THE HENRY J. KAISER FAMILY FOUNDATION

Filling the need for trusted information on national health issues...

June 2017 | Updated July 13, 2017

Summary of the Better Care Reconciliation Act of 2017

This summary describes key provisions of H.R. 1628, the Better Care Reconciliation Act of 2017, an amendment in the nature of a substitute proposed in the Senate on June 22, 2017 and revised on July 13, 2017, as a plan to repeal and replace the Affordable Care Act (ACA) and make fundamental changes to Medicaid financing through the Fiscal Year 2017 budget reconciliation process.

	Better Care Reconciliation Act of 2017 H.R. 1628
Date plan announced	Discussion draft proposed in Senate June 22, 2017 and revised July 13, 2017
Overall approach	• **Repeal ACA mandates (2016), and cost sharing subsidies (2020).** • **Modify ACA premium tax credits starting in 2020**. Extend eligibility to individuals with income under 100% FPL, end eligibility for income above 350% FPL. Tie subsidy level to a less expensive benchmark plan with 58% actuarial value (AV) and change required individual contributions at income levels above 150% FPL so younger people pay less toward subsidized coverage and older adults pay more. • **Retain private market rules, except as described below,** including requirement to guarantee issue coverage, set premiums based on modified community rating, prohibition on pre-existing condition exclusions, requirement to extend dependent coverage to age 26. Require waiting periods of 6 months for people who buy non-group coverage unless they have had continuous coverage throughout the prior 12-month period. 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 easier for states to waive it. • **Permit insurers to elect to sell non-compliant plans outside of Marketplaces.** If insurers sell ACA-compliant plans through the Marketplace in a rating area, they could elect to sell other non-compliant plans outside of the Marketplace for which most ACA rules would not apply (guaranteed issue, community rating, prohibition on pre-ex exclusion periods, requirements to cover essential health benefits and preventive benefits, limits on out-f-pocket cost sharing, etc.) About 40% of funding available under a new State Stability and Innovation Program would be transferred over to a new program to help moderate the increase in compliant plan premiums that would result from the sale of competing non-compliant plans. • **Create new association health plan option for small employers and self-employed individuals** (called "small business health plans") established in the large group market where community rating and essential health benefits requirements do not apply. • **Retain health insurance marketplaces, annual Open Enrollment periods (OE),** and special enrollment periods (SEPs). • **Establish State Stability and Innovation Program** with federal funding of $182 billion over 9 years. Program divided into short-term and long-term funding. Short-term funding of $50 billion, to be used for reinsurance program for calendar years 2018-2021, administered by CMS. Insurers in every state are eligible to participate. Long-term program with funding of $132 billion from 2019-2026 is available for states to use for 4 purposes (state reinsurance programs, reducing the cost of health insurance for high-risk individuals, providing health insurance by funding help to

