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Affordable Care Act Repeal Legislation Summary

On June 22nd, Senate leadership unveiled the Better Care Reconciliation Act (BCRA), the Senate's proposal to repeal and replace the Affordable Care Act (ACA). This bill is the accompanying measure to the American Health Care Act (AHCA) - the House's ACA repeal and replace legislation. Yesterday's release of the bill text follows weeks of uncertainty driven by an accelerated timeline coupled with a paucity of information regarding specific policies that would be included in the Senate's measure. Following the release of bill text, Senate leadership is continuing to press for a vote before the scheduled July 4th Congressional recess. In order to meet this deadline, the measure must be put on the Senate floor for a vote by the end of next week. The current understanding is that the vote will occur towards the end of the week, either on Thursday or potentially Friday, after 20 hours of debate. Senate Democrats, as well as several Republicans, have stated concerns about the expedited timeline between release of the language and the scheduled vote; however, leadership continues to express their commitment to holding a vote before the recess.

Republican leadership is using a technical parliamentary process called reconciliation which allows them to pass the bill with 50 votes, including the Vice President as a tiebreaker, instead of the usual 60-vote threshold required for Senate passage. As shared previously, this procedure places strict controls on what can and cannot be included in the legislation.[1] A number of Senators have expressed concerns that certain provisions, including restrictions on abortion providers and relaxation of some insurance regulations, might not be permitted under reconciliation rules. Democrats are expected to challenge several provisions in the measure, and the nonpartisan Senate parliamentarian will rule on whether they can remain in the final bill.

Additionally, today it remains uncertain whether the bill has sufficient support to secure 50 votes in the Senate. All Democrats and liberal-leaning independents are expected to vote against the measure, meaning that no more than two Republicans can oppose the legislation in order for it to pass. Several moderates in the Senate have expressed concern about some of the bill's provisions, such as the significant cuts to Medicaid included in the bill, restrictions on funding for Planned Parenthood, and lessening protections for consumers. However, leadership must also balance the priorities of these members against those of more conservative senators who would like to see even larger reductions to subsidies for enrollees, deeper reductions in Medicaid funding, and greater relaxation of insurance mandates and regulation. Four conservative senators have already released a statement expressing concerns about the policies contained therein and their reluctance to vote for it.[2]

[1] See http://bit.ly/2rGdbso for more information
[2] https://www.paul.senate.gov/news/press/sens-paul-cruz-johnson-and-lee-issue-joint-statement-on-senate-health-bill

The legislation is very similar to the House-passed measure, with several key differences relating to the calculation of tax credits for people purchasing coverage in the individual marketplace as well as restrictions to federal funding for both the Medicaid expansion as well as the entire Medicaid program. Some provisions are more generous to beneficiaries, including the calculation of tax credits as well as the extended phase-out of ACA's Medicaid expansion. In contrast, some provisions are more restrictive – most notably the restrictions placed upon Medicaid funding for all populations. The Senate bill sets a different benchmark for spending growth, which will lead to lower caps on services to beneficiaries over time.

This memorandum includes a chart that provides an analysis of the Senate bill and its underlying provisions as well as a comparison to the provisions in the House-passed legislation. We note that we truncated some of the discussion of the House policies in the interest of readability. You can view our more detailed analysis of the House bill at: http://bit.ly/2rG3E4U

NASUAD will continue to provide updates to members as the legislation is debated and potentially amended before next week's scheduled vote.

More information and the full Senate bill text is available at: https://www.budget.senate.gov/bettercare

Key Provisions in the Better Care Reconciliation Act (the Senate ACA Repeal and Replace bill

The legislation would enact sweeping changes to the Affordable Care Act, but does not repeal and replace it in its entirety. This results in less significant changes to the insurance marketplace than the House bill, specifically as it relates to premium tax credits and insurance regulations. However, it would still amount to a significant overhaul of the national health care system. If passed, a wide range of ACA provisions and requirements will be terminated on December 31, 2019 with significant changes to the Medicaid and insurance marketplace taking effect simultaneously. This includes provisions such as:

