Comparison of the American Health Care Act (AHCA) and the Better Care Reconciliation Act (BCRA)

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Summary

Per the reconciliation instructions in the budget resolution for FY2017 (S.Con.Res. 3), the House passed its reconciliation bill, H.R. 1628—the American Health Care Act (AHCA)—with amendments on May 4, 2017. The House bill was received in the Senate on June 7, 2017, and the next day the Senate majority leader had it placed on the calendar, making it available for floor consideration. The Senate Budget Committee published on its website a "discussion draft" titled, "The Better Care Reconciliation Act of 2017" (BCRA) on June 22, subsequently updated the discussion draft on June 26, again on July 13, and again on July 20. The Senate's draft legislation is written in the form of an amendment in the nature of a substitute, meaning that it is intended to be considered by the Senate as an amendment to H.R. 1628, as passed by the House, but that all of the House-passed language would be stricken and the language of the BCRA would be inserted in its place.

Both the AHCA and the BCRA would repeal or modify provisions of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended). For example, both would substitute the ACA's premium tax credit for premium tax credits with different eligibility rules and calculation requirements, and both would effectively eliminate the ACA's individual and employer mandates. Both the AHCA and the BCRA also would make a number of changes to the Medicaid program. They would repeal some parts of the ACA related to Medicaid, such as the changes the ACA made to presumptive eligibility and the state option to provide Medicaid coverage to non-elderly individuals with income above 133% of the federal poverty level (FPL). They also would amend the enhanced matching rates for the ACA Medicaid expansion and the ACA Medicaid disproportionate share hospital (DSH) allotment reductions.

In addition, both the AHCA and the BCRA include new programs and requirements that are not related to the ACA. For example, under each, a new fund would be created to provide funding to states for specified activities intended to improve access to health insurance and health care in the state. The most significant Medicaid-related new provisions in the AHCA and the BCRA would convert Medicaid financing to a per capita cap model (i.e., per enrollee limits on federal payments to states) starting in FY2020 with a block grant option for states. Both also include a provision that would permit states to require nondisabled, non-elderly, non-pregnant adults to satisfy a work requirement to receive Medicaid coverage.

The AHCA and the BCRA both contain provisions that could restrict federal funding for the Planned Parenthood Federation of America (PPFA) and its affiliated clinics for a period of one year, and each would appropriate an additional $422 million for FY2017 to the Community Health Center Fund. Both would repeal all funding for the ACA-established Prevention and Public Health Fund (PPHF), and both would repeal many of the new taxes and fees established under the ACA.

Although the AHCA and the BCRA share many provisions, the BCRA strikes some AHCA provisions and adds some new provisions. For example, the BCRA does not include the AHCA's provision that would repeal the requirement for private health insurance plans to meet a generosity level based on actuarial value. Furthermore, the BCRA would not allow states to apply for waivers from three federal requirements that apply to private health insurance issuers; instead, the BCRA would modify the current law state innovation waivers. In other examples, the BCRA strikes a Medicaid provision in the AHCA that would let states disenroll high-dollar lottery winners, and the BCRA adds a few new Medicaid provisions, including provisions providing states the option to cover certain inpatient psychiatric services for non-elderly adults and to establish Medicaid and State Children's Health Insurance Program (CHIP) quality performance bonus payments.

This report contains three tables that, together, provide an overview of AHCA provisions and BCRA provisions, as baselined against current law. **Table 1** includes provisions that apply to the private health insurance market; **Table 2** includes provisions that affect the Medicaid program; and **Table 3** includes provisions related to public health, taxes, and implementation funding.

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In January 2017, the House and Senate adopted a budget resolution for FY2017 (S.Con.Res. 3), which reflects an agreement between the chambers on the FY2017 budget and sets forth budgetary levels for FY2018-FY2026. S.Con.Res. 3 also includes reconciliation instructions directing specific committees to develop and report legislation that would change laws within their respective jurisdictions to reduce the deficit. These instructions trigger the budget reconciliation process, which allows certain legislation to be considered under expedited procedures. The reconciliation instructions included in S.Con.Res. 3 direct two committees in each chamber to report legislation within their jurisdictions that would reduce the deficit by $1 billion over the period FY2017-FY2026. In the House, the Committee on Ways and Means and the Energy and Commerce Committee are directed to report. In the Senate, the Committee on Finance and the Committee on Health, Education, Labor, and Pensions are directed to report.

On March 6, 2017, the House Committee on Ways and Means and the House Energy and Commerce Committee independently held markups. Each committee voted to transmit its budget reconciliation legislative recommendations to the House Committee on the Budget. On March 16, 2017, the House Committee on the Budget held a markup and voted to report a reconciliation bill, H.R. 1628, American Health Care Act (AHCA) of 2017.[1] The House subsequently passed the AHCA with amendments on May 4, 2017, by a vote of 217 to 213.[2]

The House bill was received in the Senate on June 7, 2017, and the next day the Senate majority leader had it placed on the calendar, making it available for floor consideration.[3] The Senate Budget Committee published on its website a "discussion draft" titled, "The Better Care Reconciliation Act of 2017" (BCRA) on June 22, updated the discussion draft on June 26, did so again on July 13 and again on July 20.[4] This draft legislation is written in the form of an amendment in the nature of a substitute, meaning that it is intended to be considered by the Senate as an amendment to H.R. 1628, as passed by the House, but that all of the House-passed language would be stricken and the language of the BCRA would be inserted in its place.

Both the AHCA and the BCRA would repeal or modify provisions of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended). In addition, both the AHCA and the BCRA include new programs and requirements that are not related to the ACA. This report contains three tables that, together, provide an overview of AHCA provisions and BCRA provisions. **Table 1** includes provisions that apply to the private health insurance market; **Table 2** includes provisions that affect the Medicaid program; and **Table 3** includes provisions related to public health, taxes, and implementation funding.

The Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation (JCT) issued a cost estimate for the AHCA (as passed by the House on May 4, 2017).[5] According to the estimate, the AHCA would reduce federal deficits by $119 billion over the period FY2017-

[1] U.S. Congress, House Committee on the Budget, *American Health Care Act of 2017*, 115th Cong., 1st sess., March 20, 2017.

[2] For more information on House action on H.R. 1628, see CRS Report R44785, *H.R. 1628: The American Health Care Act (AHCA)*.

[3] After the second reading of the bill, the Senate majority leader objected to further proceedings under the provisions of Rule XIV, in order to place the bill on the calendar instead of having it referred to committee. Senator McConnell, *Congressional Record*, daily edition, vol. 173, (June 8, 2017), p. S3345. For more information on Rule XIV, see CRS Report RS22299, *Bypassing Senate Committees: Rule XIV and Unanimous Consent*.

[4] The July 20 draft is at https://www.budget.senate.gov/imo/media/doc/ERN17500.pdf.

[5] Congressional Budget Office (CBO), *Cost Estimate:* H.R. 1628, *American Health Care Act of 2017*, May 24, 2017, at https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/hr1628aspassed.pdf. CBO issued cost estimates reflecting earlier versions of the AHCA on March 13, 2017, and on March 23, 2017.

FY2026. With respect to effects on health insurance coverage, CBO and JCT project that, in CY2018, 14 million more people would be uninsured under the AHCA than under current law and in CY2026, 23 million more people would be uninsured than under current law.

CBO and JCT issued a cost estimate for the July 20 version of the BCRA.[6] According to the cost estimate, the BCRA would reduce federal deficits by $420 billion over the period FY2017-2026, which is $301 billion more than the estimated savings for the AHCA. CBO and JCT estimate that the BCRA would increase the number of uninsured individuals as compared to current law—in CY2018, 15 million more people would be uninsured under the BCRA than under current law, and in CY2026, 22 million more people would be uninsured than under current law.

[6] CBO, *Cost Estimate:* H.R. 1628, *Better Care Reconciliation Act of 2017*: An Amendment in the Nature of a Substitute [ERN17500] July 20, 2017, at https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/52941-hr1628bcra.pdf. CBO issued a cost estimate reflecting an earlier version of the BCRA on June 26, 2017.

