American Health Care Act of 2017

TITLE I--ENERGY AND COMMERCE

Subtitle A--Patient Access to Public Health Programs

(Sec. 101) This bill amends the Patient Protection and Affordable Care Act (PPACA) to eliminate funding after FY2018 for the Prevention and Public Health Fund, which provides for investment in prevention and public health programs to improve health and restrain the rate of growth in health care costs. Funds that are unobligated at the end of FY2018 are rescinded.

(Sec. 102) The bill amends the Medicare Access and CHIP Reauthorization Act of 2015 to increase funding for community health centers.

(Sec. 103) For one year, certain federal funds may not be made available to states for payments to certain family planning providers (e.g., Planned Parenthood Federation of America).

Subtitle B--Medicaid Program Enhancement

(Sec. 111) The bill amends title XIX (Medicaid) of the Social Security Act (SSAct) to limit the state option for a participating-provider hospital to preliminarily determine an individual's Medicaid eligibility for purposes of providing the individual with medical assistance during a presumptive eligibility period. The bill lowers, from 133% to 100% of the official poverty line, the minimum family-income threshold that a state may use to determine the Medicaid eligibility of children between the ages of 6 and 19. In addition, the bill reduces the Federal Medical Assistance Percentage (FMAP) for Medicaid home- and community-based attendant services and supports.

(Sec. 112) Beginning in 2020, the bill eliminates: (1) the enhanced FMAP for Medicaid services furnished to adult enrollees made newly eligible for Medicaid by PPACA; and (2) the expansion of Medicaid, under PPACA, to cover such enrollees. However, a state Medicaid program may continue to provide coverage, with the enhanced FMAP, to such enrollees who were enrolled prior to 2020 and do not subsequently have any break in eligibility exceeding one month.

The bill also eliminates, beginning in 2018, the state option to extend Medicaid coverage to non-elderly adults with incomes above 133% of the official poverty line.

With respect to states that expanded Medicaid under PPACA, current law provides for transitional FMAP increases through 2019. The bill eliminates these increases after 2017, capping the FMAP at the 2017 level.

Under current law, any alternative benefit plan offered by a state Medicaid program is required to provide specified essential health benefits. The bill eliminates this requirement beginning in 2020. ("Essential health benefits" include ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative services, laboratory services, preventative and wellness services, and pediatric services.)

(Sec. 113) The bill: (1) exempts from Medicaid Disproportionate Share Hospital (DSH) payment reductions, states that did not implement Medicaid expansion under PPACA; and (2) eliminates DSH reductions after FY2019. (DSH hospitals receive additional payment under Medicaid for treating a large share of low-income patients.)

(Sec. 114) The bill specifies how a state must treat qualified lottery winnings and lump sum income, beginning in 2020, for purposes of determining an individual's income-based eligibility for a state Medicaid program. Specifically, a state shall include such winnings or income as income received: (1) in the month in which it was received, if the amount is less than $80,000; (2) over a period of two months, if the amount is at least $80,000 but less than $90,000; (3) over a period of three months, if the amount is at least $90,000 but less than $100,000; and (4) over an additional one-month period for each increment of $10,000 received, not to exceed 120 months. An individual whose income exceeds the applicable eligibility threshold due to qualified lump sum income may continue to be eligible for medical assistance to the extent that the state determines that denial of eligibility would cause undue medical or financial hardship.

Qualified lump sum income includes: (1) monetary winnings from gambling, and (2) income received as liquid assets from the estate of a deceased individual.

In addition, the bill eliminates the requirement for up to three months of retroactive coverage under Medicaid. Under current law, a state Medicaid program must provide coverage for up to three months prior to an individual's application for benefits if the individual would have been eligible for benefits during that period.

In addition, the bill disallows a state from using, for purposes of determining Medicaid eligibility for long-term care assistance, a home equity limit that exceeds the statutory minimum.