- Modifying the ACA advanced premium tax credits (APTCs) which are used to subsidize the purchase of health insurance to lower the maximum income eligibility threshold, establish the payments based on age and income, and lower the benchmark used to calculate the credit amount;
- Repealing ACA taxes, including the increased Medicare tax; the health insurer tax; and the medical device tax, among others (effective at the end of 2016):
    - The tax on high-cost health plans, known as the Cadillac tax, is delayed but not fully repealed. The new bill delays it until 2026 similar to the House measure;
- Eliminating the increased Federal match (FMAP) for 1915k/Community First Choice services;
- Removing increased FMAP for ACA expansion groups (note: this has a gradual phase-out policy explained below);

- Creating an option for states to establish work requirements on certain adults without disabilities;
- Setting a per-capita cap on Medicaid expenditures, and providing states with the option to receive a block grant for certain populations; and
- Expanding the ability of states to apply for waivers of core ACA policies under section ACA 1332 waivers.

Many of these provisions are quite similar to the House-passed legislation. In fact, the legislation largely tracks with the AHCA as passed by the House; however the Senate did modify a number of technical and policy items in the underlying bill text. Below, we provide updated detail on some of the policies included in this legislation, with a specific emphasis on changes to Medicaid and LTSS policy.

Provision	Policy in the House	Policy in the Senate
Medicaid Provisions		
The Medicaid Community First Choice (CFC) Option. Also known as the 1915(k) state plan benefit.	Retains 1915(k) services and eligibility; terminates the 6 percent FMAP increase, effective January 1, 2020.	Identical to House bill.
Medicaid expansion	• Sunsets ACA Medicaid expansion increased FMAP beginning January 1, 2020 except for "grandfathered" individuals who were enrolled before that date and who did not have a break in Medicaid eligibility of more than a month. • Prevents new states from receiving increased FMAP for ACA expansions after March 1, 2017. • Ends option for states to expand Medicaid to childless adults above 138% FPL, effective January 1, 2017. • Lowers increased FMAP to "pre-ACA" expansion states.	• Sunsets ACA mandatory Medicaid expansion group December 31, 2019 and establishes a new optional eligibility group for expansion adults on January 1, 2020 with the same eligibility criteria as the ACA group. • Slowly decreases the increased FMAP beginning January 1, 2021 (from the ACA 90% in effect in 2020) for states that covered the expansion before March 1, 2017. The reduction in FMAP follows this schedule: o 85% in calendar year 2021; o 80% in 2022; o 75% in 2023; and o The state's normal FMAP beginning in 2024. • States that did not expand ACA before 3/1/2017 would receive the standard FMAP if they choose to adopt at a later date.

		• Freezes the gradual increases in FMAP for pre-ACA expansion states at 2017 levels (the ACA gradually increases the FMAP to match rates for other states) and eventually reduces the FMAP to the regular level for these states. • Ends option for states to expand Medicaid to childless adults above 138% FPL, effective January 1, 2017 [note: there is no "grandfathering" of individuals at the higher ACA FMAP in this bill, in contrast to the House measure]
Mandatory Eligibility Level for Children age 6-18	Reverts back to the pre-ACA mandatory minimum eligibility level of 100% FPL from 133% FPL	Identical to House bill.
Medicaid Benchmark Plans include Essential Health Benefits	The bill removes the requirement that Medicaid Benchmark Benefits, also known as Alternative Benefit Plans, include the ACA Essential Health Benefits package. The provision is effective January 1, 2020.	Identical to House bill.
Medicaid "Per-Capita Caps"	Sets upper spending limits on per-capita Medicaid service expenditures, beginning in 2020. The limits are based upon FY2016 expenditures, trended forward using CPI-M for children and adults without disabilities, and CPI-M + 1 for older adults and individuals with disabilities. The aggregate spending limit is calculated by combining separate limits for five different groups of enrollees. These separate limits are calculated via multiplying each group's per-capita limit by the total enrollees in that group. The five groups are: • Individuals age 65 or older; • Individuals who are blind or have a disability;	Sets upper spending limits on Medicaid spending based on per-capita allocations beginning in 2020. States that exceed their cap will have the excess funding reduced from their FFP in the following year. The limits are based upon state spending during a period of 2 years (8 consecutive quarters) selected by the state. The five groups subject to per-capita caps are: • Individuals age 65 or older; • Individuals who are blind or have a disability; • Children under the age of 19 who are not eligible via a CHIP program; • Individuals who qualify as newly eligible for the ACA expansion; and • Other adults who are not included in the prior groups.