Table 1. Provisions Related to Private Health Insurance in the American Health Care Act (AHCA) and the Better Care Reconciliation Act (BCRA)

Provision	Current Law	AHCA	BCRA
Health Insurance Tax Credits and Cost-Sharing Subsidies			
Premium Tax Credit	The ACA established IRC Section 36B, authorizing a premium tax credit to help eligible individuals pay for QHPs offered through individual exchanges only. The tax credit cannot be used for QHPs obtained outside exchanges, and it cannot be used for any catastrophic plans, regardless of whether they are purchased inside or outside exchanges. Eligibility criteria include status as a U.S. citizen, national, or lawfully present individual; income between 100%-400% of FPL; and other criteria. Eligible individuals may receive the credit in advance (i.e., during the year). The ACA also specified the tax credit calculation formula, which includes income as a factor and is based on a standard exchange plan: the silver QHP (70% AV) that has the second-lowest premium of all silver QHPs in a given local area. Individuals may receive the credit during the year; such payments are later reconciled when individuals file income-tax returns. Individuals who receive excess credits must pay back those amounts; repayment amounts are capped for those with incomes under 400% of FPL.	Section 202 would amend IRC Section 36B to allow the ACA tax credit to apply to certain off-exchange and other plans and restrict how the credit could apply to coverage for abortion, beginning tax year 2018. It would amend the tax credit calculation formula by specifying income and age as factors, beginning tax year 2019. Section 214 would amend IRC Section 36B to replace the ACA tax credit with a different refundable, advanceable tax credit, effective beginning tax year 2020. The credit would be allowed for citizens, nationals, and qualified aliens enrolled in QHPs (individual insurance that meets requirements specified in the section) who are not eligible for other sources of coverage. The credit amounts would be based on age and adjusted by a formula that takes into account income. Credits would be capped according to a maximum dollar amount and family size. Section 214 would restrict how credits could apply to coverage for abortion. Section 201 would disregard the income-related caps applicable to excess repayments of the ACA credit, for 2018 and 2019. In other words, any individual who was overpaid in tax credits would have to repay the entire excess amount during those two years, regardless of income level.	Section 102 also would amend IRC Section 36B, like AHCA Section 202, but would make somewhat different changes to the ACA tax credit beginning tax year 2020. Similar to the AHCA, Section 102 would allow the tax credits for citizens, nationals, and qualified aliens. Section 102 would change ACA eligibility criteria regarding access to employer-provided coverage and would change income eligibility from 100%-400% of FPL to up to 350% of FPL. Eligible individuals would be allowed to use the credit toward the purchase of a catastrophic plan. The standard plan used to determine the amount of the credit would have an AV of 58% and would have the median premium of all QHPs with 58% AV in the local area. Section 102 would amend the ACA tax credit calculation formula by specifying income and age as factors, similar to AHCA Section 202, but effective beginning tax year 2020. The section also would restrict how the credit could apply to coverage for abortion beginning tax year 2018. Section 101 would disregard the income-related caps applicable to excess credit repayments, identical to AHCA Section 201. This change would go into effect beginning tax year 2018.
Cost-Sharing Subsidy	ACA Section 1402 authorized subsidies to reduce cost-sharing expenses for eligible lower-income individuals enrolled in silver level QHPs offered through exchanges. The ACA directed the HHS and	Section 131 would repeal the cost-sharing subsidies effective for plan years beginning in 2020.	Section 210 would appropriate such sums as may be necessary for cost-sharing subsidies (including adjustments to prior obligations for such payments) for the period beginning the date of

Provision	Current Law	AHCA	BCRA
	Treasury Secretaries to make payments to reimburse insurers for the reduced cost-sharing. When Congress did not provide appropriations for such payments, the Obama Administration financed the payments through a non-appropriated source. The House of Representatives filed suit, claiming that the payments violated the Appropriations Clause of the U.S. Constitution.		enactment through December 31, 2019. Payments incurred and other actions for adjustments to obligations for plan years 2018 and 2019 could be available through December 31, 2020. Section 211 is similar to AHCA Section 131, which would repeal the cost-sharing subsidies effective for plan years beginning in 2020.
Small Business Tax Credit	The ACA established a small business health insurance tax credit.	Section 203 would restrict how the small business tax credit could apply to coverage for abortion beginning in 2018, and it would sunset the credit beginning tax year 2020.	Section 103 is similar to the House provision.
Health Insurance Mandates			
Individual Mandate	The ACA created an individual mandate, a requirement for most individuals to maintain health insurance coverage or pay a penalty for noncompliance.	Section 204 would effectively eliminate the annual individual mandate penalty, retroactively beginning CY2016.	Section 104 is identical to the House provision.
Employer Mandate	The ACA required employers to either provide health coverage or face potential employer tax penalties. The penalties are imposed on firms with at least 50 full-time equivalent employees if one or more of the firm's full-time employees obtain a premium tax credit through a health insurance exchange.	Section 205 would effectively eliminate the employer tax penalties, retroactively beginning CY2016.	Section 105 is identical to the House provision.
Federal Requirements Applicable to Private Health Plans			
Age Rating Restriction	Under the ACA, premiums for certain plans offered in the individual and small-group markets may vary only by self-only or family enrollment, geographic rating area, tobacco use (limited to a ratio of 1.5:1), and age (limited to a ratio of 3:1 for adults). The age rating ratio means that a plan may not charge an older individual more than three times the premium that the plan charges a 21-year-old individual.	Under Section 135, the HHS Secretary could implement an age rating ratio of 5:1 for adults for premiums in the individual and small-group markets for plan years beginning on or after January 1, 2018. That is, a plan would not be able to charge an older individual more than five times the premium that the plan would charge a 21-year-old individual. States would have the option to implement a different ratio	Section 204 would establish (in contrast to AHCA Section 135, in which the HHS Secretary *could* establish) an age rating ratio of 5:1 for adults for plan years beginning on or after January 1, 2019. Similar to AHCA Section 135, states would have the option to implement a ratio for adults that is different from the 5:1 ratio.

Provision	Current Law	AHCA	BCRA
		for adults.	
Actuarial Value Requirement	The ACA required that certain plans offered in the individual and small-group markets must (1) cover certain benefits (i.e., the 10 EHB); (2) comply with specific cost-sharing limitations; and (3) meet a certain generosity level based on AV—bronze (60% AV), silver (70% AV), gold (80% AV), or platinum (90% AV).	Under Section 134, plans offered after December 31, 2019, would no longer need to comply with the actuarial value requirement.	No provision.
Medical Loss Ratio	The ACA required that certain plans offered in the individual, small-group, and large-group markets comply with MLR requirements. MLR measures the share of enrollee premiums that health insurance companies spend on medical claims, as opposed to non-claims expenses such as administration or profits. The ACA required covered insurers in the individual and small-group markets to meet a minimum MLR of 80% and insurers in the large-group market to meet a minimum MLR of 85%. Insurance companies must issue rebates to policyholders each year they do not meet MLR standards.	No provision.	Section 205 would amend the MLR provision to provide that the MLR ratios for individual, small-group, and large-group plans, the calculation of enrollee rebates and the penalties for noncompliance would not apply for plan years beginning on or after January 1, 2019. Instead, states would be required to set their own MLRs. States would determine the ratio of premium revenue that plans may use for non-claims costs to the total amount of the premium and would determine the amount of any annual rebate required to be paid to enrollees if plans exceeded the ratio.
Continuous Health Insurance Coverage Incentive	The ACA created an individual mandate, a requirement for most individuals to maintain health insurance coverage or pay a penalty for noncompliance. Under the ACA, premiums for certain plans offered in the individual and small-group markets may vary only by self-only or family enrollment, geographic rating area, tobacco use (limited to a ratio of 1.5:1), and age (limited to a ratio of 3:1 for adults). Most plans offered in the individual, small-group, and large-group markets must offer plans on a guaranteed-issue basis. Most private health insurance plans are prohibited from excluding coverage of preexisting conditions. Under the PHSA, creditable coverage is defined as	Section 204 would effectively eliminate the individual mandate penalty, retroactively beginning CY2016. Section 133 would require issuers offering plans in the individual market to assess a penalty (or, in essence, vary premiums) on policyholders who (1) had a gap in creditable coverage that exceeded 63 days in the prior 12 months or (2) aged out of their dependent coverage (i.e., young adults up to the age of 26) and did not enroll in coverage during the next open enrollment period. The penalty would be a 30% increase in monthly premiums during the enforcement period, which is either a 12-month period or the remainder of the plan year (if a person enrolls in coverage	Section 104 would effectively eliminate the individual mandate penalty, just like AHCA Section 204. Section 206 would require issuers offering plans in the individual market to impose a 6-month waiting period on most individuals who had a gap in creditable coverage. For an individual submitting an insurance application during an open enrollment period, a break in coverage of 63 days or longer within a 12-month period would constitute a gap. For an individual submitting an application during a special enrollment period, a gap would consist of either a break in coverage of 63 days or longer within a 12-month period or no creditable coverage during the 60 days prior to submitting such

