H.R. 1628 – American Health Care Act of 2017 (Rep. Black, R-TN)

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FLOOR SCHEDULE:

Expected to be considered on March 24, 2017.

The rule is expected to consider the manager's amendments as adopted.

TOPLINE SUMMARY:

H.R. 1628 would repeal or modify numerous provisions of the Affordable Care Act, including effectively eliminating the individual and employer mandates, repealing most of the ACA's tax increases, modifying some insurance regulations, and phasing out the ACA's health insurance subsidies and Medicaid expansion.

The bill would also institute a new advanceable refundable tax credit for health insurance purchases, create a block grant program to fund state innovation programs such as high-risk pools and insurance risk mitigation programs.

Finally, the bill would make a number of reforms to the Medicaid program, including converting the program to a per-capita cap model.

The bill would also place a one-year moratorium on funding for Planned Parenthood.

Several Manager's amendments are expected to be considered that will include both technical and policy provisions. Full details on these amendments are available below.

In summary, the manager's amendments posted Monday March 20 would restructure the refundable tax credit to make it more compliant with Senate Byrd rules and address pro-life concerns, allow states to institute a work requirement for able-bodied Medicaid recipients, allow states an option to receive a block grant for some of their Medicaid populations, and prohibit new states from expanding Medicaid at the enhanced federal match rate. These amendments would also add a special provision relating to New York's Medicaid state share funding, create an implementation fund, and accelerate the repeal of most Obamacare taxes.

The further manager's amendment posted March 23 would delay the repeal of the 0.9% Medicare tax until the end of 2022 and would allow states to utilize Patient and State Stability Fund allocations for maternity coverage and newborn care, as well as mental health and substance abuse care, and would appropriate an additional $15 billion for this fund for these purposes. Finally, this amendment would

allow states to determine essential health benefits for the purposes of the premium tax credits beginning in 2018. This change would allow states to remove significant requirements for what services insurance plans are required to cover under Obamacare for tax credit-eligible plans.

COST:

Including the Manager's Amendments posted on Monday, March 20, the Congressional Budget Office (CBO) estimates that implementing H.R. 1628, as amended, would reduce federal deficits by $150 billion over the 2017-2026 period; that reduction is the net result of a $1,150 billion reduction in direct spending, partly offset by a reduction of $999 billion in revenues. The provisions dealing with health insurance coverage would reduce deficits, on net, by $883 billion; the noncoverage provisions would increase deficits by $733 billion, mostly by reducing revenues.

This score does not incorporate effects of the additional amendment to the policy changes manager's amendment that was released March 23. This amendment's delay of the repeal of the Medicare tax would tend to increase revenues, and therefore deficit reduction achieved by the bill. However, flexibility for states to determine essential health benefits could result in lower premiums and commensurately higher utilization of the refundable tax credits, which would tend to offset the increased revenue. Further, the amendment's increase in the appropriation for the Patient and State Stability fund would increase the deficit by $15 billion.

CBO originally estimated that enacting H.R. 1628 would reduce federal deficits by $337 billion over the FY 20172026 period. Outlays would be reduced by about $1.2 trillion and revenues would be reduced by about $0.9 trillion

CONSERVATIVE VIEWPOINTS:

Full Repeal as Possible

Conservatives will be pleased that the bill does effectively eliminate the individual and employer mandates.

Some conservatives may be concerned that the bill does not fully repeal all components of the Affordable Care Act. However, it is unclear if all such provisions could be in compliance with the Senate Byrd rule.

Some conservatives may be particularly concerned that the bill does not repeal all ACA insurance regulations that drive up premium prices. H.R. 1628 does include provisions affecting some insurance regulations, which may not be Byrd compliant, though many major ACA insurance provisions are not addressed. Conservatives will also be pleased that the bill, as amended by the second manager's amendment, would allow states the ability to determine essential health benefits for tax credit-eligible plans.

Some conservatives may be concerned that the bill delays, but does not fully repeal, the Cadillac tax. Full repeal of this provision may create a point of order in the Senate, and it is possible that the tax will be fully repealed in the Senate on a vote with a 60-vote threshold.

