To: Members, Tribal Self-Governance Advisory Committee (TSGAC)
Technical Advisors, TSGAC

From: Doneg McDonough, Health System Analytics

Subject: **Affordable Care Act and IHCIA in 2017; Trump, Ryan and Price Health Insurance Approaches; State of Indiana Medicaid Expansion Plan**

Date: November 30, 2016 (Revised and Updated to include Rep. Tom Price Proposals)

Take-Away

There is great uncertainty as to: (a) how the government-financed health insurance sector will change under a Trump Administration and the new Congress; (b) to what extent the current rules applicable to employer-sponsored insurance will be modified; and, (c) whether Indian-specific health care provisions in federal law will be maintained.

On November 29, 2016, President-elect Trump named Representative Tom Price as the next secretary of the Department of Health and Human Services (HHS). The proposals presented by then-presidential candidate Donald Trump; House Speaker Paul Ryan; and Rep. Price are outlined below and provide a starting point to potential legislative action by Republicans.

- It is probably best to describe the Trump proposal as an "approach" rather than a "plan," given the lack of detail, a fact not-too-dissimilar to the "approach" outlined by candidate Obama in 2008. In contrast, though, the Obama approach—which was subsequently fashioned into the Affordable Care Act (ACA)—had an explicit goal of making affordable health insurance coverage available to all Americans. No such commitment or goal appears in the Trump approach—the Trump approach would reduce dramatically the number of Americans with health insurance coverage.

- With the Ryan plan, despite six years of promising a "replacement" to the ACA, legislation has not been drafted, key details have not been identified, and an evaluation of the proposal has not been prepared by the Congressional Budget Office (CBO). Nonetheless, the Ryan proposal is a serious effort to provide an alternative approach.

- During the current and previous three Congresses, Price has introduced legislation titled "Empowering Patients First Act—most recently in May 2015 as H.R. 2300—which would repeal the ACA in its entirety (back to the date of original enactment) and implement a number of proposals designed to promote the purchase of high-deductible health insurance plans in the individual market. However, the bill has never advanced past the introductory stages of the legislative process and has never received an evaluation by the CBO.

For the short term, the following might serve as a guide:

- For persons securing coverage in the individual market, health insurance options for the 2017 calendar year are most likely to continue as is, with the exception that the requirement for

individuals to secure insurance coverage could be waived. **As such, to the extent the Trump Administration does not proactively act to dismantle the ACA in 2017 prior to a replacement plan being in place, *the purchase of health insurance coverage for Tribal members through a Health Insurance Marketplace established under the ACA (referred to as Tribal Sponsorship) continues to offer opportunities for Tribes to secure substantial increases in health care resources for the Indian health system and for Tribal members.***

- With regard to employer-sponsored insurance, ***we could see immediate executive actions that postpone or largely relieve employer requirements under the ACA***, such as the requirement to offer coverage to full-time employees or make payments to the federal government, as well as lessen or eliminate employer reporting requirements.
- **The enhancements made to the Indian Health Care Improvement Act (IHCIA) in the ACA do not appear to be threatened** as the most recent Republican repeal effort using the "reconciliation" process ignored the IHCIA (whereas the ACA's Indian-specific Marketplace protections were repealed, although with an effective date of the repeal delayed for 2 years).
- **In 2017, the most immediate threat to funding of the Indian Health Service (IHS) is likely to be an interest in Congress to reducing the non-defense discretionary (appropriations) budget.** *Increases to IHS funding seen in recent years are likely to be halted, with a threat that appropriations could be reduced below fiscal year 2016 levels.*

As to the longer-term changes, the proposals presented by then-candidate Trump, Speaker Ryan, and Rep. Price serve as a starting point for one or more pieces of potential "replacement" legislation. But given the complexity of the health insurance market, the opposition of a sizable number of Republican members of Congress to any government intervention in the private health insurance market, and the potential ability of Senate Democrats to frustrate Republican attempts to legislate in this area, it is difficult to anticipate what the actual "replacement" to the ACA might be.

Timing of Executive and Congressional Actions

There are likely to be two tensions/goals of the Republicans as they attempt to move forward to "repeal and replace" the ACA.

1. Keep their campaign promise to "repeal the ACA."
2. Minimize disruptions to the availability and affordability of health insurance that can be blamed on Republicans as they transition to an alternative approach ("replace") to the ACA.