Provision	Current Law	AHCA	BCRA
	coverage through a group health plan, an individual health insurance plan, Medicare, Medicaid, military health care, the Indian Health Service, a state health benefits risk pool, a government organization, a public health plan, and the Peace Corps.	outside the open enrollment period). The provision would be effective for coverage obtained during special enrollment periods for plan year 2018 and for all coverage beginning plan year 2019.	application. Coverage for an individual who qualifies to obtain coverage during an open enrollment period or a special enrollment period and is subject to a waiting period would begin six months after the date on which the individual submits an application for coverage. Coverage for an individual who submits an application outside the open enrollment period, does not qualify for a special enrollment period, and is subject to a waiting period would begin the later of either (1) the date that is six months after the day on which the individual submits an application for coverage or (2) the first day of the following plan year. The definition of creditable coverage would be expanded to include coverage through a health care sharing ministry. Section 206 would be effective for coverage beginning on or after January 1, 2019.
Catastrophic Coverage	Under the ACA, certain plans that do not meet QHP requirements are allowed to be offered through the exchanges, such as catastrophic plans. A catastrophic plan covers the EHB, covers at least three primary care visits before the plan's deductible is met, imposes high deductibles, and does not meet the minimum AV standards. Catastrophic plans may be offered only in the individual market (both inside and outside exchanges) to (1) individuals under the age of 30 and (2) persons exempt from the ACA's individual mandate because no affordable coverage is available or they have a hardship exemption. Premium tax credits may not be used toward purchasing catastrophic plans. Health insurance risk pools are groups of individual entities (e.g., individuals or employers) whose medical claims experience are combined to develop rates for coverage. Under the ACA, an issuer must	No provision.	Section 208 would allow any individual to enroll in a catastrophic plan, effective plan years beginning on or after January 1, 2019. Section 102 would allow an individual who is eligible for the premium tax credit, as modified under Section 102, to apply that credit toward the purchase of a catastrophic plan. Section 208 would include enrollees in catastrophic plans as part of the single risk pools in the individual and small-group markets for plan years beginning on or after January 1, 2019.

Provision	Current Law	AHCA	BCRA
	consider all of its enrollees in plans offered in the individual market in a state to be members of a single risk pool and an issuer must do the same for all of its enrollees in plans offered in the small-group market in a state. States have the option to merge their individual and small-group markets; if a state does so, an issuer will have a single risk pool for all enrollees in its individual and small-group market plans.		
Enforcement Penalties	Under the ACA, the issuer of a QHP that provides coverage for elective abortion services cannot use any funds attributable to a premium tax credit or cost-sharing subsidy to pay for such services.[a] The issuer of a QHP that provides coverage for elective abortion services must comply with requirements for segregating enrollees' payments for the plan into two payments: one payment reflecting coverage of all health services other than elective abortion services and one payment reflecting the AV of the coverage for elective abortion services. Under existing law, there are no statutory penalties for an issuer that violates these segregation requirements.	No provision.	Section 209 would establish a penalty for violations of the ACA's abortion funding segregation requirements. An issuer that fails to comply with these requirements would be liable for a penalty of up to $100 for each day for each individual with respect to whom such a failure occurs.
State Flexibility			
Waivers	ACA Section 1332 allows states to apply for waivers (state innovation waivers) of the following provisions established under the ACA: (1) Part I of Subtitle D of the ACA—relating to establishment of QHPs; (2) Part II of Subtitle D of the ACA—relating to establishment of exchanges; (3) ACA Section 1402—cost-sharing subsidies; (4) IRC Section 36B—premium tax credits; (5) IRC Section 4980H—employer mandate; and (6) IRC Section 5000A—individual mandate. States may receive a 1332 waiver if the state's plan that would be put in place of the waived provisions	The AHCA would not modify ACA Section 1332. Section 136 would establish new waivers for states. The new waivers would allow states to apply to the HHS Secretary for a waiver for one or more of the following purposes. (1) A state could apply for a waiver to implement an age rating ratio for adults that is higher than the ratio specified in the ACA, as would be amended by AHCA Section 135. This waiver could apply to plan years beginning on or after January 1, 2018. (2) A state could apply for a waiver from the EHB and instead specify its own EHB. This	Section 207 would modify some provisions of ACA Section 1332, but it would not modify the list of ACA provisions that can be waived under ACA Section 1332. Section 207 would amend the criteria—related to coverage, affordability, comprehensiveness, and federal-deficit neutrality—that a state's plan would have to meet for the Secretary to approve a 1332 waiver.[c] Instead of the existing criteria, Section 207 would require that a state's waiver request is granted unless the Secretary determines that the state's application has required elements that are missing or the state's plan would increase the federal deficit.

Provision	Current Law	AHCA	BCRA
	meets the following criteria: it provides coverage to as many state residents as would be covered absent the waiver; the coverage is as affordable and comprehensive as it would be absent the waiver; and the state's plan does not increase the federal deficit. A state's receipt of a 1332 waiver could result in the residents of the state not receiving health insurance-related financial assistance for which they otherwise would be eligible. If this occurs, the state is to receive the aggregate amount of subsidies that would have been available to the state's residents had the state not received a 1332 waiver. A state is to use this *pass-through funding* for purposes of implementing the plan established under the waiver. Section 1332 specifies the information a state must include in its application for a waiver. A 1332 waiver cannot extend longer than five years unless a state requests continuation and such request is not denied by the Secretary.[b] The earliest a state innovation waiver could have gone into effect was January 1, 2017. The ACA applied requirements to private health insurance plans, including, but not limited to, the following: premiums for certain plans offered in the individual and small-group markets may vary only by self-only or family enrollment, geographic rating area, tobacco use (limited to a ratio of 1.5:1), and age (limited to a ratio of 3:1 for adults). The ACA prohibited most plans offered in the individual and group markets from basing eligibility for coverage on health status-related factors, and it prohibited such plans from requiring an individual to pay a larger premium than any other similarly situated enrollees of the plan on the basis of a health status-related factor of the individual or any of the individual's dependents. The ACA required certain plans offered in the individual and small-group markets to offer a core package of health care services, known as	waiver could apply to plan years beginning on or after January 1, 2020. (3) A state could apply to waive the continuous coverage penalty, as would be implemented under AHCA Section 133, and instead allow issuers to use health status as a factor when developing premiums for individuals subject to an enforcement period. This waiver could apply to coverage obtained during special enrollment periods for plan year 2018 and for all coverage beginning plan year 2019.	Section 207 would modify the ACA provisions related to the pass-through funding in three ways: (1) by allowing a state to request that all, or a portion of, the aggregate pass-through funding amounts determined by the Secretary be paid to the state; (2) by appropriating $2 billion to the Secretary for FY2017 through FY2019 to provide grants to states for purposes of submitting an application for a 1332 waiver and implementing a state plan under a 1332 waiver; and (3) by allowing a state to use funds received under the Long-Term State Stability and Innovation Program (as would be established in new SSA Section 2105(i) under BCRA Section 106) to carry out the state plan under a 1332 waiver. Section 207 would modify the information a state is required to include in its application for a 1332 waiver, and it would provide that a 1332 waiver is in effect for a period of eight years unless a state requests a shorter duration. A state could apply to renew the waiver for unlimited additional eight-year periods, and the waiver could not be canceled by the Secretary before the expiration of any eight-year period (including a renewal period).

Provision	Current Law	AHCA	BCRA
	the EHB.		
Stability Fund	NA	Section 132 would establish a Patient and State Stability Fund to provide funding to states to undertake one or more of nine different types of allowed activities. Most of the allowed activities are related to stabilizing the state's private health insurance market. Section 132 would appropriate to the fund $15 billion in each of 2018 and 2019 and $10 billion in each subsequent year through 2026. The section would provide an additional $15 billion in 2020 that states could use for two of the specified activities: (1) maternity coverage and newborn care and (2) prevention, treatment, or recovery support services for mental or substance use disorders. Section 132 also would provide an additional $8 billion for the period 2018-2023 to states with a waiver in effect under proposed AHCA Section 136 relating to allowing issuers to use health status as a factor when developing premiums for certain individuals. Section 132 would establish a Federal Invisible Risk Sharing Program to provide payments to health insurance issuers that offer individual market coverage to help with high-cost medical claims of certain individuals. Section 132 would appropriate $15 billion for the program to be used over the period 2018-2026. Section 132 would require states, as a condition of receipt of Patient and State Stability Fund allocations, to make contributions toward the activities or programs for which the application was approved. The CMS Administrator would be prohibited from making an allocation to a state if the state were to use the allocation for purposes not permitted under SSA Section	Section 106 would add two new subsections to SSA Section 2105.[d] Each new subsection would provide funding for specified activities. The new subsection (h) would appropriate $15 billion for each of 2018 and 2019 and $10 billion for each of 2020 and 2021 to the CMS Administrator, who would be required to use the monies to fund arrangements with health insurance issuers for the purpose of stabilizing premiums and promoting market participation and plan choice in the individual market. The total amount appropriated under new subsection (h) would be $50 billion to be used over the period 2018-2021. The new subsection (i) would establish a Long-Term State Stability and Innovation Program. The program would provide funding to states to undertake four types of allowed activities from 2019 through 2026. All four allowed activities are related to stabilizing the state's private health insurance market. The specific appropriation amounts under subsection (i) would vary each year. The new subsection would provide that for each of 2019-2021, at least $5 billion of the appropriated amounts for the year would have to be used by states to fund arrangements with health insurance issuers for the purpose of stabilizing premiums and promoting market participation and plan choice in the individual market. The total amount appropriated under new subsection (i) would be $132 billion to be used over the period 2019-2026. Section 106 would require that states, in order to receive funds from the program established under subsection (i), would have to make contributions

