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Provisions of Obamacare Repeal Reconciliation Act of 2017 (ORRA)

Updated July 24, 2017

Congressional Research Service
https://crsreports.congress.gov
R44903

CRS REPORT
Prepared for Members and
Committees of Congress

Summary

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

On July 19, 2017, the Senate Budget Committee posted the "Obamacare Repeal Reconciliation Act of 2017" (ORRA) on its website as another draft reconciliation bill. ORRA is largely based off the Restoring Americans' Healthcare Freedom Reconciliation Act of 2015 (H.R. 3762), which was vetoed by President Obama on January 8, 2016, and returned to the House.

ORRA would repeal several provisions of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended), and it could restrict federal funding for the Planned Parenthood Federation of America (PPFA) and its affiliates and clinics for a period of one year. The bill also would appropriate (1) an additional $422 million for FY2017 to the Community Health Center Fund and (2) $750 million for each of FY2018 and FY2019 to award grants to states to address the substance abuse public health crisis or respond to urgent mental health needs. The Congressional Budget Office and the Joint Committee on Taxation estimate that ORRA would reduce federal deficits by $473 billion from FY2017 through FY2026, and they estimate that 17 million more people would be uninsured under ORRA than under current law in FY2018, with that figure growing to 32 million in CY2026.

A number of the provisions in ORRA are also in the AHCA and/or BCRA. However, ORRA does not include the AHCA or BCRA provisions that would substitute the ACA's premium tax credit for premium tax credits with different eligibility rules and calculation requirements. ORRA also does not include the AHCA or BCRA provisions that would establish new programs and requirements that are not related to the ACA, for example, a new fund to provide funding to states for specified activities intended to improve access to health insurance and health care or provisions to convert Medicaid financing to a per capita cap model (i.e., per enrollee limits on federal payments to states) with a block grant option (i.e., a predetermined fixed amount of federal funding) for certain populations. This report provides summaries of each ORRA provision.

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

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

The House bill was received in the Senate on June 7, 2017, and the next day the Senate majority leader had it placed on the calendar, making it available for floor consideration.[3] The Senate Budget Committee published on its website a "discussion draft" titled, "The Better Care Reconciliation Act of 2017" (BCRA) on June 22, 2017, and updated the discussion draft on June 26 and July 13.[4] On July 19, 2017, the Senate Budget Committee posted the "Obamacare Repeal Reconciliation Act of 2017" (ORRA) on its website as another draft reconciliation bill.[5] The BCRA discussion draft was again amended on July 20.[6]

Each of these draft bills is written in the form of an amendment in the nature of a substitute, meaning that it is intended to be considered by the Senate as an amendment to H.R. 1628, as passed by the House, and that all of the House-passed language would be stricken and the language of the draft would be inserted in its place.

ORRA is largely based off the Restoring Americans' Healthcare Freedom Reconciliation Act of 2015 (H.R. 3762), which was vetoed by President Obama on January 8, 2016, and returned to the House.[7] ORRA would repeal several provisions of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended), and it could restrict federal funding for the Planned Parenthood Federation of America (PPFA) and its affiliates and clinics for a period of one year. The bill also would appropriate (1) an additional $422 million for FY2017 to the Community

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

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

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

[4] The Better Care Reconciliation Act (BCRA) draft language is at https://www.budget.senate.gov/bettercare.

[5] The language for the Obamacare Repeal Reconciliation Act (ORRA) is at https://www.budget.senate.gov/repeal.

[6] The July 20, 2017, BCRA draft is at https://www.budget.senate.gov/imo/media/doc/ERN17500.pdf.

[7] For more information about the Restoring Americans' Healthcare Freedom Reconciliation Act of 2015, see CRS Report R44300, *Provisions of the Senate Amendment to H.R. 3762*.

Health Center Fund and (2) $750 million for each of FY2018 and FY2019 to award grants to states to address the substance abuse public health crisis or respond to urgent mental health needs.

A number of the provisions in ORRA are also in the AHCA and/or BCRA.[8] However, ORRA does not include the AHCA or BCRA provisions that would substitute the ACA's premium tax credit for premium tax credits with different eligibility rules and calculation requirements. ORRA also does not include the AHCA or BCRA provisions that would establish new programs and requirements that are not related to the ACA, for example, a new fund to provide funding to states for specified activities intended to improve access to health insurance and health care or provisions to convert Medicaid financing to a per capita cap model (i.e., per enrollee limits on federal payments to states) with a block grant option (i.e., a predetermined fixed amount of federal funding) for certain populations. This report provides summaries of each ORRA provision.

The Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation (JCT) issued a cost estimate for ORRA on July 19, 2017.[9] CBO and JCT estimate that ORRA would reduce federal deficits by $473 billion from FY2017 through FY2026, which is $354 billion more than the AHCA and $53 billion more than the July 20, 2017, version of the BCRA.[10] The projections for the number of uninsured individuals under ORRA as compared to current law are higher than the projections under the AHCA and the BCRA. In CY2018, CBO and JCT estimate that 17 million more people would be uninsured under ORRA than under current law, and CBO and JCT estimate that that figure would grow to 32 million in CY2026. In comparison, CBO and JCT project that, in CY2026, 23 million and 22 million more people would be uninsured under the AHCA and the July 20, 2017, version of the BCRA (respectively) than under current law.

Title I

Section 101. Recapture Excess Advance Payments of Premium Tax Credits and Section 102. Premium Tax Credit

Current Law

Internal Revenue Code (IRC) Section 36B, as added by Section 1401 of the ACA and related amendments, authorized a premium tax credit to help eligible individuals pay for health insurance.[11] The tax credit applies toward premiums for qualified health plans (QHPs) offered in

[8] For more information about the provisions in the AHCA and the BCRA, see CRS Report R44883, *Comparison of the American Health Care Act (AHCA) and the Better Care Reconciliation Act (BCRA)*.