Even with control of both houses of Congress and the White House, a full repeal of ACA will remain difficult, as will enacting a replacement bill(s), as Republicans will hold fewer than the 60 seats in the Senate needed to stop a filibuster. Republicans could use the "budget reconciliation" process to make some major changes to ACA and enact replacement provisions (without being subject to a filibuster), but the breadth of the changes are constrained to items impacting federal spending, as the budget reconciliation process excludes changes to non-budgetary provisions.

In Attachment A below, a summary of the budget reconciliation legislation advanced (but vetoed by President Obama) in early 2016 is shown. The legislation demonstrates the breadth of the changes in the ACA that can be accomplished through the budget reconciliation process.

In order to transition to an alternative approach to the ACA, a replacement needs to be agreed upon and moved through the legislative process. This will require time and might ultimately require agreement with Democrats, as Senate Democrats are likely to filibuster alternatives that result in dramatically reduced affordability and lower levels of insurance coverage. Further, a sizable number of House and Senate Republicans might balk at signing on to any substantial alternative.

There will be numerous opportunities for President-elect Trump to undermine the ACA without needing congressional assistance. For instance, enforcement of the "individual mandate" and the "employer mandate" could be delayed. Cost-sharing protections could be de-funded. Risk adjustment payments to health plans could be canceled. Each of these items would show that a President Trump was acting on a promise to repeal the ACA. But each action would violate the second goal / tension if not done in conjunction with a set of "replacement" actions.

The most recent suggestions are that Congress will move early in 2017 to repeal the ACA, but the effective date of the repeal would not be until late 2018, by which time a replacement bill would have been enacted by Congress. This approach presents a number of political and legislative risks to the Republicans and Trump, and might not be the approach that is ultimately pursued.

Within the Trump Administration, Price likely will serve as the lead on efforts to repeal the ACA. On November 29, Trump also named Seema Verma, the chief architect of the recently implemented Indiana Medicaid expansion waiver (HIP 2.0), as the next administrator of the Centers for Medicare and Medicaid Services (CMS). A summary of HIP 2.0 appears in Attachment B. It is important to recognize that the Indiana Medicaid expansion approach was fashioned within the context of the ACA's governing rules and the oversight of the Obama Administration. Price and Ryan have expressed strong support for block granting Medicaid to the states and providing states wide latitude to refashion how health insurance coverage is made available to low-income Americans.

ACA's Indian-Specific Provisions, the IHCIA, and the IHCREA

None of the Trump, Ryan or Price approaches includes continuation of the ACA's Indian-specific Marketplace benefits and protections: (1) no federally-funded comprehensive cost-sharing protections for American Indians and Alaska Natives (AI/ANs); and (2) no guarantee for AI/ANs to purchase health insurance with community rating throughout the year without consideration of pre-existing conditions.[1]

Conversely, there is no mention in the materials released by the Trump campaign, Speaker Ryan, or Rep. Price that the Indian Health Care Reauthorization and Extension Act (IHCREA) was a component of the ACA, as enacted. This latter point could work to the benefit of AI/ANs. In the Republican repeal effort in early 2016 using the "reconciliation" process, the IHCREA's enhancements made to the IHCIA were not included (i.e., were not repealed). In fact, given the procedural constraints of the reconciliation process,

[1] The Price approach clarifies that health savings account provisions would apply to individuals using the Indian health system.

it is not likely that repeal of the IHCREA would be permissible in a reconciliation bill. As such, the IHCIA does not appear threatened, as repeal of the IHCREA could only occur through the non-reconciliation process, which would require 60 Senate votes for passage.

Trump, Ryan, and Price Approaches – Analysis and Impacts

President-elect Trump, Speaker Ryan, and Rep. Price each have proposed alternative approaches to the ACA. The Trump proposal is as close to non-existent as could be and still be called a proposal and, according to several analyses, would result in millions of Americans losing health insurance coverage. The Ryan approach is more substantial, but with significantly less financial support for low-income Americans than under current law, resulting in large increases in the number of uninsured Americans. The specific effect of the Price approach remains uncertain, but given its similarities with the Ryan approach—but with even lower financial assistance—it would result in additional millions of individuals losing health insurance.

