September 2017

Summary of Graham-Cassidy-Heller-Johnson Amendment

This summary describes key provisions of a proposal by Senators Graham, Cassidy, Heller, and Johnson. 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).

	Graham-Cassidy-Heller-Johnson Amendment
Date plan announced	September 13, 2017, as amended September 25, 2017
Overall approach	• **Repeal ACA mandates (2016), and premium and cost sharing subsidies (2020).** • **Establish new state block grant program, the Market-based Health Care Grant Program, appropriated at $1.176 trillion over 7 years**, to fund state-designed health care reform programs. Block grant funding would be instead of current federal spending for marketplace premium and cost sharing subsidies and the Medicaid expansion. Effectively, states must elect block grant funding or their residents will be ineligible for any federal financial assistance for health care coverage after 2019. Additional funding of $10 billion in 2019 and $15 billion in 2020 is available to states to establish a reinsurance program. • **Retain some private market rules, but permit states to set market rules for coverage under the block grant related to covered benefits and rating based on any factor (including health status), other than gender or genetic information.** • **Encourage use of Health Savings Accounts** by increasing annual tax-free contribution limit and through other changes. • **Repeal authority to cover Medicaid expansion adults as of September 1, 2017 for non-expansion states and as of January 1, 2020 for expansion states.** Repeal the enhanced FMAP for the Medicaid expansion effective January 1, 2020. • **Convert federal Medicaid funding to a per capita allotment** and limit growth in federal Medicaid spending beginning in 2020. State per-enrollee amounts for 4 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 children and adults and medical CPI for elderly and disabled adults for 2025 and beyond; provide state option to receive a block grant for nonelderly non-disabled adults. • **Add state option to require work as a condition of Medicaid eligibility** for nonelderly adults who are not disabled or pregnant. • **Prohibit federal Medicaid funding for Planned Parenthood clinics for one year.** • **Provide supplemental funding for community health centers** of $422 million for FY 2017. • **No change to Medicare benefit enhancements or provider/Medicare Advantage plan payment savings.** • **Repeal several ACA revenue provisions.**
Individual mandate	• Tax penalty for not having minimum essential coverage is eliminated effective January 1, 2016
Premium subsidies to individuals	• For 2018-2019, ACA premium tax credit formula and eligibility standards are unchanged, except – For end of year reconciliation of advance credits, the cap on repayment of excess advance payments does not apply

	– Tax credits cannot be used for plans that cover abortion, effective 2018. • Starting in 2020, repeal ACA income-based premium tax credits
Cost sharing subsidies to individuals	• ACA cost sharing subsidies are repealed effective January 1, 2020.
Individual health insurance market rules	• Some ACA market rules are retained, including prohibition on denying coverage based on health status and prohibition on excluding pre-existing conditions. • Starting in 2020 through 2026, states will establish other market rules for coverage under the block grant related to o Rating factors. States may not permit insurers to vary premium rates on the basis of sex or genetic information. For all other factors – including health status (including pregnancy), age, occupation, neighborhood, marital status, duration of coverage, etc. – states have flexibility to permit insurers to vary insurance premiums at issue and at renewal. o Single risk pool. States may also permit insurers to establish any number of separate risk pools for individuals enrolled in health coverage ▪ Conflicting language in the bill appears to limit state flexibility to establish new rating rules only for age and geographic variation.[1] o Covered benefits. States have flexibility to determine covered benefits and the level of covered benefits. Current law requirement to offer policies at certain actuarial value levels would not apply. The current law requirement to limit annual deductibles and other cost sharing expenses under a policy would not apply. • States must continue to ensure compliance with federal laws related to insurance coverage for minimum maternity stay, mental health parity, coverage of reconstruction following mastectomy, and prohibition of discrimination based on genetic information. • Provide $25 billion over 2 years ($10 billion in 2019 and $15 billion in 2020) to states to establish reinsurance programs.
Benefit design	• ACA requirement to cover 10 essential health benefit categories no longer applies to coverage under the block grant. States shall establish rules for covered benefits under the block grant program • ACA requirement for maximum out-of-pocket limit on cost sharing no longer applies to coverage under the block grant. States shall establish rules for allowable cost sharing under the block grant program • ACA requirement for plans to be offered at specified actuarial values/metal levels no longer applies to coverage under the block grant. States shall establish rules for the actuarial value of coverage under the block grant program. • Prohibition on lifetime and annual dollar limits is not changed; however, the prohibition on annual limits applies to limits on essential health benefits, which states can redefine under the block grant program • Requirement for individual market plans to cover preventive benefits with no cost sharing no longer applies. States shall establish rules for covered benefits under the block grant program • Requirement for all plans to apply in-network level of cost sharing for out-of-network emergency services is not changed; it is not clear whether states can set different rules under the block grant program • 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
Women's health	• ACA essential health benefit requirement, including requirement to cover maternity care as an essential health benefit, for individual and small group health insurance policies no longer applies to coverage under the block grant. States shall establish rules for covered benefits under the block grant program • Requirement for individual plans to cover preventive benefits, such as contraception and cancer screenings, with no cost sharing no longer applies to coverage under the block grant. States shall establish rules for covered benefits under the block grant program