(Sec. 115) With respect to states that did not expand Medicaid coverage under PPACA, the bill: (1) with specified limitations, provides for additional federal funding for certain health care services; and (2) through FY2022, increases the applicable FMAP. A non-expansion state that subsequently expands Medicaid coverage under PPACA shall become ineligible for this funding.

(Sec. 116) No less frequently than every six months, states must redetermine the eligibility of adult enrollees made newly eligible for Medicaid by PPACA. The bill temporarily increases by 5% the FMAP for expenditures that are attributable to meeting this requirement.

(Sec. 117) The bill allows a state Medicaid program to impose a work requirement as a condition of eligibility. However, a program may not apply such a requirement to: (1) a pregnant woman, (2) the sole parent or caretaker of either a child younger than age 6 or a child with disabilities, (3) an individual younger than age 19, or (4) an individual younger than age 20 who is married or head of a household and either attends secondary school or participates in employment-related education. The bill increases by 5% the FMAP for certain administrative expenditures that are attributable to implementing a work requirement.

Subtitle C--Per Capita Allotment for Medical Assistance

(Sec. 121) Under current law, state Medicaid programs are guaranteed federal matching funds for qualifying expenditures. The bill establishes limits on federal funding for state Medicaid programs beginning in FY2020. Specifically, the bill establishes targeted spending caps for each state, using a formula based on the state's FY2016 medical assistance expenditures in each enrollee category: (1) the elderly, (2) the blind and disabled, (3) children, (4) adults made newly eligible for Medicaid by PPACA, and (5) all other enrollees. With respect to a state that exceeds its targeted spending cap in a given fiscal year, the bill provides for reduced federal funding in the following fiscal year. In addition, the bill: (1) requires additional reporting and auditing of state data on medical assistance expenditures, and (2) temporarily increases the FMAP with respect to certain data reporting expenditures.

The bill reduces targeted spending for certain states that require political subdivisions to contribute funds towards medical assistance. Specifically, the bill applies to states that received, for FY2016, DSH allotments greater than six times the national average. Specified contributions are excepted.

A state Medicaid program may elect to receive, for any 10-year period beginning no earlier than FY2020, federal funding in block grant form. The bill establishes a formula, using targeted spending caps, for determining the amount of block grant funds. A state plan for administering a block grant shall specify: (1) conditions of eligibility for receiving health care assistance under the block grant; (2) the types, amount, duration, and scope of services to be covered; and (3) methods of delivery and cost-sharing with respect to covered services. Such a plan must: (1) provide for eligibility of specified children and pregnant women; and (2) offer assistance for hospital care, surgical care, medical care, obstetrical and prenatal care, prescribed drugs and prosthetic devices, other medical supplies, and pediatric care.

Subtitle D--Patient Relief and Health Insurance Market Stability

(Sec. 131) After 2019, the bill eliminates cost sharing reductions for low-income individuals with certain health insurance.

(Sec. 132) The bill amends the SSAct to establish and make appropriations for the Patient and State Stability Fund. The fund is administered by the Centers for Medicare and Medicaid Services (CMS) and provides funding to states through 2026, including to: provide financial assistance to high-risk individuals so they may enroll in health insurance, enter into arrangements with entities to stabilize health insurance premiums in the individual market, promote participation and increase options in the health insurance market, pay providers for services, and provide financial assistance to enrollees to reduce out-of-pocket costs.

Funding is allocated to states based on each state's share of incurred claims and uninsured individuals below the poverty line. To receive funding after 2019, states must provide matching funds at a rate that varies from 7% to 50% based on the year and whether the state applied for funding.

The bill increases appropriations for 2020 by $15 billion for maternity coverage, newborn care, and services for individuals with mental health or substance use disorders.

The bill establishes the Federal Invisible Risk Sharing Program, administered by the CMS, to pay health insurers for certain individuals' claims in order to lower premiums in the individual market. The bill appropriates $15 billion for this fund for 2019-2026.