	reduce out of pocket cost sharing, and direct payments to providers), though a minimum portion of total funding must be used for reinsurance. State matching funding is required for long-term program beginning in 2022. 1% of all short-term and long-term funding is reserved for additional payments in states where health insurance premiums are at least 75% higher than the national average (currently, this would be Alaska). • **Encourage use of Health Savings Accounts** by increasing annual tax free contribution limit and through other changes. • **Phase out enhanced FMAP for Medicaid expansion to states that adopted the expansion as of March 1, 2017 from 90% in 2020 to traditional state match by 2024.** • **Convert federal Medicaid funding to a per capita allotment** 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. • **Add state option to require work as a condition of eligibility for nonelderly Medicaid adults who are not disabled or pregnant.** • **Prohibit federal Medicaid funding for Planned Parenthood clinics for one year.** • **Appropriate $44.748 billion for FY 2018 through FY 2026 for grants to states to support substance use disorder treatment and recovery support services.** In addition, appropriates $50.4 million per year for each of FY 2018 through FY 2022 for research on addiction. Eliminate funding for Prevention and Public Health Fund starting in FY 2019. 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 most ACA revenue provisions.**
Individual mandate	• Tax penalty for not having minimum essential coverage is eliminated effective January 1, 2016 • Impose new waiting period penalty for people who have a break in coverage when they apply for a non-group policy, starting January 1, 2019. For people who apply during Open Enrollment, those who cannot demonstrate continuous creditable coverage (with no break longer than 63-consecutive days) for the 12-month period prior to application, a 6-month waiting period will apply in the non-group market. For people who apply during a Special Enrollment Period (SEP), the waiting period will apply for those who cannot demonstrate either 12 months of continuous creditable coverage or at least 1 day of creditable coverage during the 60-day period leading up to the date of application. The waiting period will start on the date a person applies for coverage and last until the first day of the first month that begins 6 months later. For people signing up during the year outside of a special enrollment period (which the law does not permit), the waiting period will run 6 months from the date a person applies or to the end of the calendar year, whichever is later. The waiting period does not count as a gap in coverage (for purposes of counting creditable coverage) and coverage and premiums start at the end of the waiting period. • The waiting period penalty will not apply to newborns or newly adopted children who are enrolled in coverage within 30 days. ○ In addition, the waiting period will not apply to individuals who are enrolled in other individual health insurance coverage (including, it seems, under a non-compliant plan) on the day before the effective date of coverage in which the individual is newly enrolling • The Secretary shall require health insurance issuers and health care sharing ministries to provide certificates of creditable coverage for purposes of verifying continuous creditable coverage. This provision would take effect for coverage beginning January 1, 2019. • Under the bill, insurers can also offer non-compliant plans for which most ACA market rules do not apply. (See below). Non-compliant plans are not considered creditable coverage for purposes of counting continuous coverage.

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; and penalty for erroneous claim of premium tax credit is increased to 25%.
	  – Tax credits cannot be used for plans that cover abortion, effective 2018.
	• Starting in 2020, modify ACA income-based tax credits as follows:
	  – Income eligibility for the credit is 0% FPL to 350% FPL
	  – The tax credit amount is tied to the median priced marketplace plan with actuarial value of 58%. The Secretary has authority to increase this actuarial value standard if it determines that no plan will be offered at that standard in a rating area
	  – The required individual contribution amount is changed for people with income above 150% FPL. The contribution amount is reduced for younger individuals and increased for older individuals at the same income level. For example, at 350% FPL, a 29-year old is required to contribute 6.4% of income toward the premium while a 60-year-old is required to contribute 16.2% of income.
	  – Current law requires reduction of tax credit amounts if aggregate subsidy costs exceed 0.504% of GDP for the preceding year; the bill lowers this threshold to 0.4%
	  – In general, individuals who are not incarcerated and who are not eligible for coverage through an employer plan, Medicare, Medicaid or CHIP, or TRICARE, are eligible for tax credits.
	  – Individuals who are offered any employer sponsored health plan (regardless of affordability or minimum value) are not eligible for tax credits
	  – Eligibility for noncitizens is restricted. Currently, individuals lawfully present in the U.S. are eligible; the bill restricts eligibility to "qualified aliens," a narrower category that would exclude, for example, individuals in the U.S. on worker visas or student visas.
	• Taxpayers who are also enrolled in qualified small employer health reimbursement arrangements (HRA) that apply to non-group coverage will have tax credit reduced, but not below zero, by the amount of the HRA benefit.
	• Premium tax credit can be applied to any eligible individual health insurance policy sold on the exchange.
	• Starting in 2019, anyone (not just young adults and certain others) can buy a catastrophic health plan. Starting in 2020, tax credits can also be applied to catastrophic policies, which have roughly the same actuarial value as the new benchmark 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.
	• Eligible policies do not include those for which substantially all coverage is for excepted benefits; policies that cover abortion (with Hyde exceptions) are not eligible policies.