Tax Credits

Some conservatives may be concerned that the bill creates a new advanceable, refundable tax credit for the purchase of health insurance. Some conservatives may believe that it is not the appropriate role of the federal government to fund such private purchases through direct outlays, which refundable credits are, and that these credits merely replace the premium tax credits made available under the Affordable Care Act with an alternate scheme.

Some conservatives may be concerned that the aggregate budgetary impact of these credits is similar to those provided for the purchase of insurance under the Affordable Care Act.

Some conservatives will be pleased that these credits are limited to lower-income individuals. Some conservatives may also be pleased that these credits are protected by limitations on being used to fund purchases of plans that fund elective abortions.

Medicaid
Some conservatives may be concerned that the elimination of the enhanced federal share for Medicaid expansion does not begin until 2020. Some conservatives may believe that a future Congress is unlikely to allow this reform to take effect, especially in a presidential election year. A significant portion of the bill's reduction in spending relies on the presumption that the freeze will be allowed to take effect.

Some conservatives will be pleased that the bill and the manager's amendment makes significant reforms to reduce the rate of growth of Medicaid spending and to provide additional state flexibility for some populations.

Planned Parenthood
Conservatives will be pleased the bill includes a one-year moratorium on mandatory funding for Planned Parenthood.

- **Expand the Size and Scope of the Federal Government?** The bill eliminates Affordable Care Act subsidies for insurance purchase, but institutes alternate subsidies continuing to fund the direct purchase of insurance for individuals. The bill lessens, though does not eliminate, federal overreach into insurance markets.

- **Encroach into State or Local Authority?** No.
- **Delegate Any Legislative Authority to the Executive Branch?** No.
- **Contain Earmarks/Limited Tax Benefits/Limited Tariff Benefits?** No.

DETAILED SUMMARY AND ANALYSIS:

This summary reflects the underlying legislation as reported by the Budget Committee. Several manager's amendments are expected to be adopted by the rule providing for consideration of the bill. Details and analysis of these amendments are provided below in the *AMENDMENTS* *section of this bulletin.*

The Affordable Care Act (Obamacare) created a set of mandates, subsidies, regulations, and entitlement expansions in an effort to increase the number of individuals covered by health insurance. Specifically, Obamacare created mandates that individuals carry, and employers provide, health insurance. Further, the law set up a system of refundable tax credits and cost-sharing subsidies to reduce the cost of purchasing insurance for lower-income individuals and families on state or federally-operated exchanges. The law also included a set of insurance regulations dictating what types of benefits had to be included in a plan, how that plan could be priced, and how the value of benefits had to relate to premiums charged. Finally, the law required states to expand Medicaid to cover individual adults earning up to 138% of the federal poverty level. This last provision was effectively made optional for states through the Supreme Court's decision in *NFIB v. Sebelius*.

H.R. 1628 would repeal or amend significant portions of the ACA, eliminating that law's system of tax credits and cost-sharing subsidies, eliminating most of its tax increases, amending some insurance regulations, and phasing out its Medicaid expansion.

In place of Obamacare, H.R. 1628 would stand up a new system of advanceable, refundable tax credits for the purchase of health insurance available to individuals who do not have access to employer-sponsored or other large-group insurance. The bill would also expand access to Health Savings Accounts (HSAs). Finally, H.R 1628 would also make significant reforms to Medicaid.

Repeal Provisions

Taxes

Individual and Employer Mandate
The penalty level for both the employer and individual mandate would be set to $0, effectively eliminating the mandates.

Net Investment Income Tax
The Affordable Care Act imposed a 3.8% tax on passive income for single earners over $200,000 and couples over $250,000. This tax would be repealed at the end of 2017.

Medicare Surcharge
The Affordable Care Act instituted a 0.9% additional tax on individuals earning over $200,000 (couples earning over $250,000), with revenues being deposited into the Medicare Hospital Insurance Trust Fund. This additional tax would be repealed at the end of 2017.

Cadillac Tax
The implementation of the Affordable Care Act's 40% excise tax on high-value health plans would be delayed until 2025.

Health Insurance Tax
The annual health insurance fee would be repealed at the end of 2017

Tanning Tax
The Affordable Care Act's tax on tanning services would be repealed at the end of 2017.