Provision	Current Law	AHCA	BCRA
		2105(c)(7), related to abortion. The total amount appropriated under Section 132 would be $138 billion to be used over the period 2018-2026.	toward the activities for which they are receiving funds beginning in 2022. Section 106 would apply some limitations under SSA Section 2105(c) to payments made under new subsections (h) and (i). The limitations are related to prohibiting federal funds for coverage and payment for abortion, prohibiting federal funds for required state contributions, and citizenship documentation requirements. The total amount appropriated under both new subsections—(h) and (i)—would be $182 billion to be used over the period 2018-2026.
Employment-Based Insurance Pools			
Small Business Health Plans	Federal laws that impose requirements on health insurers and plans typically have amended the PHSA, with conforming amendments to both ERISA and IRC. Both individual and group insurance are subject to federal (and state) law, although the breadth and specificity of such requirements vary across market segments and states. In general, the individual and small-group markets are more heavily regulated than the large-group market. Individuals and/or employers may pool together (such as through a trade or professional association) to purchase health insurance. Some states may regulate insurance sold to associations at the association level; associations made up of many members may be regulated as large groups in those states. However, federal regulation of association coverage generally applies at the member level. Therefore, a large association of individuals or small businesses would be federally regulated as individual insurance or small-group insurance, respectively.	No provision.	Section 138 would amend ERISA to establish SBHPs. The section would define an SBHP as a fully insured group health plan offered by a large-group insurer. Section 138 would identify who is eligible for coverage under an SBHP; list criteria that an entity must meet to sponsor an SBHP; and direct the Labor Secretary to promulgate regulations about certification of SBHPs and qualified sponsors and oversight of sponsors. Section 138 would preempt any and all state laws that would preclude an insurer from offering coverage in connection with an SBHP, but the section limits the preemption by stating that the preemption should not be construed to limit state authority to otherwise regulate health plans. The section would go into effect one year after enactment, and the Labor Secretary would be required to promulgate regulations to implement the amendments proposed under Section 138 within six months of enactment.

Sources: Congressional Research Service (CRS) analysis of H.R. 1628, American Health Care Act (AHCA) of 2017, as passed by the House on May 4, 2017, and Senate discussion draft LYN17343, Better Care Reconciliation Act of 2017, as posted on the Senate Budget Committee website on June 26, 2017.

Notes: ACA = Patient Protection and Affordable Care Act (P.L. 111-148, as amended); AHCA = American Health Care Act; AV = actuarial value; BCRA = Better Care Reconciliation Act; CMS = Centers for Medicare & Medicaid Services; CY = calendar year; EHB = essential health benefits; ERISA = Employee Retirement Income Security Act; FPL = federal poverty level; FY = fiscal year; HHS = Department of Health and Human Services; IRC = Internal Revenue Code; MLR = Medical loss ratio; NA = not applicable; PHSA = Public Health Service Act; QHP = qualified health plan; SBHP = small business health plan; SSA = Social Security Act.

a. The term *elective abortion services* is used in this section to refer to abortion services other than those available when a pregnancy is the result of an act of rape or incest, or when a woman's life would be endangered if an abortion were not performed. This definition is based on the distinction in the ACA between abortion services for which federal funds are prohibited and those for which federal funds are allowed. Under existing law, federal funds may not be used for elective abortion services. For further discussion on the public funding of abortion, see CRS Report RL33467, *Abortion: Judicial History and Legislative Response*, by Jon O. Shimabukuro.

b. ACA Section 1332(a)(6) provides that the "Secretary" is the Secretary of Health and Human Services with respect to waivers for provisions not included in the IRC and is the Secretary of the Treasury with respect to waivers for provisions included in the IRC (the premium tax credits, the employer mandate, and the individual mandate). ACA Section 1332(a)(6) provides that the "Secretary" is the Secretary of Health and Human Services with respect to waivers for provisions not included in the IRC and is the Secretary of the Treasury with respect to waivers for provisions included in the IRC (the premium tax credits, the employer mandate, and the individual mandate).

c. As described in table note a, the "Secretary" is either the Secretary of Health and Human Services or the Secretary of the Treasury.

d. SSA Title XXI established the State Children's Health Insurance Program (CHIP).

Table 2. Provisions Related to Medicaid in the American Health Care Act (AHCA) and the Better Care Reconciliation Act (BCRA)

Provision	Current Law	AHCA	BCRA
ACA Medicaid Expansion			
ACA Medicaid Expansion	The ACA established 133% of FPL as the new mandatory minimum Medicaid income-eligibility level for most non-elderly adults beginning January 1, 2014. On June 28, 2012, the U.S. Supreme Court issued its decision in *National Federation of Independent Business v. Sebelius*, which effectively made the ACA Medicaid expansion optional for states.	Section 112(a)(1)(A) would codify the ACA Medicaid expansion as optional for states after December 31, 2019.	Section 125(a)(1)(A) is almost identical to the House provision.
Definitions for Expansion Enrollees	The ACA defined an *expansion enrollee* as an individual who is a non-elderly, non-pregnant adult with annual income at or below 133% of FPL and who is not entitled to or enrolled for benefits	Section 112(a)(1)(B) would incorporate the existing ACA definition of *expansion enrollees* and add a definition of grandfathered expansion enrollees for the purposes of the new optional Medicaid eligibility group. The	Section 125(a)(1)(B) does not include a definition of *grandfathered expansion enrollees.* Like the AHCA provision, the definition for *expansion enrollees* would incorporate the existing ACA definition of the term.

Provision	Current Law	AHCA	BCRA
	in Medicare Part A or enrolled for benefits under Medicare Part B.	provision would define a *grandfathered expansion enrollee* as an expansion enrollee who was enrolled in Medicaid (under the state plan or a waiver) as of December 31, 2019, and does not have a break in eligibility for more than one month after that date. The provision also would apply these definitions to existing provisions in Medicaid statute that currently reference the ACA Medicaid expansion group.	
Newly Eligible Federal Matching Rate	Medicaid is jointly financed by the federal government and the states. The federal government's share of a state's expenditures for most Medicaid services is called the FMAP rate. Exceptions to the regular FMAP rate have been made for certain states, situations, populations, providers, and services. The ACA added a few FMAP exceptions, including the newly eligible federal matching rate (i.e., the matching rate for individuals who are newly eligible for Medicaid due to the ACA Medicaid expansion).	Section 112(a)(2)(A) would maintain the current structure of the newly eligible matching rate for expenditures before January 1, 2020, for states that covered newly eligible individuals as of March 1, 2017. However, on or after January 1, 2020, the newly eligible matching rate would apply only to expenditures for newly eligible individuals who were enrolled in Medicaid as of December 31, 2019, and do not have a break in eligibility for more than one month after that date (i.e., grandfathered expansion enrollees).	Section 125(a)(2)(A) would maintain the current structure of the newly eligible matching rate for expenditures before January 1, 2021, for states that covered newly eligible individuals as of March 1, 2017. The newly eligible matching rate would phase down to 85% in CY2021, 80% in CY2022, and 75% in CY2023. The newly eligible matching rate would not be available to states after CY2023. States that implement the expansion after February 28, 2017, would not be eligible for the newly eligible matching rate, and these states would receive their regular FMAP rate to cover the newly eligible expansion enrollees.
Expansion State Federal Matching Rate	The ACA added the expansion state federal matching rate, which is the federal matching rate available for expansion enrollees without dependent children in expansion states who were eligible for Medicaid on March 23, 2010. In this context, *expansion state* refers to states that already had implemented (or partially implemented) the ACA Medicaid expansion at the time the ACA was enacted.	Section 112(a)(2)(B) would amend the formula for the expansion state matching rate so that the matching rate would stop phasing up after CY2017 and the transition percentage would remain at the CY2017 level. In addition, after January 1, 2020, the expansion state matching rate would apply only to expenditures for eligible individuals who were enrolled in Medicaid as of December 31, 2019, and do not have a break in eligibility for more than one month after that date (i.e., grandfathered expansion enrollees).	Section 125(a)(2)(B) would amend the formula for the expansion state matching in the same way as the House provision. However, the expansion state matching rate would be available through CY2023. The expansion state matching rate would not be available to states after CY2023.
Sunset of Essential Health	The ACA amended Medicaid ABP	Section 112(b) would repeal the requirement	Section 125(b) is identical to the House provision.