Cost sharing subsidies to individuals	• 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. • ACA cost sharing subsidies are repealed effective January 1, 2020.
Individual health insurance market rules	New language in the bill would set up a system of parallel market rules. Insurers that offer ACA-compliant plans through the Marketplace would have the option to also offer non-compliant plans outside of the Marketplace starting in 2020 through 2026

	For ACA-compliant plans:
	• Require guaranteed issue of all non-group health plans during annual open enrollment. Insurers also must offer 60-day special enrollment periods (SEP) for individuals after qualifying events. However, a waiting period of 6 months will apply to people enrolling in non-group coverage who cannot demonstrate that they were continuously covered during the prior 12-month period. (Continuous coverage is defined as no break longer than 63 consecutive days.) People are considered enrolled in health insurance during the waiting period, but they do not owe premiums and claims will not be covered during the waiting period. Short-term non-renewable policies can continue to be sold using medical underwriting.
	• 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.
	• Prohibition on pre-existing condition exclusion periods is not changed. Short term non-renewable policies can continue to exclude pre-existing conditions
	
	For non-compliant plans
	• Starting with the 2020 plan year, insurers may notify the Secretary and State insurance regulator that they intend to offer non-compliant plans in a rating area outside of the marketplace; notifications must be made on or before May 3 of the preceding year
	• To offer non-compliant plans, an insurer must offer at least one benchmark compliant plan on the Marketplace, as well as a plan at the gold level and at the silver level.
	• The following ACA insurance market rules would not apply to non-compliant plans:
	  ○ Qualified health plan standards, including requirements for plans to cover essential health benefits and to limit annual out-of-pocket cost sharing
	  ○ Modified community rating (premiums cannot vary based on health status)
	  ○ Guaranteed issue (applications cannot be denied based on health status)
	  ○ Prohibition on pre-existing condition exclusion periods
	  ○ Nondiscrimination standards
	  ○ Prohibition on excessive waiting periods
	  ○ Requirement to cover preventive health services with no cost sharing
	  ○ Minimum medical loss ratio standards
	• Premium tax credits cannot be applied to non-compliant plans offered outside of the marketplace
	• Premiums for non-compliant plans can be paid for with funds from a health savings account (HSA)
	• The bill appears to not override state law; states could prohibit or limit the offering of non-compliant plans.
	• Coverage under a non-compliant plan is not considered creditable coverage for purposes of satisfying the continuous coverage requirement. However, it appears that if a person is enrolled in an individual health insurance policy (including a non-compliant plan) the day before coverage under another new plan takes effect, the 6-month waiting period penalty will not apply.
	• Non-compliant plans will not be part of the federal risk adjustment program. Non-compliant plans continue to be subject to the single-risk-pool rating requirement, though it is not clear how that would work.
	• States may use State Stability and Innovation Program funding to reduce premiums for compliant marketplace plans if a health insurer in the state is offering non-compliant plans outside of the marketplace
	• States that receive 1332 waivers cannot use pass through funding to help pay for non-compliant plans
	• Additional funds are appropriated under State Stability and Innovation Program to help offset state regulatory costs in states where non-compliant plans are offered.

Benefit design	• ACA requirement for compliant plans to cover 10 essential health benefit categories is not changed; however, the 1332 waiver authority is amended to make it easier for states to eliminate or change the essential health benefits standard for health insurance coverage offered in the individual or small group market.

	• ACA requirement for maximum out-of-pocket limit on cost sharing is not changed; however, the 1332 waiver authority is amended to make it easier for states to eliminate or change the maximum out-of-pocket limit on cost sharing. • ACA requirement for compliant plans to be offered at specified actuarial values/metal levels is not changed, however, the 1332 waiver authority is amended to make it easier for states to eliminate or change this requirement. • 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 • Requirement for group plans and compliant individual market plans to cover preventive benefits with no cost sharing is not changed. • Requirement for all plans to apply in-network level of cost sharing for out-of-network emergency services is not changed • Prohibit abortion coverage from being required. Federal premium tax credits cannot be applied to plans that cover abortion services, beyond those for saving the life of the woman or in cases of rape or incest (Hyde amendment). Nothing prevents an insurer from offering or an individual from buying separate policies to cover abortion as long as no premium tax credits are applied.
Women's health	• 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. • Requirement for individual and group plans to cover preventive benefits, such as contraception and cancer screenings, with no cost sharing is not changed. • 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. • 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. Insurance issuers that cover abortion beyond Hyde limitations in any of their plans are not eligible for short-term assistance funds made available under the State Stability and Innovation Program. • 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 • 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 • Allows non-compliant health plans to offer policies that exclude maternity care and no-cost preventive services (including contraceptive coverage, mammography and other preventive services for women)
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 persons 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 – In addition, premiums for non-compliant plans offered outside of the marketplace can be paid with HSA funds – HSA funds cannot be used to pay premiums for plans that cover abortion beyond Hyde limitations
High-risk pools	• States may use State Stability and Innovation Program grants to fund high-risk pools, and for other purposes
Selling insurance across state lines	• No provision
Exchanges/ Insurance through associations	• 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. • 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 • 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)
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 sunset for plan years beginning in 2019. Thereafter, States shall establish minimum medical loss ratios for group and non-group policies and rules governing annual rebates to enrollees • 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 • 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