Over-the-Counter Medications
The Affordable Care Act eliminated over-the-counter medications as an eligible use for tax-preferred health savings accounts (such as FSAs and HSAs). This bill would restore the ability for individuals to use these funds for OTC medications without penalty at the end of 2017.

HSA non-Qualified Expenses
The Affordable Care Act increased the penalty on HSA withdraws for non-medical expenses to 20% from 10%. This increase would be reversed at the end of 2017.

FSA Contribution Limits
The Affordable Care Act limited contributions to Flexible Spending Accounts to $2,500 per year. This limitation would be repealed at the end of 2017.

Medical Device Tax
The Affordable Care Act levied a 2.3% excise tax on the sale of medical devices. This tax would be repealed at the end of 2017.

Medical Expense Threshold
The Affordable Care Act increased the threshold individuals must cross in order to deduct medical expenses to 10% of income from 7%. This increase would be reversed at the end of 2017.

Prescription Drug Coverage
This bill would restore the ability of employers to deduct the cost of covering actual costs of prescription coverage for individuals on Medicare Part D.

Prescription Drugs
The ACA imposed a tax on pharmaceutical manufacturers and importers. This tax would be repealed at the end of 2017.

Subsidies

Premium Tax Credit
H.R. 1628 would alter the structure of the ACA's health insurance premium tax credits in 2018 and 2019 before eliminating them in 2020.

For 2018 and 2019, the credits would be available for the purchase of currently approved plans, as well as catastrophic health insurance that provides protection only against extremely high health costs. The bill would also prevent credits from being used to purchase a plan that covers elective abortion.

Further, H.R. 1628 would alter the value of the tax credit. Under the ACA, individuals are eligible for a credit that is the lesser of their actual premium costs or the amount premium costs exceed a maximum percentage of household income that varies based on income size, with a maximum of 2% of income for individuals under 133% of the federal poverty level and escalating to 9.5% of income for those at or above 300% of the federal poverty level. H.R. 1628 would amend this formula to vary both by income and age of recipient, and to increase the maximum percentage of income an individual would pay before receiving credit assistance to 11.5%.

The table below indicates the maximum percentage of income an individual of a given age in a given income tier would need to pay before becoming eligible for credit assistance:

Household Income as percentage of federal poverty level	Up to Age 29		Age 30-39		Age 40-49		Age 50-59		Over Age 59	
	Initial %	Final %	Initial %	Final %	Initial %	Final %	Initial %	Final %	Initial %	Final %
Up to 133%	2	2	2	2	2	2	2	2	2	2
133%-150%	3	4	3	4	3	4	3	4	3	4
150%-200%	4	4.3	4	5.3	4	6.3	4	7.3	4	8.3
200%-250%	4.3	4.3	5.3	5.9	6.3	8.05	7.3	9	8.3	10
250%-300%	4.3	4.3	5.9	5.9	8.05	8.35	9	10.5	10	11.5
300%-400%	4.3	4.3	5.9	5.9	8.35	8.35	10.5	10.5	11.5	11.5

Small Business Tax Credit
H.R. 1628 would repeal the small business tax credit at the end of 2019. For 2018 and 2019, the credit would not be available for the purchase of plans that fund elective abortions.

Cost-Sharing Subsidies
The ACA provided direct subsidies to reduce out-of-pocket costs of deductibles, coinsurance, and copayments for low and moderate-income individuals who purchase insurance plans with higher actuarial value. These subsidies would be repealed alongside the ACA tax credits at the end of 2019.

Other Repeal Provisions

Medicaid Expansion
The ACA required states to expand Medicaid coverage to cover adults earning up to 138% of the federal poverty level, with the federal government providing an enhanced payment share for this population beginning at 100% in calendar year 2014 and falling to 90% in 2020 and thereafter. This mandatory expansion was effectively made a voluntary state option in the Supreme Court's ruling in *NFIB v. Sebelius*. H.R.1628 would prohibit states from receiving this enhanced federal share for new enrollees beginning in 2020. Individuals on Medicaid tend to move off the program as their incomes rise, even if they eventually return to eligibility within a few months. Because of this population turnover, it is expected that a majority of enhanced share-eligible enrollees will cycle off of Medicaid within a few years of the freeze. Should these states choose to cover the expansion population beginning in 2020, the federal share for these individuals will be the same as pre-ACA, which is on average 57%.