	• Children under the age of 19 who are not eligible via a CHIP program; • Individuals who qualify as newly eligible for the ACA expansion; and • Other adults who are not included in the prior groups. This policy excludes several groups of individuals from per-capita caps: • Individuals eligible for Medicaid via a combined CHIP program; • Individuals receiving Indian health services; • Persons on Medicaid via breast and cervical cancer eligibility; • Partial-benefit dual eligible individuals; • Individuals receiving Medicaid payments for employer-sponsored insurance premiums/cost-sharing; • Undocumented immigrants who receive Medicaid-funded emergency care services. The policy also excludes several types of expenditures from the spending cap, including: • Disproportionate Share Hospital Payments; • Medicare cost-sharing payments; • Allowable supplemental payments to providers; and • Increased safety-net payments for providers in non-expansion state (that are created by the House bill legislation).	States may select a base period from any 8 consecutive quarters beginning in FY2014 and ending in the third fiscal quarter of FY2017 (ie: from October 1, 2013 through June 30th 2017). The expenditures for the base period are adjusted for inflation using CPI-M to 2019, to create the provisional per-capita expenditure caps. Between FY2020-FY2024, the provisional caps for each category of enrollee are adjusted based on the following calculation: • Caps for individuals age 65 or older and Individuals who are blind or have a disability are increased by CPI-M + 1 percentage point; • Caps for the other groups are increased by CPI-M. Beginning in FY2025 and for every year thereafter, caps for all categories are increased by CPI-U (a lower inflationary factor than CPI-M). The policy excludes several groups from the per-capita cap calculations: • Individuals eligible for Medicaid via a combined CHIP program; • Individuals receiving Indian health services; • Persons on Medicaid via breast and cervical cancer eligibility; • Partial-benefit dual eligible individuals; • Eligible due to tuberculosis infection; • Individuals eligible for family planning services only; • Individuals receiving Medicaid payments for employer-sponsored insurance premiums/cost-sharing;

		• Undocumented immigrants who receive Medicaid-funded emergency care services; and • Children under the age of 19 eligible based on blindness or a disability. The policy also excludes several types of payments, including the Vaccines for Children program; DSH payments; Medicare cost-sharing expenses; and safety-net provider payments in non-expansion states (described below). Supplemental payments to providers (non-DSH) are included in the per-capita caps, as are delivery systems reform payments, uncompensated care pools, and other similar sources of funding for providers. That is, they are allowed to continue, but will be subject to the overall spending limits. As in the House proposal, these payments are excluded from the calculation of each group's medical expenses, and then calculated as a ratio of overall medical costs. The per-capita caps are adjusted upward by this ratio to account for the supplemental payments.
Adjustment of Caps to States that are Outliers		Beginning in 2020, HHS is directed to adjust the cap amounts for states that have payments significantly above or below the national average. States that exceed the average spending in one of the per-capita cap categories (ie: children, older adults, people with disabilities, etc) by more than 25% would have the cap for that category adjusted downward by an amount determined by the Secretary which is no less than 0.5% and no more than 2% in the following year. Similarly, states with spending for a category that is at least 25% below the average spending would have a secretary-defined increase of 0.5% - 2% to the per-capita cap in the following year.

