide, as targeted health assistance, hospital care, lab and x-ray services, nursing facility services, physician services, home health care, rural health clinic and federally-qualified health center services, family planning services, pregnancy-related services including nurse midwife and freestanding birth center services. The targeted health assistance must have an actuarial value of 95% of Medicaid benchmark coverage and must include mental health and substance use disorder services on parity with physical health services. States may impose cost sharing on enrollees up to 5% of family income annually.
  - States would not have to comply with other federal requirements including comparability, statewideness, free of choice of provider, and other provisions deemed appropriate by the Secretary.
  - The block grant amount for the initial fiscal year a state elects the block grant is based on the state's target per capita medical assistance expenditures for the fiscal year multiplied by the number adult enrollees (adults in the base period increased by population growth plus three percentage points) and the federal average medical assistance matching rate for the state for the fiscal year. In subsequent fiscal years, the block grant amount is increased by annual CPI-U.
  - States have a maintenance of effort (MOE) requirement equal to the state share of the CHIP enhanced FMAP without the 23 percentage point increase. States can rollover unused block grant funds into the next fiscal year as long as they continue to elect the block grant option and meet the MOE.
  - States must submit an application that includes a description of the program, including the conditions of eligibility for program enrollees, the amount, duration and scope of services, and covered benefits; a certification that the state will meet requirements related to data and program evaluations; and a statement of program goals related to quality, access, growth rate targets,

consumer satisfaction, and outcomes. The application is subject to state and federal notice and comment periods.

- Provides for a maximum of \$5 billion for public health emergencies between 1/1/20 and 12/31/24 that is excluded from per capita cap and block grant amounts. Amounts for a state would be equal to the amount spent on medical assistance for enrollees in areas of state subject to emergency that exceeds amount spent in most recent fiscal year for that population without the emergency. Secretary must declare public health emergency and determine that exclusion is appropriate.
- Provide 100% FMAP for MMIS and eligibility systems for FY 2018 and FY 2019 and increase other administrative matching to 60% for expenses related to implementing new data requirements.
- Phase down the safe harbor threshold for provider taxes from 6.0% to 5.8% in FY 2021; 5.6% in 2022; 5.4% in 2023; 5.2% in 2024; and 5% in 2025 and beyond.
- Provide \$8 billion for FY 2023-2026 for quality performance bonus payments to states that have lower than expected medical assistance expenditures and meet quality performance or improvement for certain measures defined by the Secretary with state consultation. Payments provided to states as an increase in FMAP.
- Create a Home and Community Based Services (HCBS) demonstration of \$8 billion from January 2020 through December 2023 for 100% FMAP for HCBS provided under Section 1915 (c), (d), or (i) to per capita cap enrollees who are seniors or adults with disabilities. The Secretary shall select states with priority given to 15 with lowest population density.
- Increase federal match to 100% for medical assistance provided by non-Indian Health Service providers for tribal enrollees.
- Reduces federal match rate for territories from 55% to 50% as of January 1, 2020.

#### *Other Changes*

- Create state option to conduct eligibility redeterminations every 6 months (or more frequently) for expansion enrollees beginning October 1, 2017; increase the state administrative match rate by 5 percentage points from October 1, 2017 through December 31, 2019 for administering more frequent redeterminations.
- Eliminate 3-month retroactive coverage requirement (start eligibility “in or after” the month of application) beginning October 1, 2017 except for those 65+ or individuals eligible based on a disability
- Eliminates enrollment simplification and Marketplace coordination requirements as of January 1, 2020.
- Create state option to require work as a condition of eligibility for nondisabled, nonelderly Medicaid enrollees as of October 1, 2017, by participating in work activities as defined in the TANF program<sup>1</sup> for a period of time as determined by the state and as directed and administered by the state.
  - Exempts pregnant women through 60-days post-partum, children under 19, individuals who are the only parent/caretaker relative in family of child under age 6 or child with disability, and individuals under age 20 who are married or head of household and maintain satisfactory attendance at secondary school or equivalent or participate in education directly related to employment.
  - Provides 5 percentage point increase in the federal administration matching rate to implement the work requirement.
- Provide state option to cover qualified psychiatric hospital (IMD) services for adults ages 21-65 beginning in FY 2019. Services for individuals limited to up to 30 consecutive days and up to 90 days in a calendar year. To receive federal matching rate of 50% for these services, states must maintain the number of licensed IMD beds and the state funding for IMD services and psychiatric outpatient care as of enactment of provision or, if higher, as of date of application to provide coverage.