Prevention and Public Health Fund
H.R. 1628 would repeal the Public Health and Prevention Fund, which is a slush fund for the Secretary of Health and Human Services created by the ACA. In recent years, the Secretary has used the Prevention Fund to support grants for activities including free pet spaying and neutering, Zumba classes, and urban gardening.

Disproportionate Share Hospital Cuts
The federal government makes payments to hospitals that treat a large number of low-income patients to offset losses from treating uninsured patients and low Medicaid reimbursement rates. The ACA capped the amount of DSH payments that could be made, effectively cutting these payments. H.R. 1628 would restore these payments to their pre-ACA levels for non-expansion states immediately, and for all states in 2020 when the bill terminates new enrollment at the enhanced federal share for the expansion population.

Replacement Provisions

Advanceable, Refundable Tax Credits
H.R. 1628 would create a new stream of advanceable, refundable tax credits that would vary by age for the purchase of health insurance. Individuals would be eligible for the credits if they do not have access to employer-based coverage or other large group plan.

A tax credit directly reduces an individual's tax liability: for example, if an individual owed $10,000 in federal taxes, a $2,000 credit would reduce that liability to $8,000. A refundable credit converts any excess of credit over liability into a direct payment from the government: for example, if an individual owed $1,000 in taxes, a $2,000 refundable tax credit would first eliminate the $1,000 liability, and then the government would write the individual a check for the $1,000 in excess credit value.

The credits created by H.R. 1628 would also be advanceable, which means they would be paid in advance based on the individuals estimated income for a given year. Any discrepancy between estimated tax liability and actual liability would need to be reconciled on the individual's annual return. Credits would be paid directly to insurance providers, with any excess of credit value to premium eligible to be deposited into an HSA at the individual's election.

The credit would be cumulatively calculated for a household, with the five oldest individuals being counted and a maximum total credit value of $14,000. The credit would phase out for individuals earning greater than $75,000 and couples earning greater than $150,000, with the value of the credit being reduced by 10% of the amount an individual's or couple's income exceeds the threshold.

The credit would have the following values for each respective age group:

Under Age 30	$2,000
Age 30-39	$2,500
Age 40-49	$3,000
Age 50-59	$3,500
Age 60 and over	$4,000

The Secretary of the Treasury is directed to establish a system for administering the tax credits, and is directed to use, to the maximum extent possible, the mechanisms already established to distribute Obamacare premium tax credits. Further, the bill would require employers to report as to whether an individual has access to employer-sponsored coverage as part of their annual W-2 reporting.

HSA Limits

H.R. 1628 would increase the maximum amount individuals are allowed to contribute to HSAs annually to $6,500 for individuals and $13,100 for families, from $2,250 and $4,500 respectively. These limits would be increased for inflation.

State Innovation Grants

H.R. 1628 would provide a series of grants for states beginning in FY 2018 and totaling $100 billion through FY 2026. These funds would be eligible for use to fund financial assistance or otherwise subsidize insurance for high-risk and high-utilization individuals in the individual market, or provide cost-sharing subsidies for individuals in the individuals or small-group market.

These funds would also be eligible for use to provide risk-mitigation funding, such as reinsurance or risk corridor funding, for insurance providers, or to make direct payments to providers for services.

If a state does not submit a plan of its own for use of the grants, then the Administrator of the Center for Medicare and Medicaid Services would be directed to coordinate with the state's insurance commissioner to establish incentives to appropriate entities to enter into arrangements to help stabilize premiums in the individual market. This would create a default risk mitigation program for insurers. Some conservatives may be concerned that this provision furthers the ACA's policy of bailing out insurance companies for losses incurred as a result of ill-priced products or federal mandates.