[9] Congressional Budget Office (CBO), *Cost Estimate* – H.R. 1628, *Obamacare Repeal Reconciliation Act of 2017*: An Amendment in the Nature of a Substitute [LYN17479] as Posted on the Website of the Senate Committee on the Budget on July 19, 2017, at https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/52939-hr1628amendment.pdf.

[10] The most recent CBO cost estimate for the AHCA is Congressional Budget Office (CBO), *Cost Estimate* – H.R. 1628, *American Health Care Act of 2017*, May 24, 2017, at https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/hr1628aspassed.pdf. CBO also issued cost estimates reflecting earlier versions of the AHCA on March 13, 2017, and on March 23, 2017. The most recent CBO cost estimate for the BCRA is CBO, *Cost Estimate* – H.R. 1628, *Better Care Reconciliation Act of 2017*: An Amendment in the Nature of a Substitute [ERN17500] July 20, 2017, at https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/52941-hr1628bcra.pdf. CBO also issued a cost estimate reflecting an earlier version of the BCRA on June 26, 2017.

[11] See CRS Report R44425, *Health Insurance Premium Tax Credits and Cost-Sharing Subsidies: In Brief*.

the individual market through health insurance exchanges. QHPs are allowed to be offered outside of exchanges (*off-exchange plans*), but the premium credit may not be used toward the purchase of such plans. Catastrophic plans may be offered inside and outside of exchanges, but the credit may not be used toward purchasing such plans.[12] The premium credit is refundable, so individuals may claim the full credit amount when filing their taxes, even if they have little or no federal income-tax liability. The credit also is advanceable, so individuals may choose to receive the credit on a monthly basis to coincide with the payment of insurance premiums.

ACA Section 1411 generally made the premium tax credit available to U.S. citizens and certain aliens with lawful status who do not have access to subsidized public coverage (e.g., Medicaid) or affordable employer-sponsored coverage that provides minimum value. The amount of the premium tax credit varies from individual to individual. The ACA specified formulas for calculation of the premium tax credit amount and the amount that the individual (or family) must contribute toward the premium. That latter amount—the required premium contribution—is calculated according to a formula that incorporates a certain percentage (applicable percentage) of a given individual's (or family's) household income (based on modified adjusted gross income, or MAGI) and the premium for the second-lowest-cost silver plan—which has an actuarial value of 70%—in that individual's (or family's) local area.[13] The required premium contribution is capped according to MAGI, with such income measured relative to the federal poverty level (FPL). An individual whose MAGI is at or above 100% of FPL up to and including 400% of FPL may be eligible to receive premium credits. A smaller cap applies to lower-income individuals—compared to the cap applicable to higher-income persons—meaning lower-income individuals generally receive greater tax assistance.

ACA Section 1412 established an advance payment program to make the credit available during the year. The advanced amounts are reconciled when individuals file income-tax returns for the actual year in which they receive the credits. If a tax-filing unit's income decreases during the tax year and the filer should have received a larger credit, this additional credit amount will be included in the tax refund for the year. By contrast, any excess amount that was overpaid in credits to the filer will have to be repaid to the federal government as a tax payment. IRC Section 36B(f)(2)(B) imposed limits on the excess amounts to be repaid under certain conditions. For households with incomes below 400% of FPL, the specific limits apply to single and joint filers separately.

Explanation of New Provisions

Section 101 would *not* apply IRC Section 36B(f)(2)(B), relating to limits on the excess amounts to be repaid with respect to the premium tax credits, to taxable years ending after December 31, 2017, and before January 1, 2020. In other words, for tax years 2018 and 2019, any individual who was overpaid in premium tax credits would have to repay the entire excess amount, regardless of income.

Section 102 would exclude from the definition of QHP a plan that provides coverage for abortions (except if necessary to save the life of the mother or if the pregnancy is the result of

[12] A catastrophic plan is a high-deductible health plan that meets certain requirements specified in the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended); it is available only to individuals under 30 years of age and those who have a hardship exemption from the ACA's individual mandate.

[13] Most health plans sold through exchanges established under the ACA are required to meet actuarial value (AV) standards, among other requirements. AV is a summary measure of a plan's generosity, expressed as the percentage of medical expenses estimated to be paid by the insurer for a standard population and set of allowed charges. An exchange plan that is subject to the AV standard is given a precious metal designation: platinum (AV of 90%), gold (80%), silver (70%), or bronze (60%).

rape or incest) for taxable years beginning in 2018. The section would repeal authorization for the premium tax credit (IRC Section 36B) for taxable years beginning in 2020. Section 102 also would repeal relevant ACA provisions regarding eligibility determinations (generally ACA Section 1411) and receiving the premium credit in advance (ACA Section 1412), effective on January 1, 2020. In addition, the new provision would amend IRC Section 6103(l), related to the disclosure of taxpayer information, by providing that no disclosures may be made after December 31, 2019.

Section 103. Small Business Tax Credit

Current Law

IRC Section 45R, as added by ACA Section 1421, provided for a small business health insurance tax credit. The credit is intended to help make the premiums for small-group health insurance coverage more affordable for certain small employers. The credit generally is available to nonprofit and for-profit employers with fewer than 25 full-time-equivalent employees with average annual wages that fall under a statutorily specified cap. To qualify for the credit, employers must cover at least 50% of the cost of each of their employees' self-only health insurance coverage.

As of 2014, small employers must buy QHPs through a Small Business Health Options Program (SHOP) exchange to receive the credit and the credit is available for two consecutive tax years only. The two-year period begins with the first year an employer obtains coverage through a SHOP exchange. For example, if an employer first obtains coverage through a SHOP exchange in 2017, the credit will be available to the employer only in 2017 and 2018.

Explanation of New Provision

For taxable years beginning in 2018, Section 103 would amend IRC Section 45R to indicate that the term *qualified health plan* does not include any health plan that includes coverage for abortions, except abortions necessary to save the life of a mother or abortions for pregnancies that are a result of rape or incest.

The section would provide that the small employer health insurance credit would not be available for taxable years beginning in 2020.