(Sec. 133) Health insurers must increase premiums by 30% for one year for enrollees in the individual market who had a break in coverage of more than 62 days in the previous year. States with programs under this bill to provide financial assistance to high-risk individuals or stabilize health insurance premiums in the individual market and states participating in the Federal Invisible Risk Sharing Program may apply for a waiver to allow health insurers, for individuals with a break in coverage, to vary premiums based on an individual's health status instead of increasing premiums by 30%.

The bill appropriates $8 billion for the Patient and State Stability Fund to be allocated to states with a waiver to allow premiums to vary by health status in order to reduce costs for individuals whose premiums increased due to the waiver.

(Sec. 134) Beginning in 2020, health insurance benefits no longer must conform to actuarial tiers (e.g., silver level benefits).

(Sec. 135) The bill increases the ratio by which health insurance premiums may vary by age, from a three to one ratio to a five to one ratio. This ratio may be preempted by states.

(Sec. 136) States may apply to the Department of Health and Human Services (HHS) for waivers to increase the ratio by which health insurance premiums may vary by age and to waive the requirement for insurance to cover the essential health benefits.

These waivers and the waiver to allow premiums to vary by health status do not apply to health plans offered through the CO-OP program, multi-state plans, plans the federal government makes available to members of Congress and their staff, or plans under PPACA provisions that allow state flexibility.

Subtitle E--Implementation Funding

(Sec. 141) The bill establishes and appropriates $1 billion for the American Health Care Implementation Fund to provide for the implementation of programs in this bill

TITLE II--COMMITTEE ON WAYS AND MEANS

Subtitle A--Repeal and Replace of Health-Related Tax Policy

Sections 201-203 and 214 of the bill make several modifications to the premium assistance tax credit, which is currently provided to eligible individuals and families to subsidize the purchase of health insurance plans on an exchange.

(Sec. 201) This section makes taxpayers liable for the full amount of excess advance payments of the credit. (Under current law, liability for certain low-income households is limited to an applicable dollar amount.)

(Sec. 202) This section modifies the premium assistance tax credit to:

- make the credit available for catastrophic qualified health plans and plans that are not offered through an exchange, but otherwise meet the requirements for qualified health plans;
- prohibit the credit from being used for grandfathered or grandmothered health plans;
- prohibit the credit from being used for health plans that cover abortions (other than abortions necessary to save the life of the mother or abortions with respect to a pregnancy that is the result of an act of rape or incest); and
- revise the formula used to calculate the credit using a schedule that varies with household income and the age of individuals or family members.

Advance payments of the credit may not be made with respect to any health plan that is not enrolled in through an exchange.

(Sec. 203) This section modifies the small employer tax credit for employee health insurance expenses to: (1) prohibit the credit from being used for health plans that include coverage for abortions (other than any abortion necessary to save the life of the mother or any abortion with respect to a pregnancy that is the result of an act of rape or incest) for taxable years beginning after December 31, 2017; and (2) repeal the credit for taxable years beginning after December 31, 2019.

(Sec. 204) This section repeals the penalties for individuals who are not covered by a health plan that provides at least minimum essential coverage (commonly referred to as the individual mandate). The repeal is effective for months beginning after December 31, 2015.

(Sec. 205) This section repeals the penalties for certain large employers who do not offer full-time employees and their dependents minimum essential health coverage under an employer-sponsored health plan (commonly referred to as the employer mandate). The repeal is effective for months beginning after December 31, 2015.

(Sec. 206) This section delays the implementation of the excise tax on high cost employer-sponsored health coverage (commonly referred to as the Cadillac tax) until 2026. (Under current law, the tax goes into effect in 2020.)

(Sec. 207) This section permits tax-favored health savings accounts (HSAs), Archer Medical Savings Accounts (MSAs), health flexible spending arrangements (FSAs), and health reimbursement arrangements to be used to purchase over-the-counter medicine that is not prescribed by a physician.