		Overall, the adjustments must be budget neutral to the federal government. The adjustment is applied on a category-by-category basis, except for FY2020 and FY2021, where all categories would be treated as one for purposes of the calculation and adjustment. The adjustment would last for 1 year and would not be used to calculate caps in subsequent years (though if the state continued to be a spending outlier, it could be subject to a new adjustment in the future). The adjustment would not apply to states with less than 15 people per square mile.
Increased Administrative Matching		Between FY2018-2019, the matching rate for IT systems development is increased from 90% to 100%; the maintenance and operations rate is increased from 75% to 100%; and other administrative matching is increased from 50% to 60% for expenses associated with data requirements to calculate the per-capita caps. These increased rates apply only to a state that selects the most recent 8 calendar quarters with available data as the base rate for per capita caps.
Flexible Block Grant Option	States could elect to implement a block grant for a 10-year period, which could be extended for additional 10-year periods. States that elect to not extend a block grant would revert to per-capita cap policy, with adjustments calculated as if the block grant had never been implemented. Block grants would be allowed for one of two options: • Both children and non-pregnant, non-expansion adults (as	States may elect to implement a block grant program for a 5-year period, which could be extended for additional 5-year periods. States that elect to implement the program must finish the program period before termination. If a state elects to end the block grant their Medicaid payments would revert to per-capita cap policy, with adjustments calculated as if the block grant had never been implemented. The block grant would be allowed only for individuals who fall into the "Other non-expansion" adult category of the per capita cap groups. States would be required to cover

	defined by the per capita cap policy); or • Only non-pregnant, non-expansion adults. Block grants would be calculated based upon the per capita caps established for FY2019 multiplied by the number of enrollees in FY2019. Then, the total amount is multiplied by the average state FMAP for the FY2019 (which is calculated as part of the per-capita cap process). This sets the initial block grant amount at the Federal expenditures calculated for the per-capita caps, based on the number of enrollees in 2019. Block grant amounts are increased each year by the consumer price index for all urban consumers (CPI-U). There is no subsequent adjustment for enrollment. States must cover specific services in the block grant, but the benefit package provides more flexibility to states than core Medicaid requirements. Mandatory services include: • Hospital care; • Surgical care; • Medical care; • OB and prenatal care; • Drugs, medicines, and prosthetic devices; • Other medical supplies and services; and • Health care for children under 18.	individuals who qualify for mandatory Medicaid eligibility groups under this policy, but could establish its own eligibility criteria for other enrollees. Income calculations are required to use the ACA MAGI methodology. Block grant amounts would be calculated based upon the per capita caps established for the first year of the demonstration. These are multiplied by the number of enrollees in the second fiscal year prior to the first year of the demonstration trended forward based upon increase in state population. Then, the total amount is multiplied by the average state FMAP for the FY2019 (which is calculated as part of the per-capita cap process). This formula can be visualized as: (Average State FMAP x (Per-capita cap for population x ((Population enrollment in second fiscal year prior) x (percentage increase in state population)))) Subsequent years are calculated by trending the prior block grant amount forward by using the CPI-U increase from the second previous April to the previous April. The section of Medicaid law that prohibits funds to be used for non-Medicaid/medical services [at 1903(i)(17)] does not apply to the block grant funds. Beginning January 1, 2020, HHS is directed to establish quality standards that apply to expenditures under the block grant program. States must make maintenance of effort payments, which amounts to the block grant amount multiplied by the state's CHIP Enhanced FMAP. States that do not meet the MOE requirements will have their block grant

	Certain groups must also be covered – including mandatory pregnant women (no less than 133% of FPL) and children (currently no less than 133% FPL, but this legislation proposes to lower it to 100% FPL for children age 6-18). Medicaid requirements would not apply to block grant services, including statewideness, comparability of services, freedom of choice, and reasonable/comparable eligibility standards and procedures.	reduced by the dollar amount they underspent their MOE. A reduction could also be made for noncompliance. Services that must be included to <u>mandatory eligibility groups</u> are: • Hospital services; • Laboratory and x-ray services; • Nursing facility services for individuals age 21 and over; • Physician services; • Home health services; • Rural health clinic services; • FQHC services; • Family planning services; • Nurse midwife services; • Certified pediatric and family nurse practitioner services; • Mental health and substance use coverage; • Freestanding birth center services; • Emergency medical transportation; • Non-cosmetic dental services; and • Pregnancy services. States may also provide optional services in addition to these benefits. While the legislation does not explicitly draw the distinction, it appears that states may provide a different package of benefits to individuals who would not qualify under a mandatory Medicaid eligibility group. The targeted health assistance must have actuarial value standards of 95% of the pre-ACA benchmark benefit packages in Medicaid (which are based upon private insurance in the state). States may set their own limits on amount, duration, and scope of benefits subject to this actuarial value requirement. States may include cost-sharing requirements,

