



## Health Care Reform Reference Guide

### The Patient Protection and Affordable Care Act (ACA) vs. American Health Care Act (AHCA)

March 23, 2017

On March 6, 2017, the House Energy and Commerce Committee and the House Ways and Means Committee each released legislative language to repeal and replace specific provisions of the Affordable Care Act (ACA). The Energy and Commerce Committee legislation proposes changes to Medicaid and the health insurance marketplace, while the Ways and Means Committee legislation includes the tax provisions under the ACA. The separate bills will be combined into a single bill. In addition, a Manager's Amendment was released by the House Energy and Commerce Committee and the House Ways and Means Committee. The legislative language would lead to significant changes to the health insurance markets, subsidies, penalties and the Medicaid program. NIHB encourages Tribal members to voice their concerns about the impact the legislation will have on the health care of American Indians and Alaska Natives (AI/ANs) to their Congressional delegation.

Neither draft legislation included repeal of the Indian Health Care Improvement Act (IHCIA), which was passed in 2010 as part of the ACA but remains unrelated to the main structure of the law's healthcare reforms. Other Indian-specific pieces of the ACA are also left intact. In addition, the following key Indian-specific provisions of the ACA will remain in place: Section 2901(b), which provides that the IHS and Tribal health programs are the payor of last resort; Section 2902, which permanently preserves the ability of the IHS and Tribal health programs to bill for Medicare Part B Services through a 5-year sunset provision; and Section 9021, which excludes health benefits provided by the IHS and Tribal health programs to eligible individuals from table gross income. Due to the vital role that Medicaid program plays in fulfilling the federal trust responsibility, NIHB is extremely concerned about the changes the legislation enacts to the Medicaid program.

The Congressional Budget Office (CBO) released a comprehensive assessment of the legislation on March 13, 2017. The Report can be accessed at <https://www.cbo.gov/publication/52486>. The projected impact of the legislation is an increase of 14 million uninsured individuals in 2018 and an increase of 24 million uninsured individuals by 2026. In addition, Federal Medicaid funding would decline by \$880 billion between 2017 and 2026.

For more information, please contact NIHB Staff:

Stacy A. Bohlen, Executive Director: [sbohlen@nihb.org](mailto:sbohlen@nihb.org)

Caitrin Shuy, Director of Congressional Relations: [cshuy@nihb.org](mailto:cshuy@nihb.org)

Devin Delrow, Director of Federal Relations: [ddelrow@nihb.org](mailto:ddelrow@nihb.org)

# Health Care Reform Reference Guide

**INDIAN HEALTH CARE ACT (IHCIA):** First enacted in 1976, the Indian Health Care Improvement Act (IHCIA) is the legislative embodiment of the federal trust and treaty responsibilities to American Indian and Alaska Native people for healthcare. IHCIA was permanently enacted in 2010 as part of the ACA (Section 10221) in an effort to pass this long-stalled legislation, despite being unrelated to the overall ACA.

PATIENT PROTECTION AND AFFORDABLE CARE ACT(ACA)	AMERICAN HEALTH CARE ACT (AHCA)
<ul style="list-style-type: none"> <li>• The Indian Health Care Improvement Act (IHCIA) was permanently reauthorized in 2010 to improve and modernize the Indian health care system, as part of the Affordable Care Act (ACA).</li> <li>• Sets to improve workforce development and recruitment of health professionals in Indian Country.</li> <li>• Provides new authorities to fund facilities construction, maintenance, and improvement funds to address facility needs.</li> <li>• Creates opportunities to improve access and financing of health care services for Indians.</li> </ul>	<ul style="list-style-type: none"> <li>• The Indian Health Care Improvement Act (IHCIA) will remain fully intact.</li> </ul>

**MARKETPLACE:** The Marketplace is the one-stop shop for applying for health care coverage. It helps uninsured people find health coverage through a simple, single-streamlined application that will help find an affordable health insurance.