(Sec. 208) This section repeals the increase in the tax on distributions from HSAs and Archer MSAs that are not used for qualified medical expenses. The bill reduces the tax on HSA distributions from 20% to 10% and reduces the tax for Archer MSA's from 20% to 15% to return the taxes to the levels that existed prior to the enactment of PPACA.

(Sec. 209) This section repeals the limitation on FSA salary reduction contributions.

(Sec. 210) This section repeals the medical device excise tax for sales after December 31, 2016.

(Sec. 211) This section permits employers who provide Medicare-eligible retirees with qualified prescription drug coverage and receive federal subsidies for prescription drug plans to claim a deduction for the expenses without reducing the deduction by the amount of the subsidy.

(Sec. 212) This section reduces the income threshold used to determine whether an individual may claim an itemized deduction for unreimbursed medical expenses. The bill allows all taxpayers to claim an itemized deduction for unreimbursed expenses medical expenses that exceed 5.8% (10% under current law) of adjusted gross income.

(Sec. 213) This section repeals the additional Medicare tax that is imposed on certain employees and self-employed individuals with wages or self-employment income above specified thresholds.

(Sec. 214) The section modifies the premium assistance tax credit to allow a refundable, advanceable tax credit beginning in 2020 for certain individuals who purchase health insurance and who are not eligible for other sources of coverage.

To be eligible for the credit, an individual:

- must be covered by health insurance that is certified by the state in which the insurance is offered as meeting the requirement of this bill;
- may not be eligible for other specified sources of coverage;
- must be either a U.S. citizen or national or a qualified alien; and
- may not be incarcerated, other than incarceration pending the disposition of charges.

The credit is allowed for health insurance coverage that:

- is offered in the individual health insurance market within a state;
- substantially all of which is not for excepted benefits providing only limited coverage, such as dental, vision, or long-term care;
- does not consist of short-term limited duration insurance; is not a grandfathered or grandmothered plan; and
- does not include coverage for abortions (other than any abortion necessary to save the life of the mother or any abortion with respect to a pregnancy that is the result of an act of rape or incest).

The bill specifies credit amounts which are based on age and adjusted gross income. It also limits the annual credit amount to $14,000 per family.

The Department of the Treasury and HHS must prescribe regulations to establish and operate the advance payment program, with respect to the credit for individuals covered under qualified health plans (whether enrolled in through an exchange or otherwise), in

such a manner that protects taxpayer information, provides robust verification of all information necessary to establish eligibility of taxpayer for advance payments, ensures proper and timely payments to appropriate health providers, and protects program integrity.

(Sec. 215) This section increases the limits on HSA contributions to match the sum of the annual deductible and out-of-pocket expenses permitted under a high deductible health plan.

(Sec. 216) This section permits both spouses of a married couple who are eligible for HSA catch-up contributions to make the contributions to the same HSA account.

(Sec. 217) This section permits an HSA to be used to pay certain medical expenses that were incurred before the HSA was established. If the HSA is established during the 60-day period beginning on the date that an individual's coverage under a high deductible health plan begins, the HSA is treated as having been established on the date coverage under the high deductible health plan begins to determine whether an amount paid is used for a qualified medical expense.

Subtitle B--Repeal of Certain Consumer Taxes

(Sec. 221) This section repeals the annual fee on branded prescription pharmaceutical manufacturers and importers.

(Sec. 222) This section repeals the annual fee imposed on certain health insurance providers based on market share.

Subtitle C--Repeal of Tanning Tax

(Sec. 231) This section repeals the 10% excise tax on the price of indoor tanning services.

Subtitle D--Remuneration from Certain Insurers

(Sec. 241) The section repeals a provision that prohibits certain health insurance providers from deducting remuneration paid to an officer, director, or employee in excess of $500,000.

Subtitle E--Repeal of Net Investment Income Tax

(Sec. 251) This section repeals the 3.8% tax on the net investment income of individuals, estates, and trusts with incomes above specified amounts.