In September 2016, the Commonwealth Fund released a report that analyzed the impact of several aspects of the Trump approach, including their effect on the number of uninsured U.S. residents. The report examined the impact of the following policies: 1) repeal the ACA in its entirety; 2) repeal the ACA and allow individuals to deduct fully health insurance premiums from their tax returns; 3) repeal the ACA and provide states with Medicaid and CHIP block grants; 4) repeal the ACA and promote the sale of coverage across state lines; and 5) implement a combination of all of the policies. According to the report, each of the proposals would result in a significant increase in the number of uninsured, with a combined effect of 20.2 million, or 81%, more individuals lacking health insurance in 2018 than under current law (see Table 1 below).[2]

Table 1. Impact of Trump Health Care Policies on Number of Insured and Uninsured Individuals (in Millions), 2018

Insurance status (by coverage type)	ACA (current)	Trump Proposals					
		Repeal alone	Repeal and tax deduction	Repeal and Medicaid block grants	Repeal and sales across state lines	Combination	% Change Under Combination
All insured	251.6	231.9	236	226.5	234.1	**231.3**	**-8.07%**
Employer	156.3	158.6	156.6	158.6	157.5	**155.3**	**-0.64%**
Exchange/individual	22.6	9.6	15.3	9.6	12.9	**17.6**	**-22.12%**
Medicaid	60.3	51.5	51.8	46.1	51.5	**46.2**	**-23.38%**
Other	12.3	12.2	12.2	12.2	12.2	**12.2**	**-0.81%**
Uninsured	24.9	44.6	40.5	50	42.4	**45.1**	**81.12%**

Source: Commonwealth Fund, "Donald Trump's Health Care Reform Proposals: Anticipated Effects on Insurance Coverage, Out-of-Pocket Costs, and the Federal Deficit," September 2016.

The Committee for a Responsible Federal Budget in May 2016 also released an analysis of the Trump approach and reached a similar conclusion as the Commonwealth Fund, finding that it would cause about 21 million individuals to lose health insurance in 2018.[3] In addition, the Center for Health and

[2] See http://www.commonwealthfund.org/publications/issue-briefs/2016/sep/trump-presidential-health-care-proposal.

[3] See http://crfb.org/blogs/analysis-donald-trumps-health-care-plan.

Economy in July 2016 projected that about 18 million individuals would lose health insurance in 2017 under the Trump approach.[4]

The Ryan approach, although providing more details than the Trump approach, lacks specifics in a number of areas, making it difficult to analyze its impact on the number of uninsured U.S. residents. Using certain assumptions, however, the Center for Health and Economy in August 2016 estimated that about 1 million individuals would lose health insurance in 2018 under these policies, with the number expected to jump to 4 million by 2026.[5]

To date, the impact of the Price approach on the number of uninsured U.S. residents has not been analyzed, but it is likely to be dramatic due to the reductions in financial assistance. In addition, the Price approach reduces regulations on health plans, with the Price legislation specifically stating that there would be "no mandate of guarantee issue or community rating".

The most consequential elements of the Trump, Ryan, and Price approaches, as compared with the current ACA, are the following:

- ACA: All three approaches are predicated on full repeal of the ACA, although Speaker Ryan's budget retained the increases in tax revenues under the ACA while deleting the coverage provisions. Again, no mention is made of the Indian Health Care Improvement Act.
- IHCIA: None of the three approaches include Indian-specific provisions: Neither Marketplace protections nor IHCREA provisions. But, as full repeal of the ACA is not likely to occur—which would delete the IHCREA amendments to the IHCIA—the IHCREA provisions are likely to continue.
- Premium Tax Credits: The Trump approach would replace the ACA's income-based premium tax credits with a federal income tax deduction for the cost of health insurance coverage (tax-free spending on health insurance). This would reduce the total cost of insurance by 0% to 35% or so, depending on someone's marginal tax rate, *resulting in federal subsidies increasing as household income increases*. The Ryan approach would create a tax credit, although the size of the credit would be based on age (older, more subsidy) and not on income and would not increase based on the cost of available insurance. Information is not available on the income level at which families would be excluded from the tax credits. The Price approach would provide a similar age-adjusted tax credit. The dollar amounts of the tax credits would be, on average, substantially lower than under current (ACA) law. And, annual adjustments to the tax credit amounts would be based on general inflation (CPI) and not medical CPI.
    - In contrast, the ACA provides income-based premium tax credits that limit premium payments to no more than a specified percentage of household income (2% at 100% FPL to 9.6% at 400% FPL). As such, the ACA's tax credits are larger for lower-income families, smaller for higher-income families, and absent for families with an income above 400% FPL.

[4] See http://healthandeconomy.org/healthcare-reform-to-make-america-great-again/.
[5] See http://healthandeconomy.org/a-better-way-to-fix-health-care/.