		provided that it does not exceed 5% of family income for the beneficiary. The benefit package must include mental health and substance use coverage for all individuals, and must adhere to mental health parity requirements. If the benefit includes prescription drugs, the state must also adhere to all of the requirements of the Medicaid drug rebate program. Some Medicaid requirements would not apply to block grant services, including statewideness, comparability of services, freedom of choice, and reasonable/ comparable eligibility standards and procedures. The Secretary would also have latitude to waive other provisions of Medicaid, if appropriate.
Medicaid and CHIP Quality Bonus Payments		During FY2023-2026, states can receive bonus payments if they meet HHS-defined benchmarks for lower-than-expected expenditures and meets quality measures. The quality measures will be established via HHS rulemaking in consultation with states and other experts such as NCQA or AHRQ. The payments are made to states by adjusting FMAP upwards, subject to the aggregate limit on spending calculated under the per-capita cap policy. Overall payments cannot exceed $8 billion under the program.
Permitting States to Apply a Work Requirement	Creates a new policy allowing work requirements, as defined by TANF, for certain individuals who are not an: • Older adult; • Individual with a disability; • Pregnant woman or woman in a 60-day postpartum period; or • Child under the age of 19;	Identical to House bill.

	• The only parent/caretaker relative of a child under age 6 or a child with disabilities; and • Individuals under 20 years old who are married or head of household and who are in an educational/job training program. Provides 5% administrative matching increase to implement the work requirements.	
Optional Inpatient Psychiatric Services		Adds a new optional benefit for inpatient psychiatric hospital services for no longer than 30 consecutive days and no more than 90 days in a calendar year. In order to adopt this provision, states may not reduce the number of licensed psychiatric beds and must maintain the same level of state funding (outside of Medicaid) for inpatient services and psychiatric treatment. States receive 50% FFP for these services regardless of their normal FMAP.
Presumptive Eligibility	Ends the requirement for eligible Hospitals to provide presumptive eligibility determinations, effective January 1, 2020.	Ends the requirement for eligible Hospitals to provide presumptive eligibility determinations, effective January 1, 2020. Ends option for states to extend presumptive eligibility to ACA expansion groups or former foster care children, effective January 1, 2020.
Counting Lump Sum Payments for MAGI eligibility	This provision would count lump-sum income from sources such as a lottery, gambling, or an inheritance, in excess of $80,000 over multiple months instead of only in a single month. Under the legislation, individuals could have income from a large payment (exceeding $1,260,000) counted for up to 10 years.	
Removal of Retroactive Eligibility	Beginning October 1, 2017, retroactive eligibility would be repealed. Medicaid eligibility would be established in (or after) the month when a person applies for the program.	Identical to House bill.