Insurance Regulations

H.R. 1628 would make changes to some ACA insurance regulations. Specifically, beginning in 2019, the bill would loosen the ACA's restriction on the variation of premiums based on age, widening from 3-to-1 to 5-to-1 for what older adults can be charged relative to younger adults. Further, the bill would sunset the ACA's actuarial value requirements beginning in 2020. Both of these changes are intended to allow for a wider variety of plans to be offered.

Non-Continuous Coverage Penalty

H.R. 1628 would require insurance providers to charge a 30% penalty to any individual purchasing coverage who had a lapse of coverage longer than 62 days in the previous 12 months. Some conservatives may be concerned that this provision inappropriately sets the price of a private market product, interfering in the free market and functioning to increase the costs for healthy individuals to enroll, and thereby acting counter to its intended effect.

Payments to non-Expansion States
H.R. 1628 would provide payments to non-expansion states via an increase in the federal share of Medicaid funding for those states for each year 2018-2022. The amount each state would receive would be calculated as $2 billion multiplied by the ratio of the state's eligible expansion population to the total eligible expansion population of all non-expansion states. That is:

State funding = $2 billion X (state expansion population)/(total non-expansion state expansion population)

Medicaid Reforms

Per-Capita System
Under longstanding Medicaid law, the federal government reimburses states for a set percentage of Medicaid expenditures with no cap or limit. The size of the federal share can range from 50-83 percent according to statute, and is defined by a formula linked to per capita incomes in each state, with the federal government making smaller payments to wealthier states. H.R. 1628 would substantially reform this financing mechanism by implementing a "per-capita cap" system, which would set per-enrollee limits on federal Medicaid payments made to the states.

Spending targets would be developed for each state based on FY16 expenditures for each of five enrollee categories: elderly, blind and disabled, children, non-expansion adults, and expansion adults. The spending target for each enrollee category would be adjusted each fiscal year by the percentage increase in the medical component of the consumer price index for urban consumers (CPI-U Medical). This growth rate would be altered by the manager's amendment (see below). Beginning in FY19, states would receive an aggregate payment for the federal share for the sum of total enrollment across all enrollee categories. States that exceed their targets would receive reduced Medicaid funding in the next fiscal year, with funding being reduced on a pro rata basis each quarter.

Certain payments would still be made outside the per capita rate, including Disproportionate Share Hospital (DSH) payments, administrative payments, individuals who are covered under a CHIP Medicaid expansion program, receive medical assistance through an Indian Health Service Facility, are entitled to medical assistance coverage of breast and cervical cancer treatment due to screening through the Breast and Cervical Cancer Early Detection Program, and payments for certain partial-benefit enrollees.

Planned Parenthood

Defund Planned Parenthood
H.R. 1628 would place a one-year moratorium on federal mandatory funding for any 501(c)(3) nonprofit organization primarily engaged in providing family planning and reproductive health services that provides abortions and that received over $350 million in Medicaid funding in Fiscal Year 2014. This provision blocks federal funding for Planned Parenthood under Medicaid, CHIP, Social Services Block Grant (SSBG), and the Maternal and Child Health Block Grant program.

Community Health Center Program
H.R. 1628 would provide $422 million in mandatory funding for the Community Health Center Program in FY 2017. Community health centers provide a range of health services in medically underserved areas, including primary care family planning services, cancer screenings, and women's health exams. According to the Alliance Defending Freedom and the Charlotte Lozier Institute, "there are currently 13,540 clinics providing comprehensive health care for women, versus 665 Planned Parenthood locations."

AMENDMENTS:

1. **Manager's Amendment #1** – This amendment would make technical changes, including restructuring the tax credit in an effort to better comply with Senate Byrd rules. This change would include eliminating the requirement for the Secretary of the Treasury to coordinate with Secretary of Homeland Security and Social Security Administration to establish regulations for enforcing eligibility requirements. Instead, the Secretary of the Treasury would simply be directed to proscribe regulations to enforce eligibility requirements without reference to other agencies. Reference to these agencies could result in the bill losing privilege in the Senate. Further, the amendment would eliminate the underlying bill's rule of construction that the prohibitions on tax credit funding for plans including elective abortion does not prevent the purchase of supplemental plans that do fund such services, so long as no tax credits are used.