Provision	Current Law	AHCA	BCRA
Benefits Requirement	coverage by requiring states to include at least the 10 EHB. The 10 EHB include (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services (including behavioral health treatment); (6) prescription drugs, (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.	that Medicaid ABP coverage include at least the 10 EHB after December 31, 2019.	
Medicaid Financing			
Per Capita Allotment for Medical Assistance	The federal government reimburses states for a portion (i.e., the federal share) of each state's Medicaid program costs. Because federal Medicaid funding is an open-ended entitlement to states, there is no upper limit or cap on the amount of federal Medicaid funds a state may receive. The federal government provides broad guidelines to states regarding allowable funding sources for the state share of Medicaid expenditures. States may use state general funds (i.e., personal-income, sales, or corporate-income taxes) and "other state funds" (i.e., provider taxes, local government funds, tobacco settlement funds, etc.) to finance the state share of Medicaid. Federal statute allows as much as 60% of the state share to come from local government funding.	Section 121 would reform federal Medicaid financing to a per capita cap model (i.e., per enrollee limits on federal payments to states) starting in FY2020. Specifically, each state's spending in FY2016 would be the base to set targeted spending for each enrollee category in FY2019 and subsequent years for that state. Starting in FY2020, any state with spending higher than its specified targeted aggregate amount would receive reductions to its Medicaid funding for the following fiscal year equal to the federal share of the excess expenditures. For some enrollment categories (i.e., the categories for children; expansion enrollees; and other non-elderly, nondisabled, non-expansion adults), each state's targeted per capita amount would increase annually by the percentage increase in the medical care component of the CPI-U, and the growth rate for the disabled (including adults and children) and elderly categories would be the medical	Section 132(a) is similar to the House provision. Below are the major differences from the House provision. The base period for each state would be a period of eight consecutive fiscal quarters selected by each state. The period could begin as early as the first quarter of FY2014 and end no later than the third quarter of FY2017. After FY2024, the growth rate for a state's targeted per capita amounts for all enrollment categories would be the CPI-U. Beginning in FY2020, a state's targeted per capita amount would be adjusted if the state's per capita expenditures for a category in the preceding fiscal year exceeded or were less than the mean per capita expenditures for the enrollee category in all states by 25.0%. Disabled children would be added to the list of populations excluded from the per capita cap funding. A limited amount of expenditures for public health

Provision	Current Law	AHCA	BCRA
		care component of the CPI-U plus one percentage point. Certain Medicaid populations and expenditures would be excluded from the per capita cap funding. One provision would reduce the target amount for New York if certain local government contributions to the state share are required.	emergencies for CY2020 through CY2024 could be added to the list of excluded expenditures.
Block Grant Option	Same as directly above.	Under Section 121(i), states would have the option to receive block grant funding (i.e., a predetermined fixed amount of federal funding) instead of per capita cap funding for non-elderly, nondisabled, non-expansion adults and children starting in FY2020. States would elect this option for a 10-year period. The formula for block grant amount would be based on the target per capita amount from the per capita caps provision. The block grant amount would increase according to the CPI-U. Unspent funds would remain available in succeeding fiscal years. Under the block grant option, federal rules (such as the conditions of eligibility and cost-sharing requirements) would not apply to the coverage. Also, states would be required to cover the mandatory benefits listed for the block grant option, which would be different from the mandatory benefits under current law.	Section 133 also would provide states with a block grant option. Below are the major differences from the House provision. States would be able to cover expansion enrollees and non-elderly, nondisabled, non-expansion adults under the block grant option. States would not be able to cover children under the block grant program, which would be an option under the House provision. States would elect this option for a 5-year period instead of a 10-year period. States could receive limited federal funds in addition to the block grant amount if a state has medical assistance expenditures excluded from the Medicaid per capita caps for public health emergencies from January 1, 2020, through December 31, 2024. For enrollees whom the state is currently required to provide with Medicaid coverage under SSA Section 1902(a)(10)(A)(i), states would be required to cover the specified mandatory benefits, which would be different than the mandatory benefits listed in the House provision.
Medicaid DSH Reductions	The ACA required aggregate reductions in Medicaid DSH allotments for FY2014 through FY2020. Subsequent laws amended these	Section 113 would eliminate the Medicaid DSH allotment reductions after FY2019. In addition, non-expansion states would be exempt from the ACA Medicaid DSH allotment reductions.	Section 126 also would exempt non-expansion states from the ACA Medicaid DSH allotment reductions. In addition, certain non-expansion states would receive an increase to their Medicaid

Provision	Current Law	AHCA	BCRA
	reductions. Under current law, the aggregate reductions to the Medicaid DSH allotments are to impact FY2018 through FY2025.		DSH allotments for FY2020 through the first quarter of FY2024.
Safety-Net Funding for Non-expansion States	NA	Section 115 would establish safety-net funding for non-expansion states to adjust payment amounts for Medicaid providers. The fund would provide $2 billion each year starting in FY2018 through FY2022. Non-expansion states would receive an increased matching rate of 100% for FY2018 through FY2021 and 95% for FY2022 for the provider payment adjustments.	Section 128 is identical to the House provision.
Medicaid Provider Taxes	Many states use Medicaid provider taxes (i.e., health care-related taxes for which at least 85% of the burden of the tax revenue falls on health care providers) to finance a portion of their state share of Medicaid expenditures. Medicaid provider taxes must be broad-based, uniform, and not hold the providers harmless for the cost of the provider tax. Regulations waive the application of the hold-harmless requirement when the tax is applied at a rate less than or equal to 6% of net patient service revenues, which is referred to as the threshold.	No provision.	Section 131 would phase down the Medicaid provider tax threshold from the current level of 6% to 5.8% in FY2021, 5.6% in FY2022, 5.4% in FY2023, 5.2% in FY2024, and 5.0% in FY2025 and subsequent fiscal years.
Medicaid and CHIP Quality Performance Bonus Payments	SSA Section 1139A and 1139B require the HHS Secretary to publish, and regularly update, a core set of child and adult quality measures, respectively. States are required to submit reports to the HHS Secretary annually on children and adult health care quality, including information about state-specific child and adult health quality	No provision.	Section 134 would establish Medicaid and CHIP quality performance bonus payments for FY2023 through FY2026. To be eligible for the bonus payments, a state would (1) have lower-than-expected aggregate medical assistance expenditures and (2) submit the required quality measures and a spending plan. The quality bonus payment allotments for all states would total $8.0 billion for FY2023 through

Provision	Current Law	AHCA	BCRA
	measures applied voluntarily by the state. The HHS Secretary is required to make the information reported by the states publicly available.		FY2026. The quality bonus payment allotment funds would be used to increase the Medicaid federal matching rate of 50% for administrative services by such percentage so that the increase does not exceed each state's quality bonus payment allotment.
Home and Community-Based Services Demonstration Project	States are required to cover certain LTSS for eligible beneficiaries, such as nursing facility care and home health care. States have a range of options that allow LTSS coverage of HCBS, including: (1) SSA Section 1915(c) HCBS waiver authority, which specifies a broad range of services that states may provide (including services not available under the Medicaid state plan) to beneficiaries who have an institutional level of care need; (2) SSA Section 1915(d) waiver authority, which allows states to provide comprehensive HCBS to individuals aged 65 and older and at risk of needing institutional care; and (3) the state plan option to provide HCBS under SSA Section 1915(i), which allows states to offer the same list of authorized Section 1915(c) waiver services under their Medicaid state plans for certain eligible beneficiaries who meet specific financial and needs-based eligibility criteria that may be less than the level of care required in an institution.	No provision.	Section 132(b) would require the HHS Secretary to establish a four-year demonstration project from January 1, 2020, to December 31, 2023. Eligible states would make HCBS payment adjustments to HCBS providers for the purpose of continuing to provide and improving the quality of HCBS for a 1903A elderly or blind and disabled enrollee (as defined in BCRA Section 132(a)) under SSA Section 1915(c), (d), or (i). States would be selected on a competitive basis, with priority given to the 15 states with the lowest population density. Eligible states would receive an annual allotment amount from which to make the payment adjustments. The aggregate amount allotted to states for all years could not exceed $8 billion. Eligible state expenditures would receive a 100% federal matching rate (i.e., fully federal funded) for the HCBS payment adjustments, subject to certain limitations.
Federal Medicaid Matching Rate for Community First Choice Option	The ACA established the Community First Choice option, which allows states to offer community-based attendant services and supports as an optional Medicaid state plan benefit and to	Section 111(2) would repeal the increased FMAP rate for the Community First Choice option on January 1, 2020.	Section 124(2) is identical to the House provision.