- Cadillac Tax: The Ryan and Price plans cap the amount of the exclusion from income for employer-sponsored coverage, as does the ACA.
- Medicaid: Both the Trump and Ryan approaches block-grant Medicaid to the States and then limit the annual funding increases, *after removing* the new funding under the ACA's Medicaid expansions. Price also supports these proposals.
- Medicare: Ryan's plan converts Medicare into a voucher (i.e., defined contribution), and not, as it is today, a guaranteed level of funding for a defined set of benefits. Price also supports this proposal. Trump's plan cancels the ACA's payment reforms, as well as eliminates the tax on higher income Americans that generates revenues to extend the solvency of the Medicare Part A Trust Fund.

Outline of Proposals

President-Elect Trump, as part of his presidential campaign, proposed to repeal the ACA, most recently proposing to call a special session of Congress to address the issue. And in June 2016, Speaker Ryan issued a report outlining his health care reform elements, which included the full repeal of the ACA. Rep. Price has introduced legislation to repeal the ACA in each of the last four Congresses, most recently in May 2015. With their wins in the November 8 election, Republicans likely will move forward with efforts to repeal or scale back the ACA.

The health care proposals offered by President-Elect Trump, Speaker Ryan, and Representative Price are outlined below *(largely described in the language used by the author of each proposal)*.

Trump Approach

Trump has proposed a seven-point approach that would repeal ACA in its entirety and implement several policies generally supported by Republicans. As published on the Trump campaign Web site, the following is the Trump approach:

1. Completely repeal Obamacare. Our elected representatives must eliminate the individual mandate. No person should be required to buy insurance unless he or she wants to.
2. Modify existing law that inhibits the sale of health insurance across state lines. As long as the plan purchased complies with state requirements, any vendor ought to be able to offer insurance in any state. By allowing full competition in this market, insurance costs will go down and consumer satisfaction will go up.
3. Allow individuals to fully deduct health insurance premium payments from their tax returns under the current tax system. Businesses are allowed to take these deductions so why wouldn't Congress allow individuals the same exemptions? As we allow the free market to provide insurance coverage opportunities to companies and individuals, we must also make sure that no one slips through the cracks simply because they cannot afford insurance. We must review basic options for Medicaid and work with states to ensure that those who want healthcare coverage can have it.
4. Allow individuals to use Health Savings Accounts (HSAs). Contributions into HSAs should be tax-free and should be allowed to accumulate. These accounts would become part of the estate of the

individual and could be passed on to heirs without fear of any death penalty. These plans should be particularly attractive to young people who are healthy and can afford high-deductible insurance plans. These funds can be used by any member of a family without penalty. The flexibility and security provided by HSAs will be of great benefit to all who participate.

5. Require price transparency from all healthcare providers, especially doctors and healthcare organizations like clinics and hospitals. Individuals should be able to shop to find the best prices for procedures, exams or any other medical-related procedure.
6. Block-grant Medicaid to the states. Nearly every state already offers benefits beyond what is required in the current Medicaid structure. The state governments know their people best and can manage the administration of Medicaid far better without federal overhead. States will have the incentives to seek out and eliminate fraud, waste and abuse to preserve our precious resources.
7. Remove barriers to entry into free markets for drug providers that offer safe, reliable and cheaper products. Congress will need the courage to step away from the special interests and do what is right for America. Though the pharmaceutical industry is in the private sector, drug companies provide a public service. Allowing consumers access to imported, safe and dependable drugs from overseas will bring more options to consumers.[6]

Ryan Approach

In a 37-page report released in June 2016 and titled "A Better Way: Our Vision for a Confident America," Speaker Ryan proposed a health care plan that would repeal ACA in its entirety and implement a number of policies generally supported by Republicans.[7] A brief summary of the recommendations in the report appears below.

1. *Consumer-Directed Health Care*

- Allow spouses to make "catch-up" contributions to the same HSA account;
- Allow qualified medical expenses incurred before HSA-qualified coverage begins to be reimbursed from an HSA account as long as the account is established within 60 days;
- Set the maximum contribution to an HSA at the maximum combined and allowed annual deductible and out-of-pocket expense limits;
- Expand accessibility for HSAs to certain groups, like those who get services through the Indian Health Service and TRICARE; and
- Encourage the use of direct or "defined contribution" methods, such as health reimbursement accounts (HRAs)

2. *Portable Financial Support*

[6] See https://www.donaldjtrump.com/positions/healthcare-reform, as of November 9, 2016.
[7] See https://abetterway.speaker.gov/_assets/pdf/ABetterWay-HealthCare-PolicyPaper.pdf.