	• Prohibition on gender rating is not changed • Prohibition on pre-existing conditions exclusions, including for pregnancy, prior C-section, and history of domestic violence, is not changed • Prohibition on rating based on health status, including pregnancy, appears to be changed for coverage under the block grant program. States can establish rating rules and allow premiums to vary for individuals, except premiums cannot vary based on sex or genetic information. • Prohibit federal Medicaid funding for Planned Parenthood clinics for one year, effective upon date of enactment. Specifies that federal funds to states including those used by managed care organizations under state contract are prohibited from going to such entity • 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 • Disqualify small employers from receiving tax credits if their plans include abortion coverage beyond Hyde limitations, effective in 2018 • New block grant funds cannot be used to pay for abortion or for health insurance coverage of abortion • Prohibit HSA funds from being used to pay for either abortion services or premiums for plans that include coverage for abortion beyond Hyde limitations Clarify that state 1332 waivers will not affect the authority of the Secretary of HHS to enforce the requirement that premiums for plans covering abortion include a separate, segregated payment for the abortion benefits
Health Savings Accounts (HSAs)	• Modify certain rules for HSAs, changes take effect January 1, 2018 unless otherwise noted: – 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). – Additional catch up contribution of up to $1,000 may be made by individuals over age 55. Both spouses can make catch up contributions to the same HSA. – 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 – Tax penalty for HSA withdrawals used for non-qualified expenses is reduced from 20% to 10%, effective January 1, 2017. – 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 – Also, provide that qualified medical expenses include fees paid to private concierge physician practices – Expenses paid with HSA funds cannot be used to pay for either abortion services or premiums for plans that include coverage for abortion beyond Hyde limitations
High-risk pools	• States may use block grant funds to establish mechanisms for high-risk individuals to purchase non-group coverage, and for other purposes
Selling insurance across state lines	• No provision
Exchanges/ Insurance through associations	• The bill does not change ACA provisions requiring establishment of State exchanges. Other language eliminating marketplace subsidies and allowing states to set rules for covered benefits, cost sharing, rating practices, and the number of allowable risk pools within a market seems to mean that exchanges would not continue.

	• Single risk pool rating requirement for plans no longer applies. States may set rules for the number of allowable risk pools within a market as part of the block grant program
Dependent coverage to age 26	• Requirement to provide dependent coverage for children up to age 26 for all individual and group policies is not changed.
Other private insurance standards	• Minimum medical loss ratio standards for all health plans are not changed • Requirement for all health plans to offer independent external review is not changed. • Requirements for all plans to report transparency data, and to provide standard, easy-to-read summary of benefits and coverage are not changed.
Employer requirements and provisions	• Tax penalty for large employers that do not provide health benefits is reduced to zero, retroactive to January 1, 2016 • Wellness incentives permitted under the ACA are not changed • 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
Medicaid	*Financing* • Repeal the enhanced match rate for the Medicaid expansion for expansion states as of January 1, 2020. – Eliminate coverage group for adults up to 138% FPL as of September 1, 2017 for non-expansion states and as of January 1, 2020 for expansion states. – Eliminate option to extend coverage to adults above 133% FPL as of September 1, 2017 for non-expansion states and as of January 1, 2020 for expansion states – Creates new mandatory coverage group as of January 1, 2020 for members of Indian tribes up to 138% FPL in states that had expanded coverage as of December 31, 2019, who were enrolled in Medicaid as of December 31, 2019, and do not have a break in eligibility of 6 months (or a longer period specified by the state). – Ends the "expansion state" enhanced match rate transition percentage as of January 1, 2020. • Convert federal Medicaid financing to a per capita cap beginning in FY 2020. – Set total medical assistance expenditures for a state as the sum of the per-enrollee amounts for 4 groups - elderly, blind and disabled adults, childrenand other adults – multiplied by the number of enrollees in each group. – 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 that did not provide Medicaid to individuals in the nonelderly non-disabled adult category as of 7/1/15, but did provide coverage for that category subsequently but not later than the 4th quarter of FY 2016, can use fewer than 8 but at least 4 consecutive quarters (as drafted does not appear to apply to any state as all states cover some low-income parents and pregnant women). 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.