Section 104. Individual Mandate

Current Law

IRC Section 5000A, as added by ACA Section 1501, created an individual mandate, a requirement for most individuals to maintain health insurance coverage or pay a penalty for noncompliance. To comply with the mandate, most individuals need to obtain *minimum essential coverage*, which includes most types of private (e.g., employer-sponsored) coverage and public coverage (e.g., Medicare and Medicaid). Certain individuals are exempt from the mandate and its associated penalty.

The individual mandate went into effect in 2014. Individuals who are not exempt from the mandate are required to pay a penalty for each month of noncompliance. The annual penalty is the *greater* of either a percentage of income or a flat dollar amount (but not more than the national average premium of a specified health plan). The percentage of income increased from

1.0% in 2014 to 2.5% in 2016 and beyond. The flat dollar amount increased from $95 in 2014 to $695 in 2016 and is adjusted for inflation thereafter.

Explanation of New Provision

Section 104 would effectively eliminate the annual penalty associated with IRC Section 5000A by reducing the percentage of income to 0% and the flat dollar amount to $0, effective retroactively for months beginning in 2016.

Section 105. Employer Mandate

Current Law

IRC Section 4980H, as added by ACA Section 1513, required that employers either provide health coverage or face potential employer tax penalties. The potential employer penalties apply to all types of common-law employers, including government entities (such as federal, state, local, or Indian tribal government entities) and nonprofit organizations that are exempt from federal income taxes. The penalties are imposed on firms with at least 50 full-time-equivalent employees if one or more of their full-time employees obtain a premium tax credit through a health insurance exchange. The total penalty for any applicable large employer is based on the employer's number of full-time employees (averaging 30 hours or more per week) and whether the employer offers affordable health coverage that provides minimum value.

Explanation of New Provision

Section 105 would modify the tax penalty associated with IRC Section 4980H, effectively eliminating it by reducing the penalties to $0, effective retroactively for months beginning in 2016.

Section 106. Federal Payments to States

Current Law

The Planned Parenthood Federation of America (PPFA) is an umbrella organization supporting 56 independent affiliates that operate approximately 650 health centers across the United States. Government funding—which includes federal, state, and local funds—constitutes the PPFA's largest source of revenue, an estimated 41% in the year ending June 30, 2016.[14] CBO estimates that federal funds accounted for about one-third of PPFA's total revenue in 2013.[15] PPFA receives federal grants (either directly or through another entity, such as a state) and reimbursements for providing services to beneficiaries enrolled in federally funded programs (e.g., Medicaid). It does not receive a direct annual appropriation of any kind.

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[14] Planned Parenthood Federation of America (PPFA) Inc., *2015-2016 Annual Report*, pp. 27, at https://www.plannedparenthood.org/uploads/filer_public/18/40/1840b04b-55d3-4c00-959d-11817023ffc8/20170526_annualreport_p02_singles.pdf. For more information about PPFA and the services it provides, see CRS Report R44295, *Factors Related to the Use of Planned Parenthood Affiliated Health Centers (PPAHCs) and Federally Qualified Health Centers (FQHCs)*.

[15] Letter from CBO to Senator Mike Enzi, Chairman of the Committee on the Budget, August 3, 2015, at https://www.cbo.gov/publication/50700.

CBO and the U.S. Government Accountability Office (GAO) found that PPFA's largest source of federal funding is reimbursements for covered services provided to Medicaid beneficiaries. Specifically, CBO estimated that PPFA's federal Medicaid revenue was approximately $390 million in 2013.[16] GAO examined FY2012 PPFA reimbursements and expenditures and found that PPFA had either received reimbursements or expended funds from discretionary programs and from direct spending (as defined in the Balanced Budget and Emergency Deficit Control Act of 1985, 2 U.S.C. 900(c)(8)). *Direct spending* refers to budget authority provided by laws other than through appropriations acts, entitlement authority, and the Supplemental Nutrition Assistance Program (SNAP). PPFA's reimbursements or expenditures from direct spending include reimbursements from Medicaid, Medicare, and the State Children's Health Insurance Program (CHIP) (listed in order of the amount of reimbursements received, according to GAO), as well as certain expenditures from the Social Services Block Grant, the Crime Victims Fund (administered by the Department of Justice), the Personal Responsibility Education Program, and SNAP (administered by the Department of Agriculture). PPFA also received funds from a number of discretionary programs, either directly or through another entity (e.g., a state). For example, in FY2012, GAO found that PPFA had expended discretionary funds from the Maternal and Child Health Services Block Grants programs which are provided to states; some states provided these funds to PPFA entities to provide services.[17]

Under federal law, federal funds generally are not available to pay for abortions, except in cases of rape, incest, or endangerment of a mother's life. This restriction is the result of statutory and legislative provisions such as the Hyde amendment, which has been added to the annual Department of Health and Human Services (HHS) appropriations measure since 1976. Similar provisions exist in the appropriations measures for foreign operations, the District of Columbia, the Department of the Treasury, and the Department of Justice. Other codified restrictions limit the use of funds made available to the Department of Defense, the Indian Health Service, and the Department of Veterans Affairs.

Using nonfederal funding sources (e.g., patient fees), PPFA affiliates and clinics and other entities may perform abortions in instances that do not meet the Hyde amendment exceptions. These entities also may receive federal grants and reimbursements from federal programs for non-abortion services. No comprehensive list exists of all entities that both receive federal funding or reimbursements and provide abortions that do not meet the Hyde amendment exceptions. In addition, there is no comprehensive source that provides the amount and sources of federal funding that these facilities receive.

Explanation of New Provision

Section 106 would prohibit federal funds made available to a state through direct spending from being provided to a prohibited entity (as defined), either directly or through a managed-care organization, for a one-year period beginning upon enactment of the draft bill. The provision specifies that this prohibition would be implemented notwithstanding certain programmatic rules

[16] Government Accountability Office (GAO), *Health Care Funding: Federal Obligations to and Expenditures by Selected Entities Involved in Health-Related Activities*, 2010–2012, GAO-15-270R, March 20, 2015, at http://www.gao.gov/products/GAO-15-270R. GAO does not provide a grand total for federal funding to PPFA affiliates in FY2012; however, for specific federal funding sources, see report Tables 15, 16, 24, 25, and 26 and CBO, *Budgetary Effects of Legislation that Would Permanently Prohibit the Availability of Federal Funds to Planned Parenthood*, September 22, 2015, at https://www.cbo.gov/publication/50833.