Provision	Current Law	AHCA	BCRA
	receive an FMAP increase of 6 percentage points for doing so.		
Federal Matching Rate for State Option to Provide Certain Inpatient Psychiatric Services	The federal government's share of a state's expenditures for most Medicaid services is called the FMAP rate. FMAP rates have a statutory minimum of 50% and a statutory maximum of 83%. For FY2017, regular FMAP rates range from 50.00% to 74.63%.	No provision.	Section 137(b) would provide states a 50% federal matching rate for providing coverage of qualified inpatient psychiatric hospital services to Medicaid enrollees over the age of 21 and under the age of 65 under the option in Section 137(a).
Increased Administrative Matching Percentage for Eligibility Redeterminations	Exceptions to the regular FMAP rate have been made for certain states, situations, populations, providers, and services. Most administrative activities receive a 50% federal matching rate.	Section 116(b) would increase the federal match for administrative activities to carry out the increase in Medicaid eligibility redeterminations under Section 116(a) by 5 percentage points. This increased federal match would be available from October 1, 2017, through December 31, 2019.	Section 129(b) is almost an identical matching rate provision to the House provision for activities in Section 129(a).
Increase in Matching Rate for Implementation of Work Requirement	Same as directly above.	Section 117(b) would increase the federal match for administrative activities to implement the work requirement under Section 117(a) by 5 percentage points, in addition to any other increase to such federal matching rate.	Section 130(b) is an identical matching rate provision to the House provision for activities in Section 130(a).
Enhanced FMAP for Medical Assistance to Eligible Indians	Another exception to the FMAP is that states receive 100% federal reimbursement for Medicaid services provided at or through a facility operated by the IHS or by an IT/TO. Services "through" one of these facilities are those that are provided at non-IHS facilities under a care-coordination agreement with an IHS/IT/TO facility. Services provided to Medicaid-enrolled members of Indian tribes outside of these two facility types, including services provided at Urban Indian organizations, are	No provision.	Section 138 would extend the 100% federal matching rate for IHS facilities to medical assistance for services provided by any other provider to a Medicaid enrollee who is a member of an Indian tribe.

Provision	Current Law	AHCA	BCRA
	reimbursed at the state's regular FMAP rate.		
Medicaid Eligibility and Enrollment			
State Option for Coverage for Non-elderly Individuals with Income That Exceeds 133% of FPL	The ACA created an optional Medicaid eligibility category for all non-elderly individuals with income above 133% of FPL up to a maximum level specified in the Medicaid state plan.	Section 112(a)(1)(A)(ii) would repeal the state option to extend coverage to non-elderly individuals with income above 133% of FPL after December 31, 2017.	Section 125(a)(1)(A)(ii) is almost identical to the House provision.
Federal Payments to States: Presumptive Eligibility	The ACA expanded the types of entities (i.e., all hospitals) that are permitted to make presumptive-eligibility determinations to enroll certain groups in Medicaid for a limited time until a formal Medicaid eligibility determination is made. The ACA also expanded the groups of individuals for whom presumptive-eligibility determinations may apply.	Section 111(1)(A) would no longer allow hospitals that participate in Medicaid to elect to make presumptive-eligibility determinations after January 1, 2020, and would provide that any such election that a hospital already had made would cease to be effective as of that date. Section 111(3) would terminate the authority for certain states to make presumptive-eligibility determinations for the ACA Medicaid expansion group or the state option for coverage for non-elderly individuals with income that exceeds 133% of FPL, also effective January 1, 2020.	Section 124(1) and (3) are identical to the House provisions.
Federal Payments to States: Stairstep Children	The ACA expanded the mandatory Medicaid income eligibility level for poverty-related children aged 6 through 18 from 100% of FPL to 133% of FPL.	Section 111(1)(B) would repeal the ACA requirement, specifying the end date of the ACA requirement as December 31, 2019. After that date, states would still be required to cover children in this group with household incomes of up to 100% of FPL.	No provision.
Letting States Disenroll High-Dollar Lottery Winners	The ACA created a definition of household income based on MAGI to determine income eligibility for various Medicaid eligibility groups. Under Medicaid regulations, states are directed to include certain types of irregular income received as a lump sum (e.g., state income tax refund,	Section 114(a) would direct states on how to treat irregular income received as a lump sum when determining MAGI income eligibility on or after January 1, 2020.	No provision.

Provision	Current Law	AHCA	BCRA
	lottery or gambling winnings) when determining income eligibility based on MAGI, but only in the month the irregular income is received.		
Repeal of Retroactive Eligibility	States are required to cover Medicaid benefits retroactively for three months before the month of application for individuals who are subsequently determined eligible, if the individual would have been eligible during that period had he or she applied.	Section 114(b) would limit the effective date for retroactive coverage of Medicaid benefits to the month in which the applicant applied for Medicaid applications on or after October 1, 2017.	Similar to the AHCA provision, Section 127 would limit the effective date for retroactive coverage of Medicaid benefits to the month in which the applicant applied for Medicaid applications on or after October 1, 2017, with certain specified exceptions. Specifically, the provision would continue to require states to provide for retroactive coverage for services provided in or after the third month before the month of application for recipients who are 65 years of age or older and individuals who are eligible for medical assistance on the basis of being blind or disabled.
Updating Allowable Home-Equity Limits in Medicaid	There is a limit on the amount of home equity a Medicaid applicant can shield from aggregate asset limits that otherwise would disqualify the applicant from Medicaid eligibility for nursing-facility services or other long-term care. In 2017, the federal minimum home-equity limit is $560,000; a state may elect a higher amount, not to exceed $840,000.	Section 114(c) would repeal the authority for states to elect a home-equity limit amount above the federal minimum, effective after 180 days from enactment.	No provision.
Frequency of Eligibility Determinations	The ACA requires states to determine income eligibility based on MAGI for most of Medicaid's non-elderly populations. For such individuals, states are required to redetermine Medicaid eligibility once every 12 months, except in the case where the Medicaid agency receives information about a change in a beneficiary's circumstances that may affect eligibility. In this case, the	Section 116(a) would require states to increase the frequency of redeterminations from at least every 12 months to every 6 months (or more frequently) for individuals eligible for Medicaid through (1) the ACA Medicaid expansion or (2) the state option for coverage for non-elderly individuals with income that exceeds 133% of FPL for eligibility determinations beginning October 1, 2017.	Section 129(a) is similar to the House provision, except that the requirement to increase the frequency of eligibility redeterminations for the specified populations would be implemented at state option.

Provision	Current Law	AHCA	BCRA
	Medicaid agency must redetermine Medicaid eligibility at the appropriate time based on such changes.		
State Option for Work Requirements	The Medicaid statute does not appear to expressly address whether a state plan may permissibly impose work requirements as a condition of receiving benefits for most beneficiaries. However, SSA Section 1931 authorizes states to terminate TANF recipients' eligibility for medical assistance under Medicaid if the individuals' TANF benefits are denied for failing to comply with work requirements imposed under the TANF program.	Section 117(a) would add a new state plan option, effective October 1, 2017, to permit states to require nondisabled, non-elderly, non-pregnant adults to satisfy a work requirement as a condition for receipt of Medicaid medical assistance.	Section 130(a) is almost identical to the House provision.
Other			
Grandfathering Medicaid Managed Care Waivers	As a Medicaid state plan option, states may choose to require beneficiaries to receive their Medicaid benefits through a managed care entity, subject to various statutory requirements and exceptions. Under SSA Sections 1115 and 1915(b), states may apply to the HHS Secretary for waivers of requirements that otherwise apply to Medicaid managed care programs. SSA Section 1115 demonstration projects and SSA Section 1915(b) waivers are typically approved for fixed periods, and states must apply for an extension to continue operating the demonstration or waiver for a limited number of years.	No provision.	Section 135(a) would allow states operating *grandfathered managed care waivers* (defined as the provisions of a waiver or demonstration project relating to the authority to implement a managed care delivery system that was approved under SSA Sections 1115(a)(1), 1932, or 1915(b) prior to January 1, 2017, and that has been renewed at least one time) to elect, through a state plan amendment, to continue to implement the managed care delivery system indefinitely without submitting an application for a new waiver. The approval would be valid as long as the terms and conditions of the waiver (other than the terms and conditions that relate to budget neutrality) are not modified. To modify the terms and conditions of a grandfathered managed care waiver, a state would be required to apply for a new waiver.
Prioritization of HCBS Waivers	SSA Section 1915(c) authorizes the HHS Secretary to waive certain	No provision.	Section 135(b) would require the HHS Secretary to implement procedures encouraging states to adopt