	<ul style="list-style-type: none"> <li>• Repeal the essential health benefits requirement for those receiving alternative benefit packages, including the expansion group, as of December 31, 2019.</li> <li>• Eliminate hospital presumptive eligibility provisions for all groups and provision allowing other providers to determine presumptive eligibility for expansion adults, effective January 1, 2020</li> <li>• Repeal enhanced FMAP for the Community First Choice Option to provide attendant care services effective January 1, 2020</li> <li>• Prohibit federal Medicaid funding for Planned Parenthood for one year, effective upon date of enactment</li> </ul>
Medicare	<p><i>Revenues</i></p> <ul style="list-style-type: none"> <li>• Reinstates the tax deduction for employers who receive Part D retiree drug subsidy (RDS) payments to provide creditable prescription drug coverage to Medicare beneficiaries, beginning after December 31, 2016</li> <li>• The HI payroll tax on high earners is not changed</li> </ul> <p><i>Coverage enhancements</i></p> <ul style="list-style-type: none"> <li>• ACA benefit enhancements (no-cost preventive benefits; phased-in coverage in the Part D coverage gap) are not changed</li> </ul> <p><i>Reductions to provider and plan payments</i></p> <ul style="list-style-type: none"> <li>• ACA reductions to Medicare provider payments and Medicare Advantage payments are not changed</li> </ul> <p><i>Other ACA provisions related to Medicare are not changed, including:</i></p> <ul style="list-style-type: none"> <li>• Increase Medicare premiums (Parts B and D) for higher income beneficiaries (those with incomes above \$85,000/individual and \$170,000/couple).</li> <li>• Authorize an Independent Payment Advisory Board to recommend ways to reduce Medicare spending if the rate of growth in Medicare spending exceeds a target growth rate.</li> <li>• Establish various quality, payment and delivery system changes, including a new Center for Medicare and Medicaid Innovation to test, evaluate, and expand methods to control costs and promote quality of care; Medicare Shared Savings Accountable Care Organizations; and penalty programs for hospital readmissions and hospital-acquired conditions.</li> </ul>
State role	<ul style="list-style-type: none"> <li>• States may determine age rating ratio; otherwise federal standard of 5:1 applies, beginning in 2019.</li> <li>• Establish new short term block grant program for states called the Market-based Health Care Grant Program. <ul style="list-style-type: none"> <li>- Appropriate funding of \$1.043 trillion over 7 years (\$140 billion for calendar year 2020, \$143 billion for 2021, \$146 billion for 2022, \$149 billion for 2023, \$152 billion for 2024, \$155 billion for 2025, and \$158 billion for 2026). Block grant funds would be available instead of ACA spending for private marketplace subsidies and the Medicaid expansion. No block grant program funding is authorized or appropriated after 2026.</li> <li>- Program funds can be used for any of 6 purposes: <ul style="list-style-type: none"> <li>▪ a program or mechanism to help high-risk individuals purchase health coverage</li> <li>▪ a reinsurance program to stabilize premiums in the private individual market</li> <li>▪ direct payments to health care providers</li> <li>▪ assistance to reduce deductibles, other cost sharing and out-of-pocket costs for individuals enrolled in the individual market</li> </ul> </li> </ul> </li> </ul>