[17] GAO, *Health Care Funding: Federal Obligations to and Expenditures by Selected Entities Involved in Health-Related Activities*, 2010–2012, GAO-15-270R, March 20, 2015, at http://www.gao.gov/products/GAO-15-270R. GAO does not provide a grand total for federal funding to PPFA affiliates in FY2012; however, for specific federal funding sources see report Tables 15, 16, 24, 25, and 26.

(e.g., the Medicaid freedom of choice of provider requirement, which requires enrollees to be able to receive services from any willing Medicaid-participating provider, and states cannot exclude providers solely on the basis of the range of services they provide).

This provision does not explicitly specify that certain federal funds would not be made available to PPFA or its affiliated entities; instead, it refers to and defines a "prohibited entity" as an entity that meets the following criteria at enactment: (1) it is designated as a not-for-profit by the Internal Revenue Service (IRS); (2) it is described as an essential community provider that is primarily engaged in family planning services, reproductive health, and related medical care; (3) it is an abortion provider that provides abortion in cases that do not meet the Hyde amendment exception for federal payment; and (4) it received more than $350 million in Medicaid expenditures (both federal and state) in FY2014. In its July 19, 2017, score of ORRA, CBO stated that

> CBO expects that this provision would be implemented in a way that the prohibition would apply only if at least one entity, affiliate, subsidiary, successor, or clinic satisfied all of the criteria specified in the legislation; CBO identified only one organization that would be affected: Planned Parenthood Federation of America and its affiliates and clinics. If the provision was implemented in a way that affiliates, subsidiaries, successors, and clinics could satisfy the criteria separately, then the provision could apply to more organizations, perhaps many more.[18]

Section 107. Medicaid

Section 107(1)(A): Medicaid ACA Eligibility Provisions

Current Law

Eligibility for Medicaid is determined by federal and state law. States set individual eligibility criteria within federal standards. Individuals must meet both categorical (e.g., elderly, individuals with disabilities, children, pregnant women, parents, certain non-elderly childless adults) and financial (i.e., income and sometimes asset limits) criteria. In addition, individuals must meet federal and state requirements regarding residency, immigration status, and documentation of U.S. citizenship. Some eligibility groups are mandatory, meaning all states with a Medicaid program must cover them; others are optional. States are permitted to apply to the Centers for Medicare & Medicaid Services for a waiver of federal law to expand health coverage beyond the mandatory and optional groups listed in federal statute.

The ACA made several changes to Medicaid eligibility, including the following:

The ACA Medicaid Expansion. The ACA established 133% of FPL as the new mandatory minimum Medicaid income-eligibility level for most non-elderly individuals beginning January 1, 2014. On June 28, 2012, the U.S. Supreme Court issued its decision in *National Federation of Independent Business v. Sebelius*, finding that the enforcement mechanism for the ACA Medicaid expansion violated the Constitution, which effectively made the ACA Medicaid expansion optional for states. On January 1, 2014, 24 states and the District of Columbia implemented the

[18] CBO, *Cost Estimate* – H.R. 1628, *Obamacare Repeal Reconciliation Act of 2017*: An Amendment in the Nature of a Substitute [LYN17479] as Posted on the Website of the Senate Committee on the Budget on July 19, 2017, p. 4 (footnote 1), at https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/52939-hr1628amendment.pdf.

ACA Medicaid expansion. Since then, seven additional states have decided to implement the expansion.[19]

State Option for Coverage for Individuals with Income That Exceeds 133% of FPL. In addition to the ACA Medicaid expansion, the ACA created an optional Medicaid eligibility category for all non-elderly individuals with income above 133% of FPL up to a maximum level specified in the Medicaid state plan (or waiver), effective January 1, 2014. As of January 2017, only the District of Columbia had implemented this option.

Explanation of New Provision

Section 107(1)(A) would repeal the ACA Medicaid expansion and state option to extend coverage to adults above 133% of FPL (Section 1902(a)(10)(A)(i)(VIII) and Section 1902(a)(10)(A)(ii)(XX) of the Social Security Act [SSA], respectively) by specifying the end dates of these provisions as December 31, 2019.

Section 107(2) and 107(3): Various Federal Medicaid Matching Rate Provisions

Current Law

Medicaid is jointly financed by the federal government and the states. The federal government's share of a state's expenditures for most Medicaid services is called the *federal medical assistance percentage* (FMAP) rate, which varies by state and is designed so that the federal government pays a larger portion of Medicaid costs in states with lower per capita incomes relative to the national average (and vice versa for states with higher per capita incomes).[20] Exceptions to the regular FMAP rate have been made for certain states, situations, populations, providers, and services. The ACA added a few FMAP exceptions, including the following:

- the *newly eligible* federal matching rate (i.e., the matching rate for individuals who are newly eligible for Medicaid due to the ACA expansion);
- the *expansion state* federal matching rate (i.e., the matching rate for expansion enrollees without dependent children in expansion states who would have been eligible for Medicaid under the rules in place in their state on March 23, 2010); and
- a six-percentage-point increase to the FMAP rate for services covered under the Community First Choice option, which allows states to offer community-based attendant services and supports as an optional Medicaid state plan benefit.

In addition, the ACA increased the Medicaid FMAP rate available to all of the territories from 50% to 55% beginning July 1, 2011.

Explanation of New Provisions

Section 107(2) and 107(3) would repeal (1) the newly eligible matching rate on January 1, 2020 (SSA Section 1905(y)(1)); (2) the expansion state matching rate on January 1, 2020 (SSA Section 1905(z)(2)); and (3) the increased FMAP rate for the Community First Choice option on January

[19] For more information about the ACA Medicaid expansion, see CRS In Focus IF10399, *Overview of the ACA Medicaid Expansion*.