PATIENT PROTECTION AND AFFORDABLE CARE ACT(ACA)	AMERICAN HEALTH CARE ACT (AHCA)
<ul style="list-style-type: none"> <li>• Enacted in 2010 and became Public Law 111-148.</li> </ul>	<ul style="list-style-type: none"> <li>• Drafts released March 6, 2017 and both passed the House Energy and Commerce Committee and the Ways and Means Committee.</li> <li>• Coverage would begin January 1, 2020.</li> <li>• The Congressional Budget Office (CBO) released their impact evaluation report on March 13, 2017. The report can be accessed at <a href="https://www.cbo.gov/publication/52486">https://www.cbo.gov/publication/52486</a>.</li> <li>• The legislation is scheduled for a full House vote on March 23, 2017 and then it will be considered by the Senate.</li> </ul>

## Individual-Shared Responsibility Payment (Individual Mandate)

<ul style="list-style-type: none"> <li>• Requires individuals to have qualifying health coverage. Individuals without coverage pay a tax penalty of the greater of \$695 per year, indexed by inflation, or 2.5% of household income. Exemptions granted for affordability, financial hardship, religious objections, and other reasons.</li> <li>• Members of federally recognized Tribes, ANCSA, and for those who use I/T/U services are exempt from the individual-shared responsibility payment.</li> </ul>	<ul style="list-style-type: none"> <li>• Repeals the individual-shared responsibility payment and institutes a “continuous coverage” requirement that allows insurers to impose a 30% increase penalty in premiums for a one year penalty on individuals who have allowed their insurance coverage to lapse at least 63 continuous days.</li> <li>• Establishes a Patient and State Stability Fund to provide funding to States that submit an application to lower costs and stabilize State markets. For example, the funds could be used for high-risk individuals to enroll in the State market, reduce out-of-pocket costs, or promote preventative care.</li> <li>• Permits the use of tax credits for the purchase of non-Exchange based health plans including catastrophic health plans.</li> <li>• Increased use of Health Savings Accounts (HSAs), which are excluded from taxable gross income and may be used for qualifying medical expenses.</li> <li>• Includes over-the-counter medications as a qualifying medical expenses.</li> </ul>
--	---

### Other Provisions

<ul style="list-style-type: none"> <li>• Appropriation authority for the Prevention and Public Health Fund, which provides mandatory appropriations for prevention, wellness, and public health initiatives.</li> <li>• Actuarial value (AV) standards require plan issues to label their plans as Bronze, Silver, Gold, or Platinum depending on the AV.</li> <li>• Requires the variance of the AV in premium rates charged by insurance issuers based on an age rating to a ratio of 3 to 1. Therefore an older consumer could not be charged a premium more than three times the amount charged to a younger consumer.</li> <li>• Premium tax credits may only be used to purchase plans meeting the definition of “Qualified Health Plan” under the Marketplace.</li> </ul>	<ul style="list-style-type: none"> <li>• Essential health benefits (EHBs) determined by States.</li> <li>• Repeals Prevention and Public Health Fund appropriations for fiscal year 2019 onwards.</li> <li>• Increases funding for the Community Health Center Fund, which awards grants for Federally Qualified Health Centers (FQHCs). However, there are not funding increases or provisions regarding IHS or Tribal health programs.</li> <li>• Convert federal Medicaid financing to a per capita cap beginning in FY 2020. The federal government will pay each State a per enrollee amount for each Medicaid enrollee.</li> <li>• Repeals the actuarial value (AV) standards requiring issuers to label their plans at Bronze, Silver, Gold, or Platinum.</li> <li>• Relaxes the variance of the actuarial value (AV) in premiums rates charged by insurance issuers to a ratio of 5 to 1, which could dramatically increase premiums to consumers aged 50-64.</li> <li>• Implements similar refundable tax credit provisions would be put in place of the premium tax credits, however the Senate is expected to make additional changes that would increase the tax credit for older, low-income individuals.</li> <li>• Implementation of limited refundable tax credits based on age and household income. New refundable tax credits availability would be limited to individuals and families with lower incomes and utilized for the purchase of eligible health insurance.</li> <li>• Refundable tax credit eligibility would exclude individuals eligible for government sponsored programs listed in Section 5000A(f)(1)(A) of the Internal Revenue Code, however the Indian Health Service is not listed in the Internal</li> </ul>
--	---