Provision	Current Law	AHCA	BCRA
	provisions of Medicaid statute, allowing states to cover a broad range of HCBS (including services not available under the Medicaid state plan) for targeted groups (e.g., older adults, physically disabled individuals, individuals with intellectual and developmental disabilities) who, without these services, would require Medicaid-covered institutional care. States may limit waiver coverage by (1) geographic area and (2) the number of individuals served. States also may offer HCBS under Medicaid state plan authorities, such as the SSA Section 1905(a)(24) personal care option, SSA Section 1915(i) HCBS option, and SSA Section 1915(k) Community First Choice option.		or extend waivers related to the authority of a state to make medical assistance available for HCBS under the Medicaid state plan if the state determines that such waivers would improve patient access to services.
Coordination with States	Under the Administrative Procedure Act of 1946, federal agencies' proposed rules must be published in the *Federal Register*. Agency responses to the public comments on the proposed rule must be published in the *Federal Register* as part of the final rule. Congress may choose to add further rulemaking requirements for specific programs. States also must adhere to specified approval processes when seeking CMS approval for waivers and for amendments to their Medicaid state plans.	No provision.	Section 136 would require the HHS Secretary to solicit input from state Medicaid agencies and directors regarding the operation and financing of the Medicaid program on an ongoing basis. Before the submission of any final proposed rule, plan amendment, waiver request, or project proposal relating to the operation or financing of Medicaid, the HHS Secretary would be required to accept and consider comments from both state Medicaid agencies and a professional organization representing state Medicaid directors and to summarize these comments in the preamble to the proposed rule.
State Option to Provide Assistance for Certain Inpatient Psychiatric Services	The IMD exclusion is a long-standing policy under Medicaid that prohibits the federal government from providing federal Medicaid matching funds to	No provision.	Section 137(a) would provide states with the option on or after October 1, 2018, of providing Medicaid coverage of *qualified inpatient psychiatric hospital services* to individuals over the age of 21

Provision	Current Law	AHCA	BCRA
	states for services rendered to certain Medicaid-eligible individuals aged 21 through 64 who are patients in IMDs. IMD is defined as a "hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services." (SSA Section 1905(i))		and under the age of 65 as long as certain conditions are met regarding maintaining (1) the number of licensed beds at psychiatric hospitals in the state and (2) annual state spending. Qualified inpatient psychiatric hospital services would be services furnished at a psychiatric hospital (i.e., an institution that is primarily engaged in providing for the diagnosis and treatment of mentally ill persons) for a Medicaid enrollee who has a stay that does not exceed (1) 30 consecutive days in a month and (2) 90 days in any calendar year.

Source: CRS analysis of H.R. 1628, American Health Care Act (AHCA) of 2017, as passed by the House on May 4, 2017, and Senate discussion draft LYN17343, Better Care Reconciliation Act of 2017, as posted on the Senate Budget Committee website on June 26, 2017.

Notes: ABP = alternative benefit plan; ACA = Patient Protection and Affordable Care Act (P.L. 111-148, as amended); AHCA = American Health Care Act; BCRA = Better Care Reconciliation Act; CHIP = State Children's Health Insurance Program; CMS = Centers Medicare & Medicaid Services; CPI-U = Consumer Price Index for All Urban Consumers; CY = calendar year; DSH = disproportionate share hospital; EHB = essential health benefits; FMAP = federal medical assistance percentage; FPL = federal poverty level; FY = fiscal year; HCBS = home and community-based services; HHS = Department of Health and Human Services; IHS = Indian Health Service; IMD = institutions for mental diseases; IT/TO = Indian Tribe/Tribal Organization; LTSS = long-term services and supports; MAGI = modified adjusted gross income; NA = not applicable; SSA = Social Security Act; TANF = Temporary Assistance for Needy Families.

Table 3. Provisions Related to Public Health, Taxes, and Implementation Funding in the American Health Care Act (AHCA) and the Better Care Reconciliation Act (BCRA)

Provision	Current Law	AHCA	BCRA
Public Health			
Prevention and Public Health Fund	The ACA established the Prevention and Public Health Fund and provided a permanent annual appropriation for prevention and public health programs. Annual appropriation amounts were subsequently reduced.	Section 101 would repeal all Prevention and Public Health Fund appropriations starting in FY2019 and would rescind any unobligated balance remaining at the end of FY2018.	Section 201 also would repeal all Prevention and Public Health Fund appropriations starting in FY2019 and does not mention rescission.
Community Health Center Program	The ACA created the Community Health Center Fund, which provided mandatory appropriations to support	Section 102 would provide an additional $422 million to the Community Health Center Fund in FY2017.	Section 203 is identical to the House provision.

Provision	Current Law	AHCA	BCRA
	the Health Center Program for FY2011-FY2015. The Health Center Program provides grants to outpatient primary care facilities that provide health services to underserved populations in health professional shortage areas. These appropriations were subsequently extended for FY2016-FY2017, for which $3.6 billion was appropriated to the fund in each year.		
Federal Payments to States	Planned Parenthood Federation of America-affiliated health centers receive reimbursements, including from Medicaid and other federal programs, for family planning and other services provided to beneficiaries. Planned Parenthood Federation of America and its affiliates may receive federal grants. Some facilities provide abortions using nonfederal revenue sources because federal funds are available for abortions only in cases of rape, incest, or endangerment of a mother's life. Other types of health facilities may be similar to Planned Parenthood Federation of America-affiliated health centers because they receive federal grants, obtain reimbursements for health services provided to beneficiaries enrolled in federal programs, and may provide abortions in instances where federal reimbursement is not available.	Section 103 would restrict a prohibited entity, as defined, for a period of one year effective at enactment, from receiving direct spending (e.g., Medicaid reimbursements). A prohibited entity is (1) a nonprofit organization; (2) an essential community provider that provides family planning, reproductive health, and any other related services; (3) an organization that provides abortions in instances when the pregnancy is not the result of rape, incest, or likely to endanger the mother's life; and (4) an organization that received federal and state Medicaid reimbursements in FY2014 that exceeded $350 million. The Congressional Budget Office stated that it expects that, "according to those criteria, only the Planned Parenthood Federation of America and its affiliates and clinics would be affected."[a]	Section 123 is identical to the House provision.[a]
State Grants for Substance Abuse and Mental Health	SAMHSA administers grants and other activities to support prevention and	Prevention, treatment, and recovery services for mental or substance use disorders would	Section 202 would authorize to be appropriated and would appropriate to the HHS Secretary (1)

Provision	Current Law	AHCA	BCRA
	treatment of substance use disorder and mental illness. In CY2016, Congress authorized to be appropriated $500 million for each of FY2017 and FY2018 for state grants to address the opioid abuse crisis (P.L. 114-255). Congress appropriated $500 million for FY2017 pursuant to this authority (P.L. 114-254). NIH supports research on addiction, including addiction related to pain, primarily through NIDA. The Consolidated Appropriations Act, 2017 (P.L. 115-31), appropriated $1 billion (rounded) for NIDA in FY2017, which is approximately the same amount appropriated annually in recent years.	be among the allowed uses of funds in the Patient and State Stability Fund, as would be established under Section 132 (described in **Table 1**).	$4.972 billion for each of FY2018-FY2026 to provide grants to states "to support substance use disorder treatment and recovery support services" and (2) $50.4 million for each of FY2018-FY2022 "for research on addiction and pain related to the substance abuse crisis." Such funds would remain available until expended. Section 202 would not amend (and does not refer to) any existing authorization.
Tax Advantaged Accounts			
Tax on Over-the-Counter Medications	Taxpayers may use several different types of tax-advantaged health accounts to pay or be reimbursed for qualified medical expenses. However, the ACA imposed the requirement that amounts paid for medicine or drugs are qualified expenses only in the case of prescribed drugs and insulin and not in the case of over-the-counter medications.	Section 207 would repeal the requirement, effective beginning tax year 2017.	Section 109 is identical to the House provision.
Tax on Health Savings Account and Archer Medical Savings Account	Distributions from Archer MSAs and HSAs that are used for purposes other than paying for qualified medical expenses are taxed at 20%. Prior to the ACA, the tax rate on such distributions was 15% and 10% for Archer MSAs and HSAs, respectively.	Section 208 would reduce the applicable tax rate to 15% and 10% for Archer MSAs and HSAs, respectively, for distributions made after December 31, 2016.	Section 110 is identical to the House provision.

Provision	Current Law	AHCA	BCRA
Limitation on Contributions to Flexible Spending Account	Under the ACA, an employee may contribute a maximum of $2,500 to a health FSA established under a cafeteria plan.	Section 209 would repeal this limit, effective beginning tax year 2017.	Section 111 also would repeal this limit, but the repeal would be effective for plan years beginning in 2018.
Maximum Contribution Limit to Health Savings Account Increased to Amount of Deductible and Out-of-Pocket Limitation	HSA contributions are subject to an annual limit, which is adjusted for inflation. In 2017, the contribution limit is $3,400 for account holders enrolled in self-only coverage and $6,750 for account holders enrolled in family coverage.	Section 215 would increase the HSA annual contribution limits to match the out-of-pocket limits for HSA-qualified high-deductible health plans for self-only and family coverage, effective beginning in tax year 2018.	Section 119 is identical to the House provision.
Allow Both Spouses to Make Catch-Up Contributions to the Same Health Savings Account	HSA contributions are subject to limits. In the case of a married couple, if either spouse has HSA-qualified family coverage and both spouses have their own HSAs, then both spouses are treated as if they have only one family plan for purposes of the HSA contribution limit. Their annual contribution limit is first reduced by any amount paid to Archer MSAs of either spouse for the taxable year, and then the remaining contribution amount is divided equally between the spouses unless they agree on a different division. Each spouse is allowed to make catch-up contributions to his or her respective HSA, provided each spouse is eligible to do so.	Under Section 216, with respect to the contribution limit to an HSA, married individuals would not have to take into account whether their spouse also is covered by an HSA-qualified high-deductible health plan. The section also would effectively allow both spouses to make catch-up contributions to one HSA. The section would apply to taxable years beginning in 2018.	Section 120 is identical to the House provision.
Special Rule for Certain Medical Expenses Incurred Before Establishment of Health Savings Account	In general, withdrawals from HSAs are exempt from federal income taxes if used for qualified medical expenses, except for health insurance. However, withdrawals from HSAs are not exempt from federal income taxes if used to pay qualified medical expenses	Section 217 would provide a circumstance under which HSA withdrawals may be used to pay qualified medical expenses incurred before the HSA was established. Section 218 would apply to coverage beginning after December 31, 2017.	Section 121 is almost identical to the House provision.