[20] For more information about the federal medical assistance percentage, see CRS Report R43847, *Medicaid's Federal Medical Assistance Percentage (FMAP)*.

1, 2020 (SSA Section 1915(k)(2)). Section 107(2)(A) also would change the FMAP rate for the territories back to 50% on or after January 1, 2020 (SSA Section 1905(b)).

Section 107(1)(B), 107(4), and 107(6): Medicaid ACA Enrollment Facilitation Provisions

Current Law

Presumptive Eligibility. Prior to the enactment of the ACA, states were permitted to enroll certain groups (e.g., children, pregnant women, certain women with breast and cervical cancer, and individuals eligible for family planning services) for a limited period of time before completed Medicaid applications were filed and processed, based on a preliminary determination of likely Medicaid eligibility by certain specified Medicaid providers (i.e., *qualified entities*). Qualified entities had to be certified by the state Medicaid agency as entities that were capable of making presumptive-eligibility determinations. The type of entity that could make presumptive-eligibility determinations depended on the beneficiary's Medicaid eligibility category. For example, certain providers of clinic and outpatient hospital services could determine presumptive eligibility for pregnant women. Agencies that served low-income children under federal programs, such as the Special Supplemental Nutrition Program for Women, Infants, and Children or school lunch programs (under the Richard B. Russell National School Lunch Act [P.L. 79-396]) could make presumptive-eligibility determinations for children. Individuals who were determined to be presumptively eligible for Medicaid then had to formally apply for coverage within a given time frame to continue receiving Medicaid benefits.

The ACA expanded the types of entities that are permitted to make Medicaid presumptive-eligibility determinations as well as the groups of individuals for whom presumptive-eligibility determinations may apply. Specifically, the ACA allowed states to permit all hospitals that participate in Medicaid to elect to make presumptive-eligibility determinations for all Medicaid eligibility groups, beginning January 1, 2014.

In addition, states that elected the option to provide a presumptive-eligibility period to children or pregnant women were permitted to provide a presumptive-eligibility period for (1) the ACA Medicaid expansion group, (2) the mandatory coverage group for individuals currently or formerly in foster care who are under the age of 26, (3) low-income families eligible under SSA Section 1931, or (4) the state option for coverage for individuals with income that exceeds 133% of FPL.

Streamlined Enrollment System. As a condition of the receipt of federal financial assistance, the ACA required states to coordinate their eligibility and enrollment systems across all of the ACA low-income subsidy programs (including Medicaid, CHIP, and the health insurance exchanges).

Explanation of New Provision

Presumptive Eligibility. After January 1, 2020, Section 107(1)(B) would no longer allow hospitals that participate in Medicaid to elect to make presumptive-eligibility determinations. It also would provide that any such election that a hospital had already made would cease to be effective as of that date by modifying SSA Section 1902(a)(47)(B).

For states that elected the option to provide a presumptive-eligibility period to children and pregnant women, Section 107(4) would repeal the state option to provide a presumptive-eligibility period any time after December 31, 2019, for (1) the ACA expansion group, (2) the

mandatory foster care group through the age of 26, or (3) low-income families (SSA Section 1920(e)).

Streamlined Enrollment System. Section 107(6) would repeal the requirement for states to coordinate their eligibility and enrollment systems across all of the ACA low-income subsidy programs as of January 1, 2020 (SSA Section 1943(a)).

Section 107(5): Medicaid Alternative Benefit Plan Coverage

Current Law

As an alternative to providing all the mandatory and selected optional benefits under traditional Medicaid, the Deficit Reduction Act of 2005 (P.L. 109-171) gave states the option to enroll state-specified groups in what previously was referred to as benchmark or benchmark-equivalent coverage but currently is called *alternative benefit plans* (ABPs). States that choose to implement the ACA Medicaid expansion are required to provide ABP coverage (with exceptions for selected special-needs subgroups), rather than traditional Medicaid, to the individuals eligible for Medicaid through the expansion. In addition, states have the option to provide ABP coverage to other subgroups.

The ACA made significant changes to ABP design and ABP requirements. The ACA required such packages provide at least the 10 essential health benefits, which are (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services, including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.[21]

Explanation of New Provision

Under Section 107(5), SSA Section 1937(b)(5) would not apply after December 31, 2019. As a result, Medicaid ABP coverage would no longer be required to include the essential health benefits after that date.

Section 108. Repeal of Disproportionate Share Hospital Allotment Reductions

Current Law

SSA Section 1923 required states to make Medicaid disproportionate share hospital (DSH) payments to hospitals treating large numbers of low-income patients.[22] This provision was intended to recognize the disadvantaged financial situation of those hospitals because low-income patients are more likely to be uninsured or Medicaid enrollees. Hospitals often do not receive payment for services rendered to uninsured patients, and Medicaid provider payment rates generally are lower than the rates paid by Medicare and private insurance.

[21] For more information about the essential health benefits, see CRS Report R44163, *The Patient Protection and Affordable Care Act's Essential Health Benefits (EHB)*.

[22] For more information about Medicaid disproportionate share hospital (DSH) payments, see CRS Report R42865, *Medicaid Disproportionate Share Hospital Payments*.

Whereas most federal Medicaid funding is provided on an open-ended basis, federal Medicaid DSH funding is capped. Each state receives an annual DSH allotment, which is the maximum amount of federal matching funds that each state is permitted to claim for Medicaid DSH payments. Each state's Medicaid DSH allotment increases annually by the percentage change in the Consumer Price Index for All Urban Consumers for the prior fiscal year.