- Provide every American with access to financial support for an insurance plan chosen by the individual, allowing them to take the payment with them job-to-job, home to start a small business or raise a family, and into retirement years;
- Make the portable payment available at the beginning of every month, adjusting it for age over time; and
- For those who do not have access to job-based coverage, Medicare, or Medicaid, provide a universal advanceable, refundable tax credit for individuals and families.

3. Employer-Sponsored Health Insurance Tax Exclusion

- Cap the amount of the tax exclusion employees can take for the value of employer-sponsored health insurance.

4. Purchasing Coverage Across State Lines

- Allow consumers to purchase health insurance licensed in another state; and
- Make it easier for states to enter into interstate compacts for pooling.

5. Small Business Health Plans

- Allow small businesses to band together to offer small business health plans, also known as association health plans (AHPs).

6. Employee Wellness Programs

- To encourage healthy lifestyle behaviors and lower costs, companies that sponsor a weight loss or smoking-cessation program should have the ability to continue to offer participating employees health care coverage at a lower cost, provided that those programs do not exceed the limits under current law; and
- Stipulate that voluntary collection of medical information from employee family members as part of a wellness program cannot violate the Genetic Information Nondiscrimination Act of 2008 (GINA).

7. Employer Flexibility for Self-Insurance

- Prevent restrictions on employer choice of health insurance options, including self-insurance and stop-loss protections, by preserving the current definition of stop-loss insurance and maintaining its distinct difference from “group health insurance.”

8. Medical Liability Reform

- Cap non-economic damage awards in medical malpractice lawsuits;
- Work with the states to pursue a wide variety of reform options, such as loser-pays, proportional liability, the collateral source rule, consideration of the statute of limitation, safe harbor provisions, health courts, and independent pre-discovery medical review panels; and
- Seek to strengthen federal health programs by pursuing laws that allow safe harbors and higher standards of evidence for medical professionals following clinical practice guidelines developed by national and state professional medical societies.

9. Patient Protections

- No American should ever be denied coverage or face a coverage exclusion on the basis of a pre-existing condition. [But insurers would be able to charge sicker patients higher rates.]
- We would allow dependents up to age 26 to stay on their parents' plan.
- Insurers should never be able to unfairly cancel coverage.

10. Conscience Protections

- Permanently enact and expand the Weldon amendment, which bars distribution of federal funding to states that discriminate against health care providers exercising their conscience.
- Ensure the application of the Hyde amendment, which prohibits the use of federal funding for abortion or abortion services

11. Medicaid Reform

- Allow states to opt for a per capita federal Medicaid allotment: Under this proposal, in 2019, each state could draw down a total federal Medicaid allotment based on its federal matching rate. The amount of the allotment would equal the product of the per capita allotment of the state for the four major beneficiary categories—aged, blind and disabled, children, and adults—and the number of enrollees in each of those four categories, with the per capita allotment for each beneficiary category determined by the average medical assistance and non-benefit expenditures per full-year-equivalent enrollee during the base year (2016), adjusted for inflation; or
- Allow states to opt for a Medicaid block grant: Under this approach, states would receive federal Medicaid funding using a base year in a manner that would assume the transition of individuals currently enrolled in Medicaid under the optional ACA expansion into other sources of coverage. States would receive maximum flexibility for the management of eligibility and benefits for non-disabled, non-elderly adults and children, no longer having to obtain waivers from HHS for changes to their Medicaid programs. States would have to provide required services to elderly and disabled individuals described as mandatory Medicaid populations under current law.

- [For states that previously expanded Medicaid under the ACA, the enhanced federally matching rate (FMAP) under the expansion would be phased down to the state's traditional FMAP rate. States that did not previously expand Medicaid under the ACA would not be able to do so.]

12. Medicare Reform

- Repeal many of the Medicare provisions contained in ACA;
- Implement a number of structural reforms to Medicare; and
- Implement a premium support program, under which, beginning in 2024, Medicare beneficiaries would receive a premium support payment to cover or help offset the premium of the plan chosen by the beneficiary on a newly created Medicare Exchange, where private health plans would compete alongside traditional FFS Medicare.

Price Approach

Rep. Price during the current and previous three Congresses has introduced a bill titled "Empowering Patients First Act," which would repeal the ACA in its entirety and implement a number of policies generally supported by Republicans.[8] A brief summary of the provisions in the legislation appears below.

