

# SECTION-BY-SECTION SUMMARY

## Subtitle A: Patient Access to Public Health Programs

### **Section 101 – The Prevention and Public Health Fund**

Section 4002 in the Patient Protection and Affordable Care Act established the Prevention and Public Health Fund (PPHF) as an advanced appropriation for prevention, wellness, and public health initiatives to be administered Department of Health and Human Services (HHS). Annual appropriations for the PPHF continue in perpetuity. If Congress does not explicitly allocate the funding, the HHS Secretary has broad authority to spend these dollars without Congressional oversight. This section repeals PPHF appropriations for fiscal year 2019 onwards. Any unobligated PPHF funds remaining at the end of fiscal year 2018 are to be rescinded.

### **Section 102 – Community Health Center Program**

This section provides increased funding for the Community Health Center Fund, which awards grants to Federally Qualified Health Centers (FQHCs). FQHCs are community-based outpatient facilities that provide health services to medically underserved populations. These health services include comprehensive medical, dental, mental health and reproductive care, in addition to other primary care services.

### **Section 103 – Federal Payments to States**

This section imposes a one-year freeze on mandatory funding to a class of providers designated as prohibited entities. This funding includes Medicaid, the Children’s Health Insurance Program, Maternal and Child Health Services Block Grants, and Social Services Block Grants. A prohibited entity is one that meets the following criteria: it is designated as a non-profit by the Internal Revenue Service; it is an essential community provider primarily engaged in family planning and reproductive health services; it provides abortions in cases that do not meet the Hyde amendment exception for federal payment; and it received over \$350 million in federal and state Medicaid dollars in fiscal year 2014.

## Subtitle B: Medicaid Program Enhancement

### **Section 111 – Repeal of Medicaid Provisions**

#### **Section (111) (a) and 111 (3)**

- Repeals States expanded authority to make presumptive eligibility determination. States would still be allowed to make presumptive eligibility determinations for children, pregnant women, and breast cancer and cervical cancer patients.

#### **Section 111 (1) (b)**

- Reverts the mandatory Medicaid income eligibility level for poverty-related children back to 100 percent of federal poverty level. States could cover this population in their State Children’s Health Insurance Program (CHIP).

### **Section 111 (2)**

- Repeals the 6 percentage point bonus in the federal match rate for community-based attendant services and supports, and would return to prior law without the 6 percent bonus.

### **Section 112 – Repeal of Medicaid Expansion**

#### **Section 112 (a)**

- Codifies NFIB v. Sebelius and makes Medicaid expansion optional for States
- Repeals the State option to extend coverage to adults above 133% of federal poverty by December 31, 2019.

#### **Section 112 (b)**

- Repeals the enhanced match rate for newly eligible beneficiaries on December 31, 2019. States can keep the enhanced match for *newly eligible* expenditures that occur before January 1, 2020. However, for expenditures after January 1, 2020, the *newly eligible* matching rate would only apply to expenditures for newly eligible individuals who were enrolled in Medicaid (under the State plan or a waiver) as of December 31, 2019 and do not have a break in eligibility for more than one month after that date. After January 1, 2020, the State could only enroll newly eligible individuals at the State's traditional FMAP for that individual.

#### **Section 112 (b)(2)**

- The ACA added a few FMAP exceptions, including the *expansion State* federal matching rate, which is the federal matching rate available for non-pregnant childless adults in expansion States that implemented the ACA Medicaid expansion before March 23, 2010. For this population the ACA created a phase up matching rate for these groups. The *expansion State* federal matching rate varies from State to State. However, the formula used to calculate the *expansion State* federal matching rates is based on each State's regular FMAP rate and annual transition percentages set in statute. The annual transition percentages for the *expansion State* matching rate formula are 50% in CY2014, 60% in CY2015, 70% in CY2016, 80% in CY2017, 90% in CY2018, and 100% for CY2019 and subsequent years.
- Section 112 (b)(2) amends the formula for the *expansion State* matching rate so that the matching rate stops phasing up after CY2017 and the transition percentage would remain at the CY2017 level for each subsequent year. In addition, for expenditures after January 1, 2020, the *expansion State* matching rate would only apply to expenditures for individuals who are eligible for the *expansion State* matching rate and were enrolled in Medicaid (under the State

plan or a waiver) as of December 31, 2019 and do not have a break in eligibility for more than one month after that date. After January 1, 2020, the State would have the option to enroll newly eligible individuals, but the State would receive the State's traditional FMAP for that individual.

**Section 112 (c)**

- Repeals the requirement that State Medicaid plans must provide the same “essential health benefits” that are required by plans on the exchanges, returning flexibility to the States on December 31, 2019.

**Section 113 – Elimination of DSH Cuts**

Repeals the Medicaid Disproportionate Share Hospital (DSH) cuts for non-expansion States in 2018. States that expanded Medicaid would have their DSH cuts repealed in 2020.