	<p>Revenue Code as a government sponsored program. Therefore, IHS beneficiaries would not be excluded from eligibility for the refundable tax credit.</p> <ul style="list-style-type: none"> <li>• Implementation date of the Cadillac Tax is moved from 2025 to 2026.</li> <li>• Repeals the employer mandate by eliminating the tax penalties associated with it.</li> <li>• Repeals the fee on each covered entity engaged in providing health insurance for U.S. health risks in 2017.</li> <li>• Repeals the 2.3% tax on manufacturers and importers for sales of certain medical devices beginning 2017</li> </ul>
--	--

**INDIAN-SPECIFIC PROVISIONS:** Section 10221 of the Affordable Care Act incorporates and enacts the Senate IHCA bill titled the Indian Health Care Improvement Reauthorization and Extension Act of 2009 (S.1790) as reported by the Senate Committee on Indian Affairs in December 2009.

<b>PATIENT PROTECTION AND AFFORDABLE CARE ACT(ACA)</b>	<b>AMERICAN HEALTH CARE ACT (AHCA)</b>
<ul style="list-style-type: none"> <li>• Section 2901(b) provides that the IHS and Tribal health programs are the payor of last resort.</li> <li>• Section 2902, which permanently preserves the ability of the IHS and Tribal health programs to bill for Medicare Part B Services through a 5-year sunset provision.</li> <li>• Section 9021, which excludes health benefits provided by the IHS and Tribal health programs to eligible individuals from being calculated as taxable gross income.</li> <li>• Special zero (100-300% FPL) or limited cost-sharing protections depending on income for American Indians and Alaska Natives</li> <li>• Monthly special enrollment period (M-SEPs) for American Indians and Alaska Natives to enroll or change plans once per month.</li> <li>• Members of federally recognized Tribes, ANCSA, and for those who use I/T/U services are exempt from the individual-shared responsibility payment.</li> </ul>	<ul style="list-style-type: none"> <li>• Section 2901(b) of the ACA provides IHS and Tribal health programs as the payor of last resort will remain intact.</li> <li>• Section 2902 of the ACA, which preserves the ability of IHS and Tribal health programs to bill for Medicare Part B Services will remain intact.</li> <li>• Section 9021 of the ACA, which excludes health benefits provided by IHS and Tribal health programs to eligible individuals from being calculated as taxable gross income will remain intact.</li> <li>• There are no Indian-specific special cost-sharing or premium tax credit protections starting in 2020.</li> <li>• Credible coverage includes eligible IHS beneficiaries. Therefore, IHS beneficiaries would not be subject to the 30% penalty if there is a break in coverage for more than 63 continuous days (effective 2018).</li> <li>• Tax credits will be calculated based on age and capped by income level.</li> <li>• There are no monthly special enrollment periods (M-SEPs). The individual-shared responsibility payment will disappear in 2017.</li> </ul>

**MEDICAID/CHIP:** Medicaid is a program created by the federal government, but administered by the State, to provide payment for medical services for low-income individuals and families. Children’s Health Insurance Program (CHIP) is a federal-State partnership that provides comprehensive health care coverage for children from families whose incomes are too low to afford private insurance but too high to qualify for Medicaid.