The ACA reduced the number of uninsured individuals in the United States through its health insurance coverage provisions. Built on the premise that with fewer uninsured individuals there should be less need for Medicaid DSH payments, the ACA included a provision directing the HHS Secretary to make aggregate reductions in Medicaid DSH allotments for FY2014 through FY2020. However, multiple subsequent laws have amended these reductions. Under current law, the aggregate reductions to the Medicaid DSH allotments are to impact FY2018 through FY2025. After FY2025, allotments will be calculated as though the reductions never occurred, which means the allotments will include the inflation adjustments for the years during the reductions.[23]

Explanation of New Provision

Section 108 would repeal the Medicaid DSH allotment reductions.

Section 109. Repeal of the Tax on Employee Health Insurance Premiums and Health Plan Benefits

Current Law

IRC Section 4980I, as added by ACA Section 9001, created a new excise tax on high-cost employer-sponsored coverage (the so-called Cadillac tax) under Chapter 43 of the IRC. Under the ACA, the tax was scheduled to take effect in 2018; however, the Consolidated Appropriations Act, 2016 (P.L. 114-113), delayed implementation of the tax until 2020. When it is implemented, the tax is to be imposed at a 40% rate on the aggregate cost of employer-sponsored health coverage that exceeds a specified dollar limit. If a tax is owed, it is to be levied on the entity providing the coverage (e.g., the health insurance issuer or the employer).

Explanation of New Provision

Section 109 would delay implementation of IRC Section 4980I (the so-called Cadillac tax) until taxable periods beginning January 1, 2026.

Section 110. Repeal of the Tax on Over-the-Counter Medications

Current Law

Under the IRC, taxpayers may use several different types of tax-advantaged health accounts to pay or be reimbursed for qualified medical expenses: health flexible spending accounts (health FSAs), health reimbursement accounts (HRAs), Archer Medical Savings Accounts (MSAs), and health savings accounts (HSAs). ACA Section 9003 amended the relevant IRC provisions (IRC Sections 106, 220, and 223) to provide that, for each of these accounts, amounts paid for medicine or drugs are qualified expenses only in the case of prescribed drugs and insulin.

[23] For more information about the ACA Medicaid DSH reductions, see CRS In Focus IF10422, *Medicaid Disproportionate Share Hospital (DSH) Reductions*.

Explanation of New Provision

Section 110 would repeal the language in IRC Sections 106, 220, and 223 stipulating that a medicine or drug must be a prescribed drug or insulin to be considered a qualified expense in terms of spending from a tax-advantaged health account. The provision would be generally effective for taxable years beginning in 2017.

Section 111. Repeal of the Tax on Health Savings Accounts

Current Law

ACA Section 9004 amended IRC Sections 220 and 223 to impose a 20% tax on distributions from Archer MSAs and HSAs that are used for purposes other than paying for qualified medical expenses. Prior to the ACA, IRC Section 220 applied a 15% rate on such distributions if made from an Archer MSA and IRC Section 223 applied a 10% rate on such distributions if made from an HSA.

Explanation of New Provision

Section 111 would amend IRC Sections 220 and 223 to reduce the applicable rate to 15% and 10% for Archer MSAs and HSAs, respectively. The lower rates would apply to distributions made after December 31, 2016.

Section 112. Repeal of Limitations on Contributions to Flexible Spending Accounts

Current Law

IRC Section 125 allowed employers to establish cafeteria plans, benefit plans under which employees may choose between receiving cash (typically additional take-home pay) and certain nontaxable benefits (such as employer-paid health insurance) without being taxed on the value of the benefits if they select the latter. (A general rule of taxation is that when given a choice between taxable and nontaxable benefits, taxpayers will be taxed on whichever they choose because they are deemed to be in constructive receipt of the cash.)

ACA Section 9005 amended IRC Section 125(i) to provide that a health FSA cannot be a nontaxable benefit under a cafeteria plan unless the cafeteria plan provides that an employee may not elect for any taxable year to have a salary reduction contribution in excess of $2,500 made to such arrangement. Also, the $2,500 limit is indexed for cost-of-living adjustments for plan years beginning after December 31, 2013.

Explanation of New Provision

Section 112 would repeal IRC Section 125(i), the $2,500 contribution limit to health FSAs, effective for plan years beginning in 2018.

Section 113. Repeal of Tax on Prescription Medications

Current Law

ACA Section 9008 imposed an annual tax on covered entities engaged in the business of manufacturing or importing branded prescription drugs. In general, the tax is imposed on covered manufacturers and importers with aggregated branded prescription drug sales of more than $5 million to specified government programs or pursuant to coverage under these programs.

Explanation of New Provision

Section 113 would amend ACA Section 9008(j) to provide that the tax would not be imposed effective 2018.

Section 114. Repeal of Medical Device Excise Tax

Current Law

Section 1405 of the Health Care and Education Reconciliation Act of 2010 (HCERA; P.L. 111-152) created a new excise tax that is imposed on the sale of certain medical devices. The tax is codified in IRC Section 4191. The tax is equal to 2.3% of the device's sales price and generally is imposed on the manufacturer or importer of the device. The tax took effect on January 1, 2013. The Consolidated Appropriations Act, 2016 (P.L. 114-113), provided a two-year moratorium on the tax. The tax does not apply to sales in the period beginning January 1, 2016, and ending December 31, 2017.

Explanation of New Provision

Section 114 would amend IRC Section 4191 to provide that the medical device excise tax would not apply to sales after December 31, 2017.

Section 115. Repeal of Health Insurance Tax

Current Law

ACA Section 9010 imposed an annual fee on certain health insurers beginning in 2014. The ACA fee is based on net health care premiums written by covered issuers during the year prior to the year that payment is due. The aggregate ACA fee is set at $8.0 billion in 2014, $11.3 billion in 2015 and 2016, $13.9 billion in 2017, and $14.3 billion in 2018. After 2018, the fee is indexed to the annual rate of U.S. health insurance premium growth. Each year, the IRS apportions the fee among affected insurers based on (1) their net premiums written in the previous calendar year as a share of total net premiums written by all covered insurers and (2) their dollar value of business. Covered insurers are not subject to the fee on their first $25 million of net premiums written. The fee is imposed on 50% of net premiums above $25 million and up to $50 million, and it is imposed on 100% of net premiums in excess of $50 million.