Removal of Ability to Increase Home Equity Exclusion	The legislation would remove the option for states to increase home equity exclusions above the minimum rate; thus all states would set their home equity exclusions at the $560,000 rate (and, in future years, at the dollar amounts calculated using the CPI-U inflationary factor).	
Excluded providers from Medicaid	Creates a payment exclusion for certain providers of abortion services, namely Planned Parenthood. The payment exclusion lasts for 1 year from the enactment of the law.	Identical to House bill.
Treatment of Medicaid DSH Cuts	The legislation rescinds the DSH cuts and returns national DSH levels to pre-ACA amounts in two waves. States that did not expand Medicaid under the ACA would have their DSH allotments restored in 2018. States that expanded Medicaid would have the DSH levels restored in 2020.	States that did not expand Medicaid would not have DSH cuts applied to their allotments. Expansion states would receive DSH cuts, but those cuts would be calculated as though the other non-expansion states did not have a reprieve from the reductions.
Additional Payments under DSH	Provides increased funds for safety net providers in states that did not expand Medicaid during calendar Fiscal years 2018-2022. Allocates $2 billion a year for those five years ($10b total) for these payments. Eligible states receive 100% FMAP for these payments for the first four years and 95% for the fifth year. Funds for states are determined by the ratio of individuals with income below 138% FPL across the non-expansion states. Payments to individual providers are limited to the costs incurred providing services to uninsured and Medicaid-eligible individuals.	Non-expansion states that receive less than the national average of 2016 DSH payments per Medicaid enrollee would receive an increase in allotments during 2020. The increase is calculated as the difference between the state's 2016 allotment and what the state would have received if it was at the national average of DSH dollars per enrollee. Future DSH payments are calculated as though the increase never occurred.
Safety Net Payments		Establishes a temporary program, funded at $2 billion annually, which allows non-expansion states to increase payments to Medicaid providers up to the cost of delivering care to Medicaid enrollees and uninsured

		individuals. States receive 100% FMAP for FYs2018-2021 and 95% FMAP for FY2022 for payments. Each state has a maximum amount they may spend on these payments, calculated by determining the ratio of individuals below 138% that live in the state compared to the national number of those individuals and allocating the $2 billion accordingly.
Provider Taxes		Reduces the allowable safe-harbor threshold for provider taxes from 6% under current law to 5% in 2025 and every year thereafter. This reduction occurs as follows: the 2021 threshold is 5.8%, 2022 is 5.6%, 2023 is 5.4%, 2024 is 5.2%, 2025 and thereafter is 5%.
Requires More Frequent Eligibility Determinations for Expansion Populations	Beginning October 1, 2017, states would be required to do eligibility redeterminations at least every 6 months for individuals in the ACA Medicaid expansion.	Beginning October 1, 2017, states would have the option to do eligibility redeterminations at least every 6 months, or more frequently if they choose, for individuals in the ACA Medicaid expansion. Provides 5% increase in administrative matching for states that elect this option.
Grandfathering of Managed Care Waivers		Enables states with managed care waivers approved as of 2017 and renewed at least once to operate these programs in perpetuity (without renewal) unless the waiver is modified for something other than budget neutrality calculations. If the waiver is modified it will count as a new submission. Grandfathered waivers that are modified under a new submission must be approved or denied within 90 days, unless a request for more information is issued. CMS must issue the RAI within 30 days of submission.
HCBS Waiver Encouragement		This provision directs HHS/CMS to implement procedures that encourage states to adopt or extend HCBS waivers.
Coordination with States		Establishes a new requirement that prohibits HHS from establishing new proposed regulations after January 1, 2018 unless it first establishes a process to solicit advice from Medicaid agencies, and accepts written and oral comments from State Medicaid agencies

		and the Medicaid agency association (i.e. NAMD) that are incorporated and summarized in the NPRM's preamble.
Other Health Care Provisions		
Calculation of Tax Credits	Repeals ACA advance premium tax credits. Establishes a new tax credit to purchase insurance that is based upon age rather than income. The credit would vary from $2,000 for individuals younger than 30 to $4,000 for individuals over 60. The tax credit is available for each individual in a family up to a maximum of $14,000 per household. Includes a gradual phase-out of the tax credits for individuals making more than $75,000 a year (or couples making more than $150,000). For every $1,000 in income above these thresholds, the credit decreases by $100.	Does not repeal ACA credits but modifies them to apply to individuals with income below 350% FPL, which includes individuals under 100% FPL (who are excluded from the ACA credits). Continues to calculate the subsidies based upon the income of the individual and plan costs. Adds a provision that also takes the age of the individual into account for the calculation. Changes the plan premium used to base the calculation of credits from the second-lowest cost silver plan (which covers 70% of health care costs) to the median premium of a plan that covers 58% of health care costs.
Incentives for Coverage	Provides incentives for continuous coverage – notably, allowing insurers to impose a 30% surcharge for individuals who have a gap in coverage.	
Mandate	Sets the Individual and Business mandate penalties at $0, effective January 1, 2016	Identical to House bill.
ACA Taxes and Fees	Repeals ACA taxes, including the increased Medicare tax; the health insurer tax; and the medical device tax, among others (effective at the end of 2016). The tax on high-cost health plans, known as the Cadillac tax, is delayed until 2026 but not fully repealed.	Identical to House bill.
State Waiver of Insurance Requirements	Allows states to apply for waivers of core ACA policies, including community-rating requirements, limit age-based premiums, and the essential health benefits requirements.	Expands the ACA section 1332 waiver authority and modifies it to provide that waivers must "not increase the Federal deficit" instead of "be budget neutral to the Federal government." This could potentially allow for states to count other Federal savings outside of the 1332 itself, such as those from