  - 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 for adults and children and medical CPI for elderly and disabled.
  - 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 the mean per capita expenditures and by .5% to 3% for states spending 25% or more 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).
  - 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 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 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.
- Provide 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 designing, developing, installing, and operating information processing and retrieval systems for FY 2018 and 2019 for states that select the most recent 8 consecutive quarters for which data are available as their per capita cap base period.
- Reduce FY 2021-2025 DSH cuts for certain states (amount of reduction is the difference between the state's CY 2020 Market-based Health Care Grant Program (described below) allotment increased by medical-CPI and the state's allotment for the last CY). Provides 1-time DSH increase for FY 2026 for these states (increase is the difference between state's total DSH cuts for FY 2021-2025 and the total DSH cut reduction received by the state for FY 2021-2025).
- Phase down the safe harbor threshold for provider taxes from 6.0% to 5.6% in FY 2021; 5.2% in 2022; 4.8% in 2023; 4.4% in 2024; and 4% 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.
- Increase FMAP for states that have separate poverty guidelines in 2017 that are higher than the poverty guidelines for most states (Alaska and Hawaii), effective as of the 2nd quarter of FY 2018 and for each FY thereafter, as follows: Alaska's FMAP shall be increased by 25% of the weighted average of the FMAPs for states that did not have a separate poverty guideline, and Hawaii's FMAP shall be increased by 15% of the weighted average of the FMAPs for states that did not have a separate poverty guideline, not to exceed 100%.

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.
- Change 3-month retroactive coverage requirement to 2 months 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[2] 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, 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, regular participants in inpatient or intensive outpatient substance use disorder

	treatment and rehabilitation programs that satisfy state criteria, and full-time students at institutions of higher education. – 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. 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. Federal matching funds are 50% or the state's regular FMAP as of September 30, 2018. • Repeal the essential health benefits requirement for those receiving alternative benefit packages, including the expansion group, as of December 31, 2019. • Eliminate hospital presumptive eligibility provisions for all groups and provision allowing other providers to determine presumptive eligibility for expansion adults and low-income parents, effective January 1, 2020 • Repeal enhanced FMAP for the Community First Choice Option to provide attendant care services effective January 1, 2020 • Prohibit federal Medicaid funding for Planned Parenthood for one year, effective upon date of enactment • Require states to report on (1) spending and enrollment for the groups that will be subject to the per capita cap and those to be excluded from the per capita cap beginning 10/1/18, (2) IMD spending beginning 60 days after enactment, and (3) data on children with complex medical conditions beginning 1/1/20.
Medicare	*Revenues* • Reinstate 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 • The HI payroll tax on high earners is not changed *Coverage enhancements* • ACA benefit enhancements (no-cost preventive benefits; phased-in coverage in the Part D coverage gap) are not changed *Reductions to provider and plan payments* • ACA reductions to Medicare provider payments and Medicare Advantage payments are not changed *Other ACA provisions related to Medicare are not changed, including:* • Increase Medicare premiums (Parts B and D) for higher income beneficiaries (those with incomes above $85,000/individual and $170,000/couple). • 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. • 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.
State role	• Establish new short-term block grant program for states called the Market-based Health Care Grant Program. – Appropriate funding of $1.176 trillion over 7 years ($146 billion for calendar year 2020, $146 billion for 2021, $157 billion for 2022, $168 billion for 2023,

$179 billion for 2024, $190 billion for 2025, and $190 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.

- Program funds can be used for any of 7 purposes:
  - a program or mechanism to help high-risk individuals purchase health coverage
  - a reinsurance program to stabilize premiums in the private individual market
  - direct payments to health care providers
  - assistance to reduce deductibles, other cost sharing and out-of-pocket costs for individuals enrolled in the individual market
  - a program or mechanism to help individuals buy non-group coverage
  - to provide private insurance coverage to individuals who are eligible for Medicaid, limited to no more than 15% of a state's allotment, except that states may use 20% of their allotment for this purpose if states submit a waiver application and the Secretary determines that funds are used to supplement and not supplant state Medicaid spending and provided that states certify that block grant funds will not be used to finance the non-Federal share of Medicaid or other spending
  - to provide private managed care coverage to individuals who are not eligible for Medicaid or CHIP
- Block grant funds cannot be used for health insurance coverage of abortion or to pay for abortion; block grant funds cannot be used for required state contributions; Medicaid/CHIP rules for citizenship and documentation apply to state uses of block grant funds
- States providing coverage through this program will set rules relating to insurer rating practices and covered benefits. No standard is established under the bill for state rules except that states may not allow premiums to be based on sex or genetic information. States can allow rating based on health status and any other factor. States can set standards (if any) for covered benefits and allowable cost sharing under insurance policies.
- States must use at least 50% of block grant funds to provide assistance to individuals with incomes 50%-300% of the poverty level.
- Allocation of block grant amounts in 2020 is based on State spending in the premium assistance base period inflated to November 2019. The premium assistance base period amount is determined using state-selected 4 consecutive quarters from FY 2014 through the first quarter of FY 2018 for federal payments to states for Medicaid expansion enrollees and Basic Health Program (BHP) enrollees, and advance payment of premium tax credits (APTCs) and cost sharing subsidies provided to marketplace enrollees. Base period amounts for Medicaid expansion payments are inflated to November 2019 by the projected increase in Medicaid expenditures as determined by the Medicaid and CHIP Payment and Access Commission. Base period amounts for BHP payments, APTCs, and cost sharing subsidies are inflated to November 2019 by medical CPI.
- The base period amount for low density states with per capita health care spending that is 20% greater than the average per capita spending across all states will be increased by the percentage by which the state's per capita spending exceeds the average spending.
- In 2026, the allocation of block grant funding is equal to 4/10 of the base period amount and 6/10 based on the ratio of the number of low-income residents with incomes 50%-138% of the poverty level to the total number of