Certain types of health insurers or insurance arrangements are not subject to the fee, including self-insured plans; voluntary employees' beneficiary associations; and federal, state, or other governmental entities, including Indian tribal governments and nonprofit entities incorporated under state law that receive more than 80% of their gross revenues from government programs

that target low-income, elderly, or disabled populations. In addition, only 50% of net premiums written by tax-exempt entities are included in determining an entity's market share.

ACA Section 9010(j) made these provisions effective for calendar years beginning after December 31, 2013. The Consolidated Appropriations Act, 2016 (P.L. 114-113), provided a one-year moratorium on the tax for 2017.

Explanation of New Provision

Section 115 would amend ACA Section 9010(j) to provide that the annual fee would not be imposed, effective 2017.

Section 116. Repeal of Elimination of Deduction for Expenses Allocable to Medicare Part D Subsidy

Current Law

Employers that provide Medicare-eligible retirees with prescription drug coverage that meets or exceeds set federal standards are eligible for federal subsidy payments. The subsidies are equal to 28% of plans' actual spending for prescription drug costs in excess of $400 and not to exceed $8,250 (for 2017).[24] The subsidies were created as part of the Medicare Part D prescription drug program (Medicare Modernization Act of 2003; P.L. 108-173) to provide employers with an incentive to maintain drug coverage for their retirees.

Under IRC Section 139A, employers are allowed to exclude qualified retiree prescription drug plan subsidies from gross income for the purposes of corporate income tax. Prior to implementation of the ACA, employers also were allowed to claim a business deduction for their qualifying retiree prescription drug expenses, even if they also received the federal subsidy to cover a portion of those expenses. ACA Section 9012 amended IRC Section 139A, beginning in 2013, to effectively require employers to coordinate the subsidy and the deduction for retiree prescription drug coverage. The amount allowable as a deduction for the costs of providing retiree prescription drug coverage is reduced by the amount of the federal subsidy received.

Explanation of New Provision

Section 116 would amend IRC Section 139A to reinstate prior law so that business-expense deductions for retiree prescription drug costs would be allowable without reduction by the amount of any federal subsidy. The change would be effective for taxable years beginning after December 31, 2016.

Section 117. Repeal of Chronic Care Tax

Current Law

Under IRC Section 213, taxpayers who itemize their deductions may deduct qualifying medical expenses. The medical-expense deduction may be claimed only for expenses that exceed 10% of the taxpayer's adjusted gross income (AGI), a threshold that was reduced for taxable years ending

[24] CMS, "Announcement of Calendar Year (CY) 2017 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter," April 4, 2016, p. 69, at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2017.pdf.

before January 1, 2017, to 7.5% if the taxpayer or spouse was aged 65 or older. The 10% threshold was imposed by ACA Section 9013. Prior to the ACA, the AGI threshold was 7.5% for all taxpayers.

Explanation of New Provision

Section 117 would amend IRC Section 213(a) to reduce the AGI threshold to 7.5% for all taxpayers, effective tax year 2017.

Section 118. Repeal of Medicare Tax Increase

Current Law

ACA Sections 9015 and 10906 imposed a Medicare Hospital Insurance (HI) surtax at a rate equal to 0.9% of an employee's wages or a self-employed individual's self-employment income. The surtax, which is found in IRC Sections 1401 and 3101, applies only to taxpayers with taxable income in excess of $250,000 if married filing jointly; $125,000 if married filing separately; and $200,000 for all other taxpayers. The tax is in addition to the regular Federal Insurance Contributions Act and Self-Employment Contributions Act taxes that generally apply (i.e., Social Security and Medicare taxes).

Explanation of New Provision

Section 118 would amend IRC Sections 1401(b) and 3101(b) to repeal the 0.9% Medicare surtax, effective for remuneration received and taxable years beginning after December 31, 2017.

Section 119. Repeal of Tanning Tax

Current Law

ACA Section 10907 created a new excise tax on indoor tanning services. The tax is equal to 10% of the amount paid for such services. The provision is codified in Chapter 49 of the IRC.

Explanation of New Provision

Section 119 would repeal the tax on indoor tanning services (IRC Chapter 49), effective for services performed after September 30, 2017.

Section 120. Repeal of Net Investment Tax

Current Law

HCERA Section 1402 imposed a net investment tax on high-income taxpayers. The tax, which is codified in Chapter 2A of Subtitle A of the IRC, applies at a rate of 3.8% to certain net investment income of individuals, estates, and trusts with income above amounts specified in the statute.

Explanation of New Provision

Section 120 would repeal the net investment tax (Chapter 2A of IRC Subtitle A), effective beginning tax year 2017.

Section 121. Remuneration

Current Law

Generally, employers may deduct the remuneration paid to employees as "ordinary and necessary" business expenses under IRC Section 162, subject to any statutory limitations. ACA Section 9014(b) added a statutory limitation for certain health insurance providers. Under the provision, which is codified at IRC Section 162(m)(6), covered health insurance providers may not deduct the remuneration paid to an officer, director, or employee in excess of $500,000.

Explanation of New Provision

Section 121 would terminate IRC Section 162(m)(6), effective beginning tax year 2017.

Title II

Section 201. Prevention and Public Health Fund

Current Law

ACA Section 4002 established the Prevention and Public Health Fund (PPHF), to be administered by the HHS Secretary, and provided it with a permanent annual appropriation.[25] The PPHF is intended to support an "expanded and sustained national investment in prevention and public health programs." In general, PPHF funds have been distributed to HHS agencies in the Public Health Service, in particular the Centers for Disease Control and Prevention. Amounts for each fiscal year are available to the HHS Secretary beginning October 1, the start of the respective fiscal year. Congress may explicitly direct the distribution of PPHF funds and did so for FY2014 through FY2017.