**Section 114 – Reducing State Medicaid Costs**

**Section 114 (a)**

- Would eliminate an unintended consequence in the current statute and regulations by requiring States, for purposes of determining MAGI for Medicaid and CHIP eligibility, to consider monetary winnings from lotteries (and other lump sum payments) as if they were obtained over multiple months, even if obtained in a single month.
- It would count lottery winnings above \$80,000 over multiple months, thus preventing individuals with significant financial means from inappropriately shifting the cost of their care to the Medicaid program.
- It includes a hardship exemption by which States could continue to provide Medicaid coverage for an individual if the denial of coverage would cause an undue medical or financial hardship as determined based on criteria established by the Secretary of HHS.

**Section 114 (b)**

- Would limit the effective date for retroactive coverage of Medicaid benefits to the month in which the applicant applied. This provision would apply to Medicaid applications made (or deemed to be made) on or after October 1, 2017.

**Section 114 (c)**

- In general, Medicaid coverage is only available for individuals who are U.S. citizens or have legal immigration status. However, under current law, State Medicaid programs are currently required to provide applicants who attest to

being U.S. citizens or to having satisfactory immigration status and are determined otherwise eligible for Medicaid, a reasonable opportunity period to provide documentation that would verify their citizenship or eligible immigration status. States are required to enroll applicants in Medicaid and are eligible to receive federal matching funding for their care, during this reasonable opportunity period. As a result, individuals who are not citizens or eligible legal permanent residents may be enrolled and receive Medicaid benefits.

- This section would close the loophole in current practice by requiring individuals to provide documentation of citizenship or lawful presence before obtaining coverage.

#### **Section 114 (d)**

- Would repeal the authority for States to elect to substitute a higher home equity limit that is above the statutory minimum in law. It would apply to Medicaid eligibility determinations that are made more than 180 days after enactment. In situations where the Secretary of HHS determines that State legislation would be required to amend the State plan, then States would have additional time to comply with these requirements.

#### **Section 115 – Safety Net Funding for Non-Expansion States**

Provides \$10 billion over five years to non-expansion States for safety net funding. For CY2018 through CY2022, each State that has not implemented the ACA Medicaid expansion as of July 1<sup>st</sup> of the preceding year may receive safety net funding to adjust payment amounts for Medicaid providers. For these payment adjustments using the safety net funding, non-expansion States would receive an increased matching rate of 100% for CY2018 through CY2021 and 95% for CY2022. Each non-expansion State's allotment from the \$2 billion would be determined according to the number of individuals in the State with income below 138% of FPL in 2015 relative to the total number of individuals with income below 138% of FPL for all the non-expansion States in 2015. The 2015 American Community Survey 1-year estimates as published by the Bureau of the Census would be used to determine the portion of each State's population that is below 138% of the FPL. If a non-expansion State for a year implements the ACA Medicaid expansion during the year, the State shall no longer be treated as a non-expansion State for safety net funding for subsequent years.

#### **Section 116 – Providing Incentives for Increased Frequency of Eligibility Redeterminations**

Requires States with Medicaid expansion populations to redetermine expansion enrollees' eligibility every 6 months. This ensures individuals not eligible for the program are not remaining enrolled longer than they should, while also allowing eligible individuals to remain enrolled. To boost enforcement and prevent gaming, this policy also increases the allowable civil

monetary penalty the HHS Inspector General is permitted levy if someone intentionally defrauds the program by claiming Medicaid matching funds for an individual not eligible for expansion. This policy also provides a temporary five percent FMAP increase to States for activities directly related to complying with this section.

### **Subtitle C: Per Capita Allotment for Medical Assistance**

#### **Section 121 – Per Capita Allotment for Medical Assistance**

Reforms federal Medicaid financing by creating a per capita cap model (i.e., per enrollee limits on federal payments to States) starting in FY2020. Section 121 would use each State's spending in FY2016 as the base year to set targeted spending for each enrollee category (elderly, blind and disabled, children, non-expansion adults, and expansion adults) in FY2019 and subsequent years for that State. Each State's targeted spending amount would increase by the percentage increase in the medical care component of the consumer price index for all urban consumers from September 2019 to September of the next fiscal year. Starting in FY2020, any State with spending higher than their specified targeted aggregate amount would receive reductions to their Medicaid funding for the following fiscal year.

Section 121 would also modernize Medicaid's data and reporting systems. The additional reporting requirements would include data on medical assistance expenditures within categories of services and categories of all enrollees on Medicaid. Providing a full picture of spending in the program for the first time in the program's history and helping to make the transition to a per capita model smooth and efficient. To help States prepare for these new reporting requirements, section 121 would provide a temporary increase to the federal matching percentage to improve data reporting systems. The temporary increases would impact expenditures on or after October 1, 2017, and before October 1, 2019.

Certain payments are exempt from the caps. For example, DSH payments operate outside of the caps since they are already a capped allotment. Administrative payments are also exempt. In addition, certain populations would be exempt:

- Individuals covered under a CHIP Medicaid expansion program;
- Individuals who receive medical assistance through an Indian Health Service facility;
- Individuals entitled to medical assistance coverage of breast and cervical cancer treatment due to screening under the Breast and Cervical Cancer Early Detection Program;
- The following partial-benefit enrollees:
  - Unauthorized aliens eligible for Medicaid emergency medical care;
  - Individuals eligible for Medicaid family planning options;

- Dual-eligible individuals eligible for coverage of Medicare cost sharing;
- Individuals eligible for premium assistance;
- Coverage of tuberculosis-related services for individuals infected with TB.