<b>PATIENT PROTECTION AND AFFORDABLE CARE ACT(ACA)</b>	<b>AMERICAN HEALTH CARE ACT (AHCA)</b>
<ul style="list-style-type: none"> <li>American Indians and Alaska Natives are subject to State income and eligibility determinations for Medicaid.</li> </ul>	<ul style="list-style-type: none"> <li>American Indians and Alaska Natives are subject to State income and eligibility determinations for Medicaid. Therefore, IHS and Tribal health program funding will be significantly impacted if States are forced to reduce eligibility or control expenditures to remain within the cap.</li> <li>In FY 2020, States will have the option to receive a flexible block grant of funds for providing health care in the per capita allotment. States can choose to provide care through a block grant of funds for a period of 10 years instead of providing care through the per capita allotment. At the end of the 10 year period, if the block grant option is not renewed by the State it would revert to the per capita allotment</li> <li>The caps will be increased annually by the percentage increase in the medical care component of the consumer price index, but would not be adjusted for population. There is also an increase to the annual inflation factor by 1% for the elderly, blind, and disabled enrollees.</li> <li>Block grant funding shall be calculated by computing the per capita cost for the eligible population, multiplied by the number of enrollees in the year prior to adopting a block grant.</li> <li>Any transition to a per capita allotment or block grant program would exclude services provided to American Indians and Alaska Natives through an IHS or Tribal health facility and States would continue to receive 100% FMAP for those services.</li> <li>The overall decrease in Medicaid funding could have a significant impact on the IHS and Tribal health programs by forcing States to choose between allocating additional State funding to maintain coverage, or reduce eligibility, decrease covered services in future years.</li> <li>Effective October 1, 2017, establishes a new section to the Social Security Act to give States the broad flexibility to institute a work requirement for Medicaid eligibility. States would not be permitted to impose the work requirement on pregnant individuals, individuals under 19 years, single parents, or caretaker relatives of children under 6 or children with disabilities, and individuals under 20 years attending school. There is no exemption for American Indians and Alaska Natives from the optional work requirement. States who choose to implement this option would receive an additional 5% FMAP.</li> </ul>
<b>Medicaid Expansion to 138% FPL &amp; 100% Federal Medical Assistance Percentage (FMAP)</b>	
<ul style="list-style-type: none"> <li>Medicaid eligibility expansion was mandatory to all non-elderly adults with household incomes up to 138% FPL based on a modified adjusted gross income.</li> </ul>	<ul style="list-style-type: none"> <li>Defunds Medicaid expansion beginning in 2020, and caps Medicaid funding going forward using a per capita allocation funding formula.</li> </ul>

- Availability of an enhanced federal financial medical assistance percentage (FMAP) rate covering 100% of Medicaid spending on health care services for newly eligible adults in expansion States through 2016, decreasing to 90% in 2020.
- Medicaid expansion would become a State option. Defunds Medicaid expansion coverage to adults above 138% FPL (childless non-elderly, non-pregnant, non-disabled adults) effective December 31, 2017.
- Medicaid expansion enrollees enrolled prior to December 31, 2019 receive a “grandfathered” status and States will be able to receive the enhanced matching rate as long as such individuals remain eligible and enrolled in the program.
- States can choose to provide health care to non-expansion adults and children, or just non-expansion adults. However, the Manager’s Amendments restricts the enhanced FMAP rate (including grandfathered individuals beginning 2020) to States that expanded Medicaid as of March 1, 2017.
- States have the option to cover adults in the expansion population (newly enrolled or existing) after 2020, but the enhanced FMAP rate for non-grandfathered individuals (new enrollees or those with a break in coverage for more than 30 days) will end in 2020.
- Payments for individuals who received medical assistance through an IHS or Tribal health facility that currently qualify for 100% FMAP would not count towards the total per capita allotment.
- Includes the 100% FMAP for services to eligible beneficiaries receiving services through IHS and Tribal health facilities.
- Beginning in 2020, 90% FMAP applies only to persons enrolled as of January 2020 with no break in coverage greater than 30 days.
- States can continue Medicaid eligibility expansion, but at regular federal medical assistance percentage (FMAP) rates.
- The States will be required to re-determine the eligibility of expansion enrollees every 6 months, beginning October 1, 2017. This will likely result in a greater number of expansion enrollees losing coverage. Once an expansion enrollee experiences a break in coverage for more than one month, the expanded FMAP would no longer be available if they re-enroll after December 31, 2019.
- States would receive a temporary 5% FMAP increase for activities related to the State increased eligibility determination requirements.
- States who choose to implement a work requirement will receive a 5% administrative FMAP increase.
- Return the mandatory Medicaid income eligibility level for poverty-related children back to 100% FPL.
- For non-expansion States, \$10 billion over 5 years would be provided in safety-net funding to adjust payment amounts to Medicaid providers. States that did not expand Medicaid would receive 100% FMAP for the payment adjustments in 2018-2021 and 95% FMAP in 2022.