- a program or mechanism to help individuals buy non-group coverage
  - to provide private insurance coverage to individuals who are eligible for Medicaid, except no more than 10% of a state's allotment can be used for this purpose and no block grant funding can be used to provide health insurance to the Medicaid expansion population
- The formula for allocating block grant funding to states is based on a number of factors, including the share of low-income residents in a state, population density of a state, and whether the state has elected the ACA Medicaid expansion.
- States must provide matching funds to draw down allotment of block grant funds. The required matching rate is 3% for calendar years 2020 and 2021, 4% in 2022 and 2023, and 5% in 2024-2026. Any unclaimed state allotment amounts are returned to the Treasury to reduce the federal deficit. However, in 2026, it appears unused amounts can be redistributed to other states.
- State option to establish a state based health insurance exchange remains, but states can apply, under Section 1332 waivers, to change or eliminate exchanges or to make premium subsidies available for plans sold outside of exchanges, effective January 1, 2018.
- Amend state waiver authority under Section 1332 of the ACA, effective on date of enactment:
  - As under current law, States may apply to waive the following requirements:
    - Standards for qualified health plans, including requirements to cover essential health benefits, to apply a maximum annual out of pocket limit on cost sharing, to offer plans at different metal levels;
    - Standards for state health insurance exchanges, including requirements to establish individual and SHOP exchanges, offer annual open enrollment periods, operate web sites, provide navigators, and other exchange requirements, and the requirement that Members of Congress must obtain health coverage through the Exchange;
    - Requirement to provide cost sharing subsidies; and
    - Requirement to provide premium tax credits.
  - The bill retains current law requirements that 1332 waivers must demonstrate that at least as many state residents will be insured at least as affordably and comprehensively; also that waivers will not increase the federal deficit.
  - The bill limits the Secretary's discretion to disapprove 1332 waivers; it requires that waivers shall be approved unless they increase the federal deficit or do not meet other ACA requirements. The Secretary shall establish an expedited application and approval process for 1332 waiver applications that respond to urgent or emergency situations in a state.
  - State waiver applications must explain the provision(s) to be waived, what will take the place of waived requirements, and how the waiver will provide alternative ways to promote access to coverage, affordability, and enrollment.
  - 1332 waivers will be in effect for 8 years unless State requests a shorter duration; waivers may be renewed for an unlimited number of times.
  - For FY 2017, \$2 billion is authorized and appropriated for grants to states to develop 1332 waiver applications and implement waiver plans. Funding will remain available through the end of FY 2019.
- State consumer assistance/ombudsman program is not changed, and is not funded.
- State option to establish a Basic Health Program (BHP) is retained, though federal subsidy funding that would flow through BHP would end starting in 2020.
- States continue to administer the Medicaid program with Federal matching funds available up to the federal per capita cap with the option of a block grant for certain populations.



Financing	<ul style="list-style-type: none"> <li>• Certain ACA taxes repealed, effective January 1, 2017, except where otherwise noted: <ul style="list-style-type: none"> <li>– Tax penalties associated with individual and large employer mandate, reduced to zero effective on January 1, 2016</li> <li>– Cadillac tax on high-cost employer-sponsored group health plans is suspended for tax years 2020 through 2025, no revenues shall be collected during this period</li> <li>– Excise tax on sale of medical devices, effective January 1, 2018</li> <li>– Provision excluding costs for over-the-counter drugs from being reimbursed through a tax preferred health savings account (HSA)</li> <li>– Provision increasing the tax (from 10% to 20%) on HSA distributions that are not used for qualified medical expenses</li> </ul> </li> <li>• Cap federal Medicaid funding, effective FY 2020; enhanced match for Medicaid expansion population repealed beginning January 1, 2020</li> <li>• Appropriate \$2 billion for federal administration of the premium tax credit changes, State block grant program, Medicaid changes, and other implementation responsibilities.</li> </ul>
Endnotes	<p><sup>1</sup> Work activities under the TANF program include unsubsidized employment, subsidized private sector employment, subsidized public sector employment, work experience (including refurbishing publicly assisted housing) if sufficient private sector employment is not available, on-the-job training, job search and job readiness assistance, community service programs, vocational educational training (not to exceed 12 months for any individual), job skills training directly related to employment, education directly related to employment for those who have not received a high school diploma or certificate of high school equivalency, satisfactory attendance at secondary school or in a general equivalency certificate course for those who have not already completed, and provision of child care services to an individual participating in a community service program.</p>
Sources of information	<p><a href="https://www.congress.gov/crec/2017/07/27/CREC-2017-07-27-pt1-PgS4440.pdf">https://www.congress.gov/crec/2017/07/27/CREC-2017-07-27-pt1-PgS4440.pdf</a></p>