Medicaid

Financing

- Limit and phase down the enhanced match rate for the Medicaid expansion for states that adopted the expansion as of March 1, 2017 to 90% in CY 2020 (same as current law), 85% in 2021, 80% in 2022, 75% in 2023 and then to the regular state match rate in 2024 and beyond.
  - Eliminate option to extend coverage to adults above 133% FPL effective December 31, 2017
  - Limit the "expansion state" enhanced match rate transition percentage to CY 2017 levels of 80% (instead of phasing up the match to equal the ACA enhanced match rate by 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 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).
  - 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.
  - 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.
- Decrease per capita cap target medical assistance expenditures by the amount of certain expenditures required by political subdivisions of certain states that are

unreimbursed by the state beginning in FY 2020 – as written appears to apply only to New York.[1]

- 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.
- Exempt non-expansion states from DSH cuts. Provide an increase in the FY 2020 DSH allotment for non-expansion states where the 2016 DSH allotment divided by the number of uninsured individuals is below the national average in an amount that would increase the ratio up to the national average ratio. These increases would not be applicable to determining the DSH allotment in 2024 and beyond. Provide $10 billion over 5 years (FY2018 – FY 2022) to non-expansion states for safety-net funding (applies to states not adopting the expansion by July 1 of the previous year). Allotments based on the number of individuals in the State with income below 138% of FPL in 2015 relative to the total number of individuals with income below 138% of

FPL for all the non-expansion States in 2015. Payments 100% funded by the federal government in FY 2018-2021 and 95% in FY 2022. Payments to providers may not exceed providers' costs in providing health care services to Medicaid and uninsured patients. States receiving these funds in a year in which they also adopt expansion shall no longer be eligible to receive these funds in any subsequent year.

- 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.

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
- 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, 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.
- Require states to report on qualified expenditures for IMDs (inpatient psychiatric hospital services) within 60 days post enactment and to report on children with complex medical conditions by January 1, 2020.
- Grandfather certain managed care waivers (those renewed at least 1 time) to continue without application. Modifications would require an application, but would be deemed approved unless the Secretary issues a denial or request for additional information within 90 days of application. Also requires the Secretary to implement procedures to encourage states to adopt or extend HCBS waivers.
- 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.
- 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, 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 Secretary to coordinate with states on a regular and ongoing basis with regard to rules and implementation of provisions in the bill.
Medicare	*Revenues* • Repeal the annual fee paid by branded prescription drug manufacturers, beginning after December 31, 2017 • 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	• States may determine age rating ratio; otherwise federal standard of 5:1 applies, beginning in 2019. • Establish new State Stability and Innovation Program within Title XXI of the Social Security Act (so Hyde restrictions on spending for abortion and abortion coverage apply). Short-term and long-term assistance is provided under the Program – For short-term program, $50 billion is authorized and appropriated for 4 calendar years ($15 billion for each of calendar years 2018 and 2019, $10 billion for each of calendar years 2020 and 2021.) Short-term funding will be used for reinsurance. CMS will administer reinsurance program and make payments directly to health insurers. The CMS Administrator appears to have authority to design reinsurance program features (such as attachment point, coinsurance rates, etc.) as the bill does not specify these details. Insurers will notify CMS of their intent to participate in reinsurance program (within 35 days of date of enactment for calendar year 2018; and for later years, by March 31 of previous year.) No state matching funds are required for short term reinsurance program.