Under the ACA, the PPHF's annual appropriation would increase from $500 million for FY2010 to $2 billion for FY2015 and each subsequent fiscal year. Congress has amended the provision two times, using a portion of PPHF funds as an offset for the costs of other activities. Annual appropriations to the PPHF in current law are as follows:

1. $500 million for FY2010;
2. $1.0 billion for each of FY2012 through FY2017;[26]
3. $900 million for each of FY2018 and FY2019;
4. $1.0 billion for each of FY2020 and FY2021;
5. $1.5 billion for FY2022;
6. $1.0 billion for FY2023;
7. $1.7 billion for FY2024; and
8. $2.0 billion for FY2025 and each fiscal year thereafter.[27]

[25] For more information, see CRS Report R44796, *The ACA Prevention and Public Health Fund: In Brief*.

[26] The ACA also appropriated $750 million to the Prevention and Public Health Fund for FY2011. This line of text was removed from the provision in P.L. 112-96 in 2012, which did not affect the availability of FY2011 funds.

[27] Amounts do not reflect sequestration of funds for FY2013 and subsequent fiscal years.

Explanation of New Provision

Section 201 would amend ACA Section 4002(b) by repealing all PPHF appropriations for FY2019 and subsequent fiscal years.

Section 202. Support for State Response to Substance Abuse Public Health Crisis and Urgent Mental Health Needs

Current Law

The Substance Abuse and Mental Health Services Administration (SAMHSA) supports community-based substance abuse and mental health treatment and prevention services through formula grants to the states and U.S. territories and through competitive grant programs to states, territories, tribal organizations, local communities, and private entities. SAMHSA and most of its programs and activities are authorized under Public Health Service Act (PHSA) Title V; SAMHSA's two largest grant programs, the Substance Abuse Prevention and Treatment Block Grant and the Community Mental Health Services Block Grant, are authorized under PHSA Title XIX. PHSA Section 399O required the HHS Secretary to award formula grants to states to support state prescription drug monitoring programs, but this grant program has not received funding since FY2010. Other agencies within HHS also support substance abuse or mental health prevention and treatment under more general authorities.

Explanation of New Provision

Section 202 would authorize to be appropriated and would appropriate, out of monies in the Treasury not otherwise obligated, $750 million for each of FY2018 and FY2019 to the HHS Secretary to award grants to states to address the substance abuse public health crisis or respond to urgent mental health needs by (1) improving state prescription drug monitoring programs, (2) implementing and evaluating substance abuse prevention activities, (3) training health care practitioners in topics related to substance abuse, (4) supporting access to substance abuse or mental health services, and/or (5) other public health-related activities related to substance abuse or mental health. Funds appropriated pursuant to this authority would remain available until expended.

Section 203. Community Health Center Program

Current Law

ACA Section 10503 created the Community Health Center Fund, which provided mandatory appropriations to the Health Center Program from FY2011 through FY2015.[28] The Health Center Program provides grants to outpatient primary care facilities that provide health services to underserved populations in health professional shortage areas. These appropriations were subsequently extended through FY2017 by Section 221(a) of the Medicare Access and CHIP Reauthorization Act of 2015 (P.L. 114-10), which provided $3.6 billion for each of FY2016-FY2017.

[28] For more information about the Community Health Center Fund, see CRS Report R43911, *The Community Health Center Fund: In Brief*.

Prior to the ACA, the Health Center Program had received only discretionary appropriations, which made up the entirety of the program's appropriated funds. Since the Community Health Center Fund's creation, the fund has made up an increasing percentage of the Health Center Program's appropriation, ranging from 39% for FY2011 to 70% for FY2017. Under current law, for FY2018, the Community Health Center Fund will not receive a mandatory appropriation.

Explanation of New Provision

Section 203 would provide $422 million to the Community Health Center Fund for FY2017 in addition to the $3.6 billion appropriated under current law.

Section 204. Funding for Cost-Sharing Payments and Section 205. Repeal of Cost-Sharing Subsidy Program

Current Law

ACA Section 1402 authorized subsidies to eligible individuals to reduce the cost-sharing expenses for health insurance plans offered in the individual market through health insurance exchanges.[29] Cost-sharing assistance is provided in two forms. The first form of assistance reduces the out-of-pocket limit applicable for a given exchange plan; the second reduces actual cost-sharing requirements (e.g., lowers the deductible or reduces a co-payment) applicable to a given exchange plan. Both types of assistance provide greater subsidy amounts to individuals with lower household incomes. Individuals who meet applicable eligibility requirements may receive both types of cost-sharing subsidies.

The ACA directed the HHS and the Treasury Secretaries to make payments to reimburse insurers for the required reductions but did not expressly address the source of funds to be used for these payments. The Obama Administration made cost-sharing reduction payments to insurers using an appropriation that covered premium subsidies. The House of Representatives filed suit, claiming that the payments violated the appropriations clause of the U.S. Constitution.[30] After holding that the House has standing to sue the Obama Administration, the U.S. District Court for the District of Columbia concluded that the Secretaries' payment of the cost-sharing reimbursements was unconstitutional for lack of a valid appropriation enacted by Congress. The court barred the Obama Administration from making the cost-sharing payments but stayed its decision pending appeal of the case. Should the appeal of the case not go forward, the district court's decision apparently could take effect, likely preventing the federal government from reimbursing insurers for these required cost-sharing reductions absent a subsequent appropriation of funds or other action by Congress.

Explanation of New Provisions

Section 204 would appropriate to the HHS Secretary such sums as may be necessary for cost-sharing subsidies (including adjustments to prior obligations for such payments) for the period beginning the date of enactment through December 31, 2019. Payments incurred and other actions for adjustments to obligations for plan years 2018 and 2019 could be available through December 31, 2020.

[29] See CRS Report R44425, *Health Insurance Premium Tax Credits and Cost-Sharing Subsidies: In Brief*.

[30] See CRS Legal Sidebar, *Pending ACA Legal Challenges Remain as Congress Pursues Health Care Reform*.

Section 205 would repeal ACA Section 1402, terminating the cost-sharing subsidies (and payments to issuers for such reductions), effective for plan years beginning in 2020.

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