Provision	Current Law	AHCA	BCRA
	incurred before the HSA was established.		
Purchase of Insurance from Health Savings Account	In general, withdrawals from HSAs are exempt from federal income taxes if used for qualified medical expenses. Qualified medical expenses include amounts paid for medical care for the account holder, the account holder's spouse, and any dependents, as defined in IRC Section 152 (with some modifications). In general, for a child to be considered a dependent under IRC Section 152, the child must be under the age of 19 or under the age of 24 and a student, among other requirements. HSA funds cannot be used to pay insurance premiums, except for long-term care insurance; health insurance premiums during periods of continuation coverage required by federal law; health insurance premiums during periods in which the individual is receiving unemployment compensation; and, for individuals aged 65 years and older, any health insurance premiums (including Medicare Part B premiums) other than a Medicare supplemental policy (as defined in SSA Section 1882).	No provision.	Section 118 would amend the definition of qualified medical expenses to include amounts paid for an account holder's children who are under the age of 27. Section 118 also would provide that HSA funds may be used to pay premiums for an HDHP that meets specified requirements. The changes made by Section 118 would apply to coverage beginning in 2018.
High-Deductible Health Plans and Coverage for Abortion	As described directly above, withdrawals from HSAs are exempt from federal income taxes if used for qualified medical expenses and HSA funds cannot be used to pay insurance premiums, except in certain circumstances.	No provision.	Section 118 would provide that HSA funds may be used to pay premiums for an HDHP that meets specified requirements. Section 122 would provide that HSA funds cannot be used to pay for an HDHP that provides coverage for abortions (except if necessary to save the life of the mother or if the pregnancy is

Provision	Current Law	AHCA	BCRA
			the result of rape or incest). Section 122 would apply to coverage beginning after December 31, 2017.
Tax Provisions			
Remuneration from Certain Insurers	Generally, employers may deduct the remuneration paid to employees as "ordinary and necessary" business expenses, subject to any statutory limitations. However, under the ACA, certain health insurance providers cannot deduct the remuneration paid to an officer, director, or employee in excess of $500,000.	Section 241 would repeal this limit, effective beginning tax year 2017.	No provision.
Tanning Tax	The ACA imposes an excise tax on indoor tanning services equal to 10% of the amount paid.	Section 231 would repeal the tax, effective after June 30, 2017.	Section 117 also would repeal the tax, but the repeal would be effective after September 30, 2017.
Tax on Prescription Medications	The ACA imposes an annual tax on certain manufacturers or importers of branded prescription drugs.	Section 221 would repeal the tax, effective CY2017.	Section 112 also would repeal the tax, but the repeal would be effective CY2018.
Health Insurance Tax	The ACA imposes an annual fee on certain health insurers. The fee has been suspended for CY2017 but is to apply again beginning in CY2018.	Section 222 would repeal the fee, effective CY2017.	Section 114 is almost identical to the House provision.
Net Investment Income Tax	The ACA applies a 3.8% tax to certain net investment income of individuals, estates, and trusts with income above specified amounts.	Section 251 would repeal the net investment tax, effective beginning tax year 2017.	No provision.
Tax on Employee Health Insurance Premiums and Health Plan Benefits	The ACA established a 40% excise tax on high-cost employer-sponsored coverage (the so-called Cadillac tax) effective in 2018; however, a subsequent law delayed implementation until 2020.	Section 206 would further delay implementation of the tax until 2026.	Section 108 is effectively the same as the House provision.
Medical Device Excise Tax	The ACA established a 2.3% excise tax	Section 210 would repeal the tax, effective for	Section 113 also would repeal the tax, but the

Provision	Current Law	AHCA	BCRA
	that is imposed on the sale of certain medical devices. The tax took effect on January 1, 2013, but a subsequent law imposed a two-year moratorium for CY2016-CY2017.	sales after December 31, 2016.	repeal would be effective for sales after December 31, 2017.
Elimination of Deduction for Expenses Allocable to Medicare Part D Subsidy	Employers that provide Medicare-eligible retirees with qualified prescription drug coverage are eligible for federal subsidy payments. Prior to implementation of the ACA, employers were allowed to claim a business deduction for their qualified retiree prescription drug expenses, even though they also received the federal subsidy to cover a portion of those expenses. Under the ACA, beginning in 2013, the amount allowable as a deduction is reduced by the amount of the federal subsidy received.	Section 211 would repeal the ACA change and reinstate business-expense deductions for retiree prescription drug costs without reduction by the amount of any federal subsidy. The change would be effective for taxable years beginning after December 31, 2016.	Section 115 is identical to the House provision.
Income Threshold for Determining Medical Care Deduction	Under the ACA, taxpayers who itemize their deductions may deduct qualifying medical expenses if the expenses exceed 10% of the taxpayer's adjusted gross income. Prior to the ACA, the AGI threshold was 7.5% for all taxpayers.	Section 212 would reduce the AGI threshold to 5.8% for all taxpayers, effective beginning tax year 2017.	Section 116 would reduce the AGI threshold to 7.5% for all taxpayers, effective beginning tax year 2017.
Medicare Tax Increase	Under the ACA, a Medicare Hospital Insurance surtax is imposed at a rate equal to 0.9% of an employee's wages or a self-employed individual's self-employment income. The surtax applies only to taxpayers with taxable income in excess of $250,000 if married filing jointly; $125,000 if married filing separately; and $200,000 for all other taxpayers.	Section 213 would repeal the 0.9% Medicare surtax, with respect to remuneration received after, and taxable years beginning after, December 31, 2022.	No provision.

Provision	Current Law	AHCA	BCRA
Implementation Funding			
Implementation Funding	NA	Section 141 would establish an American Health Care Implementation Fund within HHS to be used to implement the following AHCA provisions: per capita allotment for medical assistance, Patient and State Stability Fund, additional modifications to the premium tax credit, and refundable tax credit for health insurance coverage. Section 141 would appropriate $1 billion to the fund.	Section 107 also would establish a fund within HHS. The Better Care Reconciliation Implementation Fund could be used for federal administrative expenses for carrying out the draft bill. Section 107 would appropriate $0.5 billion to the fund.

Sources: CRS analysis of H.R. 1628, American Health Care Act (AHCA) of 2017, as passed by the House on May 4, 2017, and Senate discussion draft LYN17343, Better Care Reconciliation Act of 2017, as posted on the Senate Budget Committee website on June 26, 2017.

Notes: ACA = Patient Protection and Affordable Care Act (P.L. 111-148, as amended); AGI = adjusted gross income; AHCA = American Health Care Act; BCRA = Better Care Reconciliation Act; CY = calendar year; FSA = flexible spending account; FY = fiscal year; HDHP = High-Deductible Health Plan; HHS = Department of Health and Human Services; HSA = health savings account; MSA = medical savings account; NIH = National Institute of Health; NIDA = National Institute on Drug Abuse; SAMHSA = Substance Abuse and Mental Health Services Administration.

a. Congressional Budget Office (CBO) and Joint Committee on Taxation, American Health Care Act Budget Reconciliation Recommendations of the House Committees on Ways and Means and Energy and Commerce, March 9, 2017, p. 23. In the CBO's cost estimate of the June 26, 2017 version of BCRA, CBO states that it expects that "the prohibition, as phrased, would apply only if at least one entity, affiliate, subsidiary, successor, or clinic satisfied the first three criteria. CBO identified only one organization that would be affected: Planned Parenthood Federation of America and its affiliates and clinics." CBO also wrote, in a footnote, that "[i]f the provision was implemented in a way that affiliates, subsidiaries, successors, and clinics could satisfy the criteria separately, then the provision could apply to more entities, perhaps many more." See CBO, *Cost Estimate: H.R. 1628, Better Care Reconciliation Act of 2017*, June 26, 2017, p. 33, at https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/52849-hr1628senate.pdf. The provision in the July 20, 2017, version of BCRA is identical to the provision in the June 26, 2017, version of BCRA that CBO analyzed.

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