   In addition to technical changes, this amendment would affect the following policy changes:

   Excess Tax Credit Payment to HSAs
   The amendment would eliminate the ability for individuals to elect to transfer excess value of their refundable credits over premiums to an HSA account. Some conservatives had expressed concerns that such transfer would create a stream of direct federal funding that could be used to directly fund elective abortions.

   Per-Capita Payments
   This amendment would include all non-DSH supplemental payments in the base calculation for per-capita allocations.

   Veteran Eligibility
   The amendment would alter what veterans are eligible for the tax credits, making only veterans who are not eligible for VA plans eligible to receive the credit. The underlying bill would make veterans who are not enrolled in a VA plan eligible.

2. **Manager's Amendment #2** – This amendment makes a number of changes in policy to the underlying bill.

   The following three provisions, in addition to the HSA refundability of excess tax credits addressed as part of amendment #1 above, are part of an agreement negotiated by RSC Chairman Walker and House conservatives and President Trump:

   Prohibition on New State Expansions
   The amendment would prohibit new states from expanding Medicaid at the enhanced federal medical assistance percentage (FMAP) retroactively to March 1, 2017. States would continue to receive the enhanced percentage for all grandfathered enrollees enrolled prior to December 31, 2019 who do not have a break in eligibility exceeding one month.

   States would be allowed to expand Medicaid to newly eligible populations while receiving their normal FMAP.

   Work Requirement Option
   The amendment would allow for states to implement a work requirement for able-bodied, non-pregnant, non-elderly adults on Medicaid. The requirements would also not be allowed to be applied to single parents or caretakers, or individuals who are married or the head of the household and enrolled in school or participating in education directly related to employment.

   These work requirements could require, at a state's direction, individuals to be working or involved in a wide-variety of education, job training, or searching for employment. These are the same

activities that satisfy the work requirement under TANF. A full list of eligible activities is available at 42 USC 607(d).

The amendment would provide an additional 5 percentage point increase in state administrative costs FMAPs to compensate for the costs of implementing a work requirement option.

Block Grant Option
The amendment would create an option for states to elect to receive a single block grant for ten-year period to provide medical assistance for some populations beginning in 2020. States would be able to elect a block grant for either the nonelderly, nondisabled, non-expansion adults, or for these adults and children. If, at the end of the ten-year period, the state chooses not to renew its block grant plan, then the per-capita model would be reapplied and calculated as though no election had ever been made. So long as an election is in effect, states can roll over unused block grant funds to future years.

The states would generally be able to determine the eligibility for this program, except that states would be required to provide coverage for pregnant women and, in the case of a state electing to cover children via block grant, children. While states would be allowed flexibility in determining the amount, duration, scope, cost-sharing, and delivery methods of medical assistance to block grant populations, the state must still provide for: hospital care, surgical care; medical care; obstetrical and prenatal care; prescription drugs and prosthetics; medical supplies and services; and, health care for children under the age of 18.

The block grant allocation would be calculated in the first year of the ten-year election as an amount equal to that which would have been received for medical assistance under the per-capita allocation for each population for that year. In subsequent years, the first year base amount would be increased by the compounded growth of the consumer price index (CPI). Because the per capita caps will grow at CPI-M, which is higher than CPI, some states may choose not to elect a block grant, or not to renew a block grant plan after the initial ten-year election, because the amount of federal funding available under per-capita caps will be larger over time than the block grant funding.

Additionally, the second manager's amendment would:

Increase in Per Capita Growth Rate for Some Populations
The amendment would increase the growth rate for the elderly and blind and disabled populations under the per-capita model to CPI-U Medical plus 1%, rather than CPI-U Medical in the underlying bill.

Special New York Provision
The amendment would, via a specific description of a state with a DSH allotment more than 6 times the national average in 2016, enact a special policy for New York. Specifically, the amendment would reduce federal Medicaid funding to New York by the amount the state requires local political subdivisions to contribute to the state share of Medicaid. There would be an exemption for payments made by any subdivision with a population in excess of 5 million and that levies a specific Medicaid tax. This would prohibit the State of New York from requiring political subdivisions other than New York City to pay contributions to the state Medicaid share with seeing a concomitant reduction in federal Medicaid funding.