	low-income residents (50%-138% FPL) across all states. Allocations for 2021-2025 would phase-in the transition from the allocation based on the state's base period funding to the allocation in 2026 based on the state's share of the low-income population. – Beginning in 2022, adjustments to state allocations will also be made based on population risk factors using clinical risk categories and may be adjusted based on population factors that impact health expenditures, including demographic characteristics, wage rates, cost of care, and income. If the total state allocation amounts using the specified formula and including any adjustments exceed the appropriated block grant amount for any year, the amount for each state would be reduced proportionally. If the allocations are less than the appropriated block grant amount, additional funds will be distributed based on the state's share of low-income residents with incomes 50%-138% of the poverty level. – An additional $6 billion in 2020 and $5 billion in 2021 will be available to increase the block grant amounts for states—25% of the total will go to low-density states; 50% will go to non-expansion states; and 25% will go to expansion states. – An additional $750 million is appropriated to increase the allotments for 2023-2026 for states that implemented the Medicaid expansion after December 31, 2015. This provision appears to benefit Louisiana and Montana. • The bill does not amend ACA state waiver authority under Section 1332. However, it requires that pass-through funding continue to be available to states with approved 1332 waivers from 2020 through 2023 and appropriates $500 million for these payments. • State consumer assistance/ombudsman program is not changed, and is not funded. • State option to establish a Basic Health Program (BHP) is not changed, though federal funding to support BHP would end 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	• Certain ACA taxes repealed, effective January 1, 2017, except where otherwise noted: – Tax penalties associated with individual and large employer mandate, reduced to zero effective on January 1, 2016 – Excise tax on medical devices repealed, effective January 1, 2018 – Provision excluding costs for over-the-counter drugs from being reimbursed through a tax preferred health savings account (HSA) – Other expansions of HSA tax preferences, effective January 1, 2018 – Provision increasing the tax (from 10% to 20%) on HSA distributions that are not used for qualified medical expenses • Cap federal Medicaid funding, effective FY 2020; enhanced match for Medicaid expansion population repealed beginning January 1, 2020 • Appropriate $2 billion for federal administration of the premium tax credit changes, State block grant program, Medicaid changes, and other implementation responsibilities.
Endnotes	[1] Section 204 of the proposal contains two provisions that appear in conflict. Basically, the section says that certain ACA rules no longer apply to coverage funded by the block grant. These include a portion of ACA rating rules (relating to geography and age rating), rules requiring coverage of essential benefits, preventive benefits, rules capping deductibles and other cost sharing in a year, the requirement to offer child only plans, and the single-risk-pool rating requirement. By specifying a list of provisions that no longer apply, this language retains other current law provisions that would continue to apply. However, the section goes on to say states can establish rules for rating practices, covered benefits, and the number of risk pools insurers can establish in a market for health insurance established under a coverage program funded by the block grant, and if

	those rules conflict with any of several specified provisions in the law, the state's rule are considered to be in compliance with the specified provisions (even if they are not). With respect to rating rules, the section could be read to allow States to only further vary rating rules with respect to rating based on age and geographic location. States also can allow insurers to have more than one risk pool. However, because Section 204 goes on to explicitly say that states in their application must identify the criteria by which a health insurer could vary premiums for coverage (except that in no case could an insurer vary premiums based on sex or genetic information) the bill could also be read to allow States to allow rating variation based on <u>any</u> factor, other than sex or genetic information. Inclusion of this language would make no sense if the intent was to limit state flexibility to only change existing rating provisions with respect to geography and age. [2] 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.
Sources of information	https://www.cassidy.senate.gov/imo/media/doc/LYN17752.pdf