1. *Refundable Tax Credit for Health Insurance*

- Establish refundable, age-adjusted tax credits with amounts specified in law for first year (2016) and then adjusted by general inflation (CPI) in subsequent years, with the initial amounts:
    - $1,200 for those between 18 to 35 years of age;
    - $2,100 for those between 35 and 50 years of age;
    - $3,000 for those who are 50 years and older; and
    - $900 per child up to age 18

- Make tax credits available to individuals who purchase health insurance in the individual market.
- Exclude from tax credits individuals enrolled in employer-sponsored group health insurance or federal programs such as Medicare, Medicaid, CHIP, TRICARE, Department of Veterans Affairs (VA) benefits, or the Federal Employees Health Benefits Program (FEHBP).
- Exclude from tax credits individuals who are not U.S. citizens or legal residents.
- Allow individuals to opt out of employer-sponsored group health insurance or federal programs and receive tax credit to purchase health insurance in the individual market.

2. *Health Savings Accounts (HSAs)*
    - Promote the use of HSAs with a one-time tax credit of $1,000;

[8] See H.R. 2300 at https://www.congress.gov/bill/114th-congress/house-bill/2300.

- Allow an HSA to roll over to a surviving spouse, child, parent, or grandparent;
- Increase the allowable HSA contribution, making it equal to the maximum IRA contribution level
- Allow the transfer of the minimum distribution requirement from a retirement plan to an HSA and prohibit its inclusion in gross, taxable income;
- Protect HSA funds from seizure in bankruptcy proceedings;
- Allow spouses with an HSA to double their "catch-up" contributions to the account for their eligible spouses;
- Allow individuals enrolled only in Medicare Part A to continue to contribute to their HSAs
- Allow veterans with service-related disabilities to contribute to their HSAs regardless of their use of VA medical services;
- Allow AI/ANs to contribute to their HSAs regardless of their use of IHS or Tribal medical services;
- Allow individuals eligible for TRICARE Extra or TRICARE Standard to contribute to their HSAs; and,
- Implement a number of other provisions to promote the use of HSAs

3. *Employer-Sponsored Health Insurance Exclusion*

    - Cap the amount of the tax exclusion employees can take for the value of employer-sponsored health insurance at $8,000 for an individual and $20,000 for a family

4. *Abortion Funding*

    - Require that no federal funds made available through this legislation are used to pay for abortions (with certain exceptions) or cover any part of the cost of a health plan that includes coverage of abortions; and
    - Prohibit discrimination against any individual or health care entity that does not provide, cover, pay for abortions and allow for accommodations of the conscientious objection of a purchaser or health care provider when a procedure conflicts with the religious beliefs or moral convictions of such purchaser or provider

5. *Employer Defined Contribution for Health Insurance*

    - Allow employers to grant all employees a pre-tax benefit through a monetary ("defined") contribution, which employees could use to remain in employer-sponsored health insurance or enroll in coverage in the individual market

6. *State Health Insurance Pools*

    - Allow each state to receive federal grants for providing health insurance through a high-risk pool, a reinsurance pool, or other risk-adjustment mechanism used for the purpose of subsidizing the purchase of coverage in the individual market; and,

- Extend federal funding currently available to implement and administer high-risk or reinsurance pools for individuals rejected by individual market issuers or offered premiums that exceed a certain level.

7. *Independent Health Pools (IHPs)*

- Establish IHPs (as legal non-profit entities) to reform and expand enrollment in health insurance in the individual and small group markets;
- Allow individuals to pool together to provide for health insurance through IHPs;
- Allow individuals to enroll in health insurance (including coverage for dependents of such individuals) offered by a issuer through an IHP; and,
- Allow employers to enroll employees in health insurance (including coverage for dependents of such employees) offered by an issuer through an IHP.

8. *Association Health Plans (AHPs)*

- Allow small businesses to band together across state lines to form AHPs through their membership in a bona fide trade or professional association to purchase health insurance for their families and employees

9. *Enrollee Protections*

- Provide comparable health insurance protections for individuals who purchase coverage in the individual market to those currently established for individuals who have coverage in the group market

10. *Interstate Market for Health Insurance*

- Allow health insurance issuers licensed to sell policies in one state to offer them to residents of any other state; and
- Allows individuals to purchase health insurance across state lines

11. *Medical Liability Measures*

12. *Wellness Programs*

- Allow variation for wellness programs focused on health promotion and disease prevention from 20% to 50% of the cost of health insurance

13. *Health Insurance Transparency, Quality, and Choice Measures*

Attachment A: Summary of HR 3762, “reconciliation” legislation passed by the Republican Congress in 2016 and vetoed by President Obama.