- 1% of funding otherwise available under the short-term program is reserved and will be made available to issuers in states where health insurance premiums exceed the national average by at least 75% (Alaska)
- A separate long-term program is authorized for 2019 through 2026. The bill appropriates $132 billion for 8 years ($8 billion for calendar year 2019, $14 billion for each of calendar years 2020 and 2021, $19.2 billion for each of calendar years 2022 through 2026. States must apply for funding for a year no later than March 31 of the prior year.
  - Long-term funding can be used for one or more of four specified purposes: to help high-risk individuals buy health insurance coverage, including by reducing their premiums; to stabilize private insurance premiums (reinsurance); to make direct payments to health care providers; or to provide health insurance coverage through the individual market by funding assistance to reduce out-of-pocket costs. However, for 2019, 2020, and 2021, at least $5 billion of the amounts appropriated for each year must be used for state reinsurance programs.
  - Long-term funding will be allocated among states based on a methodology to be developed by CMS. Any unallocated funds will be distributed to other states with an approved application.
  - For long-term program, state matching funding of 7% is required starting in 2022, phasing up to 35% in 2026.
  - 1% of funding otherwise available under the long-term program is reserved and will be made available to states where health insurance premiums exceed the national average by at least 75% (Alaska)
  - An additional $2 billion is appropriated to this fund for the period 2020-2026 for states to where insurers offer non-compliant plans. This funding is available to offset state regulatory and oversight expenses. State matching is not required to draw down allotments from this $2 billion funding.
  - $70 billion will be transferred out of the Long Term State Stability program to the Secretary. For 2020 through 2026 the Secretary will use the $70 billion to make federal reinsurance payments to compliant plans (offered by insurers that also offer non-compliant plans) to help bring down the cost of compliant plans. (Compliant plans would effectively become high-risk pools, so their costs would increase dramatically)

- 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 repeals the following standards for granting 1332 waivers:

	▪ Requirement that coverage under the waiver program will be at least as comprehensive as the ACA would otherwise provide; ▪ Requirement that coverage and cost sharing protections are at least as affordable as the ACA would otherwise provide; and ▪ Requirement that at least as many state residents will be insured – The bill retains the current law requirement that 1332 waivers cannot result in an increase in the federal deficit. – The bill eliminates the Secretary's discretion to disapprove 1332 waivers; it requires that waivers shall be approved unless they increase the federal deficit. 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. – Any 1332 waivers already approved as of the date of enactment continue to be subject to 1332 requirements under current law; waivers submitted but not yet approved as of the date enactment can be governed by current law standards or new standards, at the State's option. – 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. States may also use funds from the Long-term State Innovation and Stability allotment to implement a waiver plan. • Appropriate $4.972 billion for each of FY 2018 through 2026 for grants to states to support substance use disorder treatment and recovery support services. In addition, appropriate $50.4 million per year for each of FY 2018-2022 for research on addiction and pain related to the substance abuse crisis. • 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 be reduced. • 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	• ACA taxes repealed, effective January 1, 2018, except where otherwise noted: – Tax penalties associated with individual and large employer mandate, reduced to zero effective on January 1, 2016 – 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 – Tax on tanning beds, effective for services received after September 30, 2017 – Tax on health insurers – Tax on pharmaceutical manufacturers – Excise tax on sale of medical devices – Provision excluding costs for over-the-counter drugs from being reimbursed through a tax preferred health savings account (HSA) – Provision increasing the tax (from 10% to 20%) on HSA distributions that are not used for qualified medical expenses, effective January 1, 2017. – Annual limit on contributions to Flexible Spending Accounts (FSAs) repealed – Annual limit on deduction for salary in excess of $1 million paid to employees of publicly held corporations repealed – Income threshold for medical expense deduction reduced from 10% to 7.5%, effective January 1, 2017

	• Cap federal Medicaid funding, effective FY 2020; enhanced match for Medicaid expansion population phased out beginning January 1, 2020 • Appropriate $500 million for federal administration of the premium tax credit changes, State Stability and Innovation Program, Medicaid changes, and other implementation responsibilities.
Endnotes	[1] State must have had FY 2016 DSH allotment more than six times the national average. Contributions required by the state from political subdivisions that, as of the 1st day of the CY in which the FY begins, has a population of more than 5,000,000 and imposes a local income tax and those for administrative expenses if required as of January 1, 2107 are included. [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.budget.senate.gov/imo/media/doc/BetterCareJuly13.2017.pdf