		Medicaid, towards the budget neutrality calculation if there is an interaction. Removes the requirements that waivers must provide the same amount of coverage and cost protections as would be in place without the waiver. This would provide significantly more flexibility for state waiver applications. Allocates $2 billion from 2017-2019 to provide grants to States to implement the waivers.
Medical Loss Ratio		Allows states to set their own MLR requirements beginning January 1, 2019. Current law sets the ratio nationwide at 85% for large group plans and 80% for small group plans.
State Innovation Fund	Creates a grant program for providing assistance to high-risk individuals; stabilizing and reducing insurance prices; promoting access to preventive care; and reducing out-of-pocket costs. Allocates $100 billion over a nine year period - $15 billion in FY2018 & FY2019, and $10 billion in each of the following seven years. Additionally, $15 billion funds are provided to assist with maternity and behavioral health (including substance abuse) prevention and treatment. Another $15 billion are provided for an "invisible risk sharing" program that is intended to reduce premiums in the individual marketplace. An additional $8 billion over five-years was added to support premium payments for high-risk individuals (ie: creation of a subsidized high-risk pool) in states that apply for a waiver of the ACA's community-rating, age rating,	Allocates $50 billion to a short-term stability fund - $15 billion in FY2018 & FY2019, and $10 billion in FY2020 & FY2021. The intent is to work directly with insurance issuers to "address coverage and access disruption and respond to urgent health care needs within States." Establishes a separate "Long-term State Stability and Innovation Program" that states may apply to in order to provide direct assistance to individuals; stabilize insurance prices; pay providers for health care services; and reduce out-of-pocket costs. The fund is given $8 billion in calendar year 2019, $14 billion in 2020 & 2021; $6 billion in 2022 & 2023; $5 billion in 2024 & 2025; and $4 billion in 2026. State matching requirement begins in 2022 at 7%, increasing to 14% in 2023; 21% in 2024; 28% in 2025; 35% in 2026.

	and/or essential health benefits requirements. In total, $138 billion is provided to support these various initiatives intended to reduce the cost of insurance in the private market place.	
Age Rating Provisions	Under the ACA, insurers are prohibited from charging more than a 3-to-1 variation on premiums based upon an individual's age. The provision increases this limit to 5-to-1 variation beginning January 1, 2018 or allows states to apply for a waiver to set at any level they choose.	The provision increases this limit to 5-to-1 variation beginning January 1, 2019, or a different rate determined by the state.
Public Health and Prevention Fund	The legislation would end funding for the Public Health and Prevention Fund after September 30th, 2018 (FY18). Any unused funding at the end of FY18 would be rescinded.	The legislation would end funding for the Public Health and Prevention Fund after September 30th, 2017 (FY17).
Funding for Opioid Crisis Response		Provides $2 billion for grants to states to respond to the opioid crisis.
Federally Qualified Health Centers	The legislation allocates an additional $422 million for FQHCs in FY2017.	Identical to House bill.
AHCA Implementation Fund	Allocates $1 billion for Federal administrative expenses to implement the changes required by the legislation.	Allocates $500 million to HHS in order to implement the legislation.
Cost Sharing Subsidies		Fully funds the ACA cost-sharing subsidies for small group market individuals in plan years 2018-2019. Repeals the subsidies beginning in 2020.