Attachment B: Summary of Indiana Medicaid Expansion Waiver

Attachment A

A summary of the provisions of HR 3762, a Republican-sponsored budget reconciliation bill vetoed by President Obama in early 2016, appears below. The legislation included a number of provisions designed to scale back the ACA. Additional information on the bill is available at https://www.congress.gov/bill/114th-congress/house-bill/3762. This legislation is significant for showing the breadth / extent to which provisions of the ACA can be overturned through the budget reconciliation process.

TITLE I--HEALTH, EDUCATION, LABOR, AND PENSIONS

(Sec. 101) This bill amends the Patient Protection and Affordable Care Act (PPACA) to terminate the Prevention and Public Health Fund, which provides for investment in prevention and public health programs to improve health and restrain the rate of growth in health care costs. Unobligated funds are rescinded.

(Sec. 102) Funding for community health centers is increased.

(Sec. 103) Certain funding for U.S. territories that establish health insurance exchanges is no longer available after 2017.

(Sec. 104) The Department of Health and Human Services (HHS) may not collect fees or make payments under the transitional reinsurance program.

(Sec. 105) This bill makes appropriations for FY2016 and FY2017 for HHS to award grants to states to address substance abuse or to respond to urgent mental health needs.

TITLE II--FINANCE

(Sec. 201) This bill amends the Internal Revenue Code to require individuals to pay back the full amount of advance payments in excess of their premium assistance tax credit. (Currently, there is a limit on the amount of excess an individual must pay back.)

(Sec. 202) Provisions relating to the premium assistance tax credit, reduced cost-sharing (including Indian-specific cost-sharing protections), and eligibility determinations for these subsidies are repealed on December 31, 2017. (These are the core ACA provisions making health insurance and health care services more affordable for low and moderate income Americans.)

(Sec. 203) The small employer health insurance tax credit does not apply after 2017. (This credit is for certain employers who make contributions toward employee health coverage purchased through a health insurance exchange.)

(Sec. 204) The penalty for individuals who do not maintain minimum essential health care coverage is eliminated.

(Sec. 205) Large employers are no longer required to make shared responsibility payments.

(Sec. 206) For one year, this bill restricts the availability of federal funding to a state for payments to an entity (e.g., Planned Parenthood Federation of America) that:

- Is a 501(c)(3) tax-exempt organization;
- Is an essential community provider primarily engaged in family planning services and reproductive health;
- Provides for abortions other than abortions in cases of rape or incest, or where a physical condition endangers a woman's life unless an abortion is performed; and
- Received a total of more than $350 million under Medicaid in FY2014, including payments to affiliates, subsidiaries, successors, or clinics.

(Sec. 207) This bill amends part A (General Provisions) of title XI of the Social Security Act (SSAct) to require the additional payments to U.S. territories for Medicaid under the Health Care and Education Reconciliation Act of 2010 to be made by the end of FY2017 instead of the end of FY2019. In addition:

- This bill amends title XIX (Medicaid) of the SSAct to end the expansion of Medicaid under PPACA on December 31, 2017.
- After 2017, hospitals may no longer elect to provide Medicaid services to individuals during a presumptive eligibility period.
- States must maintain Medicaid eligibility standards for individuals under 19 years old through FY2017 instead of through FY2019.
- The federal medical assistance percentage (FMAP, the federal matching rate for Medicaid expenditures) for U.S. territories is 50% after 2017 (currently, the FMAP is 55%).
- The increased FMAP for childless adults and home and community-based attendant services under PPACA ends December 31, 2017.
- After 2017, states may no longer elect to provide certain individuals with a presumptive eligibility period for Medicaid.
- Medicaid benchmark plans are no longer required to provide minimum essential health benefits after 2017.
- After 2017, states are no longer required to operate a website for Medicaid enrollment that is linked to the state's health benefit exchange and Children's Health Insurance program (CHIP).

(Sec. 208) Medicaid allotments for disproportionate share hospitals are increased.

(Sec. 209) The excise tax on high cost employer-sponsored health coverage (popularly known as the "Cadillac tax") does not apply after 2017.

(Sec. 210) Health savings accounts (HSAs), Archer medical savings accounts (MSAs), health flexible spending arrangements (HFSAs), and health reimbursement arrangements may be used to pay for over-the-counter medications.

(Sec. 211) This bill lowers the tax on distributions from HSAs and Archer MSAs that are not used for medical expenses.

(Sec. 212) Salary reduction contributions to an HFSA under a cafeteria plan are no longer limited.