Finally, to ensure that gaming does not take place the Secretary of HHS would conduct audits of each State's enrollment and expenditures reported on the Form CMS-64 for FY2016, FY2019, and subsequent years.

## **Subtitle D: Patient Relief and Health Insurance Market Stability**

### **Section 131 – Repeal of Cost-Sharing Subsidy**

Section 1402, the cost-sharing subsidy program, of *the Patient Protection and Affordable Care Act* is repealed in 2020 by this section. The program is designed to lower out-of-pocket costs for those who purchase Silver plans through an exchange established by the law. The Obama administration executed this program without an appropriation, leading to a lawsuit from House Republicans arguing that Congress – and in particular, the House of Representatives – alone holds the constitutional power of the purse. The lawsuit, now entitled *House v. Price*, is being held in abeyance. The next filing date in the case for both parties is May 22, 2017.

### **Section 132 – Patient and State Stability Fund**

This section establishes the Patient and State Stability Fund, which is designed to lower patient costs and stabilize State markets. Under the use of funds, a State may use the resources for any of the following purposes:

- Helping, through the provision of financial assistance, high-risk individuals who do not have access to health insurance coverage offered through an employer enroll in health insurance coverage in the individual market in the State, as such market is defined by the State (whether through the establishment of a new mechanism or maintenance of an existing mechanism for such purpose).
- Providing incentives to appropriate entities to enter into arrangements with the State to help stabilize premiums for health insurance coverage in the individual, as such markets are defined by the State.
- Reducing the cost of providing health insurance coverage in the individual market and small group market, as such markets are defined by the State, to individuals who have, or are projected to have, a high rate of utilization of health services (as measured by cost).
- Promoting participation in the individual market and small group market in the State and increasing health insurance options available through such market.

- Promoting access to preventive services, dental care services (whether preventive or medically necessary), or any combination of such services, as well as mental health and substance use disorders.
- Providing payments, directly or indirectly, to health care providers for the provision of such health care services as are specified by the Administrator.
- Providing assistance to reduce out-of-pocket costs, such as copayments, coinsurance, premiums, and deductibles, of individuals enrolled in health insurance coverage in the State.

If a State chooses not to use the funding for their own program, the resources will be available to the Administrator of the Centers for Medicare & Medicaid Services (CMS) to help stabilize premiums for patients.

The formula used to calculate a State's allotment for years 2018 and 2019 uses two criteria. The first is for 85 percent of the annual funding and is based off of incurred claims for benefit year 2015, and subsequently 2016, which provides for the latest medical loss ratio (MLR) data available that reflects total costs for the on-exchange individual market. The second is for States to access a proportion of the remaining 15 percent. In order to receive this funding, a State must meet one of two triggers: their uninsured population for individuals below 100 percent of federal poverty level (FPL) increased from 2013-2015; or, fewer than three plans are offering coverage on the on-exchange individual market in 2017.

Beginning in 2020, the Administrator will set an allocation methodology to reflect cost, risk, low-income uninsured population, and issuer competition. To determine this methodology, the Administrator will consult with health care consumers, health insurance issuers, State insurance commissioners, and other stakeholders and after taking into consideration additional cost and risk factors that may inhibit health care consumer and health insurance issuer participation.

This section annually appropriates \$15 billion for State use for 2018 and 2019. For years 2020 through 2026, \$10 billion is appropriated annually. A State match is phased in beginning 2020 at a different schedule, depending on if a State chooses to use the money for their own program or utilizes the federal default program administered through CMS.

### **Section – 133 Continuous Health Insurance Coverage Incentive**

The continuous coverage incentive is designed to limit adverse selection in health care markets. Beginning in open enrollment for benefit year 2019, there will be a 12-month lookback period to determine if the applicant went longer than 63 days without continuous health insurance coverage. If the applicant had a lapse in coverage for greater than 63 days, issuers will assess a flat 30 percent late-enrollment surcharge on top of their base premium based on their decision to forgo coverage. This late-enrollment surcharge would be the same for all market entrants, regardless of health status, and discontinued after 12 months, incentivizing enrollees to remain covered. This process would be for special enrollment period applicants in benefit year 2018.

### **Section – 134 Increasing Coverage Options**

Under the Affordable Care Act, plan issuers are required to label their offerings by metal tier: Bronze, Silver, Gold, and Platinum. These metal tiers are determined by a calculation known as actuarial value (AV). In an attempt to improve plan choice, this section repeals the AV standards, which helps improve benefit design flexibility.

### **Section – 135 Change in Permissible Age Variation in Health Insurance Premium Rates**

Current law limits the cost of the most generous plan for older Americans to three times the cost of the least generous plan for younger Americans. The true cost of care is 4.8-to-one, according to health economists. This provision loosens the ratio to five-to-one and gives States the flexibility to set their own ratio.