## Children's Health Insurance Program (CHIP)

- Require States to maintain current income eligibility levels for children in Medicaid and the Children's Health Insurance Program (CHIP) until 2019 and extend funding for CHIP through 2015. Beginning in 2015, increase CHIP match rate by 23 percentage points up to a cap of 100%.

### Other Provisions

- Impose new reporting requirements relating to medical assistance expenditures.
- Provides a temporary increase to the federal matching percentage between October 2017 and October 2019 for States to improve data reporting systems.
- Eliminates 3-month retroactive coverage requirement (start eligibility "in or after" the month of application) beginning October 1, 2017.
- Repeals the 6% bonus point in the federal matching rate for community-based attendant services and supports.
- Repeals the Medicaid Disproportionate Share Hospital (DSH) cuts in 2018 for non-expansion States and in 2020 for expansion States.
- States will be required to include lottery winnings for purposes of determining Medicaid and CHIP eligibility.

**MEDICARE:** Changes will affect individuals who are 65 and older, children and adults with disabilities.

#### PATIENT PROTECTION AND AFFORDABLE CARE ACT(ACA)

- Gradually close the Medicare Part D coverage gap ("donut hole") by 2020.
- Reduce Medicare Disproportionate Share Hospital (DSH) payments.
- Establish various quality, payment and delivery system changes, including a new Center for Medicare and Medicaid Innovation to test, evaluate, and expand methods to control costs and promote quality of care.

#### AMERICAN HEALTH CARE ACT (AHCA)

- Repeal of elimination of deduction for expenses allocable to Medicare Part D Subsidy beginning 2017.
- Reduces qualifying adjusted gross income threshold from 10% to 5.8% providing additional support for Americans with high health costs.
- Establish various quality, payment and delivery system changes, including a new Center for Medicare and Medicaid Innovation to test, evaluate, and expand methods to control costs and promote quality of care; Medicare Shared Savings Accountable Care Organizations; and penalty programs for hospital readmissions and hospital-acquired conditions.

**STATE ROLE:** The role States play in the respective pieces of health care legislation.

<b>PATIENT PROTECTION AND AFFORDABLE CARE ACT(ACA)</b>	<b>AMERICAN HEALTH CARE ACT (AHCA)</b>
<ul style="list-style-type: none"><li>• Establish a State based health insurance exchange and provide oversight of health plans with regard to the new insurance market regulations, consumer protections, rate reviews, solvency, reserve fund requirements, premium taxes, and to define rating areas.</li><li>• Permit States to create a Basic Health Plan for uninsured individuals with incomes between 138% and 200% FPL in lieu of these individuals receiving premium subsidies to purchase coverage in the exchanges.</li></ul>	<ul style="list-style-type: none"><li>• States can choose to utilize the block grant funding or a per capita allotment. States would be required to submit a State Plan for administering the block grant for approval by the Secretary of Health and Human Services (HHS). The State Plan will be deemed approved unless the Secretary rejects the plan in 30 days.</li><li>• States who choose the block grant must submit a report that identifies eligibility, except for low-income pregnant women and children. States must also outline the services, cost-sharing for such services, and duration in lieu of required services in current law.</li><li>• States may determine age rating ratio; otherwise federal standard of 5:1 applies.</li><li>• Establish new Patient and State Stability Fund. Funds can be used by States for financial help for high-risk individuals, to stabilize private insurance premiums, promote access to preventive services, provide cost sharing subsidies, and for other purposes.</li><li>• State option to establish a State based health insurance exchange is not changed.</li><li>• State option to obtain a five-year waiver of certain new health insurance requirements (Section 1332 waiver) is not changed.</li><li>• States continue to administer the Medicaid program with Federal matching funds available up to the federal cap.</li></ul>