(Sec. 213) The annual fee on manufacturers and importers of brand name prescription drugs is eliminated.

(Sec. 214) The excise tax on medical devices is eliminated.

(Sec. 215) The annual fee on health insurers is eliminated.

(Sec. 216) Medical costs are allowed as a tax deduction regardless of whether the costs are taken into account when determining the amount of the subsidy for an employer-sponsored retiree prescription drug plan under Medicare part D (Voluntary Prescription Drug Benefit Program).

(Sec. 217) A tax deduction is allowed for medical expenses in excess of 7.5% (currently, 10%) of adjusted gross income.

(Sec. 218) The additional Medicare tax on income above a certain threshold is eliminated.

(Sec. 219) The indoor tanning services tax is eliminated.

(Sec. 220) The net investment income tax is eliminated.

(Sec. 221) A health insurer is allowed a tax deduction for the full amount of an employee's compensation. (Currently, there is a limit on the amount of an employee's compensation that a health insurer may deduct.)

(Sec. 222) Provisions relating to the economic substance doctrine are repealed. (The economic substance doctrine treats a transaction as having economic substance if it has a purpose other than reducing income taxes. Currently, there are penalties for claiming tax benefits for transactions without economic substance.)

(Sec. 223) Funds are transferred from the Department of the Treasury to the Federal Hospital Insurance Trust Fund. (This provision maintains the length of solvency of the Medicare Part A Trust Fund but reduces funds available for general government operations as the existing associated tax is repealed.)

Attachment B

Indiana Medicaid Expansion Waiver Summary

In January 2015, CMS approved an amendment to the Indiana § 1115 Medicaid demonstration waiver, Healthy Indiana Plan (HIP), as a means of implementing the optional Medicaid expansion available under the ACA.

Under the Indiana Medicaid expansion waiver (HIP 2.0), the program now covers almost all adults ages 19-64 with income from 0-138% FPL. The program has multiple parts, including four different Medicaid benefit packages for the populations covered by the waiver (aside from premium assistance for employer-sponsored insurance). It also requires administering and tracking a number of elements, such as premium payments or copayments, compliance with healthy behaviors, HSA balances and rollover funds, presumptive eligibility determinations, and coverage of certain services. The program treats beneficiaries differently based on their coverage group and treats beneficiaries within the same coverage group differently based on their income level, medical frailty status, and whether they have paid premiums.

Unlike other state Medicaid expansion waivers, HIP 2.0 allows the state to prevent certain newly eligible beneficiaries (non-medically frail adults with an income higher than 100% FPL) from re-enrolling in coverage for six months if they are disenrolled for non-payment of premiums. The waiver provides a less generous benefit package to newly eligible beneficiaries with an income at or less than 100% FPL who do not pay premiums. To receive the more generous benefit package, even beneficiaries with no or a very low income must pay premiums of $1 per month. Medically frail beneficiaries have access to the state plan benefit package, in accordance with federal law, but those with an income higher than 100% FPL who do not pay premiums must make copayments. HIP 2.0, again differing from other state Medicaid expansion waivers, makes coverage effective on the date of the first premium payment, rather than on the date of application.

Indiana also sought, but failed to receive CMS approval for, waiver authority to require a work referral as a condition of Medicaid eligibility. Instead, the state can administer a voluntary state work search and job training program separate from the Medicaid expansion demonstration. Indiana also sought, but failed to receive CMS approval for, a waiver of Early Periodic Screening Diagnostic and Treatment (EPSDT) benefits (specifically, vision and dental) for 19- and 20-year-old enrollees in the HIP Basic plan.

Indian-Specific Provisions

AI/ANs were given the option to secure coverage under the Medicaid expansion but to opt-out of the HIP 2.0 managed care plans and the additional requirements under HIP 2.0.[9] For example, AI/ANs were excluded from cost-sharing requirements and making POWER account contributions in order to receive a broader benefit package. In addition, American Recovery and Reinvestment Act (ARRA) protections were continued, ensuring that Indian health care providers are paid whether in-network or

[99] See page 12 of 58 of the approved Indiana HIP 2.0 plan for a listing of the Indian-specific provisions. https://www.in.gov/fssa/hip/files/HIP_CMS_Approved_STC_Technical_Corrections_5.14.15.pdf

not. Although all the Indian-specific provisions ultimately were agreed to by the State, some of the provisions were added to the waiver by CMS over the initial objections of the State.

Additional information on the Indiana Medicaid expansion waiver is available from the Kaiser Family Foundation at http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-indiana/.