Implementation Fund
The amendment would appropriate $1 billion to fund administrative costs to implement the legislation.

Taxes
The amendment would generally accelerate the repeal of various ACA taxes by one year, making them effective in 2017, including: HSA tax increase; over-the-counter medications tax; FSA limitations; medical device tax; deduction for employer prescription drug coverage; Medicare surtax; tax on pharmaceutical manufacturers and importers; health insurance tax; insurer tax; and, the net investment income tax.

The amendment would accelerate the repeal of the tanning by six months, to June 30, 2017.

The amendment would further delay the implementation of the Cadillac tax to 2026.

The amendment would further lower the medical expense deduction threshold to 5.8% of adjusted gross income from 7.5% in the underlying bill and 10% under current law.

Further, the following changes would be made by the amendment to the manager's amendment posted on March 23:

Taxes
This amendment would delay the repeal of the 0.9% Medicare Hospital Insurance tax until the end of 2022. Based on the CBO score for the bill as amendment by the underlying manager's amendment, this change would increase revenues by roughly $63.5 billion.

Patient and State Stability Fund (PSSF)
This amendment would add the provision of maternity coverage and newborn care to the eligible uses for state innovation grant allocations. Further, it would clarify that the funds may be used for inpatient and outpatient care for mental illness, and early identification of mental health conditions in children.

This amendment would appropriate an additional $15 billion in 2020 for the PSSF for these purposes.

This amendment would also add reducing the cost of health insurance coverage for individuals in rural areas as an authorized use of PSSF funds.

Essential Health Benefits
This amendment would allow states, beginning in 2018, to determine essential health benefits for the purposes of health plans eligible for receiving the refundable tax credits included in the bill.

The ACA created a list of 10 essential health benefits that all plans must include. The mandatory inclusion of these benefits, which often were not required, desired, or even possibly utilized by those insured by them, have increased premiums and reduced choice in the market.

While this amendment would only allow states to adjust EHB for tax credit-eligible plans, combined with the repeal of the actuarial value regulation in 2020, this change should allow greater flexibility of plan design. By allowing states to determine the content and level of these benefits, rather than using the federally mandated requirements, should allow for a wider variety of plans to be offered at lower prices. Further, the increased competition in the marketplace resulting from this increase in plans should also reduce premiums.

OUTSIDE GROUPS:

Support

National Taxpayers Union
Americans for Tax Reform
American Conservative Union
Council for Citizens Against Government Waste
SBA List
National Right to Life
U.S. Chamber of Commerce (Key Vote)

Opposed

Heritage Action (Key Vote)
Club for Growth (Key Vote)
Americans for Prosperity

COMMITTEE ACTION:

S. Con. Res. 3 directed the House Energy and Commerce and House Ways and Means committees to produce reconciliation recommendations to achieve at least $1 billion in deficit reduction each. The Ways and Means and Energy and Commerce committees both convened in markup on March 8 and completed markup on March 9. The House Budget Committee met to report the combined recommendations on March 16, and the reported combined recommendations were introduced on March 20 as H.R. 1628.

Read the report from the Budget Committee here.

ADMINISTRATION POSITION:

"The Administration strongly supports H.R. 1628, the American Health Care Act of 2017 (AHCA). This bill begins to fulfill the President's commitment to rescue Americans from the failures of the Affordable Care Act (ACA) and expand access to affordable, quality healthcare. The AHCA offers patient-centered healthcare solutions that will promote innovation, reduce health insurance premiums, and empower doctors and patients to make healthcare choices.

The AHCA makes significant and important changes as part of a three step process to repeal and replace the ACA. The AHCA would provide tax credits for Americans to promote affordability; improve Medicaid's sustainability and target resources to those most in need; and return healthcare choices to patients by expanding the use of health savings accounts. The AHCA also would provide for a stable transition from the onerous requirements of the ACA, while providing peace of mind to Americans with pre-existing conditions.

If H.R. 1628 were presented to the President in its current form, his advisors would recommend that he sign the bill into law"

CONSTITUTIONAL AUTHORITY:

A constitutional authority statement is not available.

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