



The American Health Care Act of 2017 (H.R. 1628)

Section-by-Section

(Updated to reflect amendments accepted at Rules Committee)

Title I— Energy and Commerce

Subtitle A: Patient Access to Public Health Programs

Section 101 – The Prevention and Public Health Fund

Section 4002 in the Patient Protection and Affordable Care Act established the Prevention and Public Health Fund (PPHF) as an advanced appropriation for prevention, wellness, and public health initiatives to be administered Department of Health and Human Services (HHS). Annual appropriations for the PPHF continue in perpetuity. If Congress does not explicitly allocate the funding, the HHS Secretary has broad authority to spend these dollars without Congressional oversight. This section repeals PPHF appropriations for fiscal year 2019 onwards. Any unobligated PPHF funds remaining at the end of fiscal year 2018 are to be rescinded.

Section 102 – Community Health Center Program

This section provides increased funding for the Community Health Center Fund, which awards grants to Federally Qualified Health Centers (FQHCs). FQHCs are community-based outpatient facilities that provide health services to medically underserved populations. These health services include comprehensive medical, dental, mental health and reproductive care, in addition to other primary care services.

Section 103 – Federal Payments to States

This section imposes a one-year freeze on mandatory funding to a class of providers designated as prohibited entities. This funding includes Medicaid, the Children’s Health Insurance Program, Maternal and Child Health Services Block Grants, and Social Services Block Grants. A prohibited entity is one that meets the following criteria: it is designated as a non-profit by the Internal Revenue Service; it is an essential community provider primarily engaged in family planning and reproductive health services; it provides abortions in cases that do not meet the Hyde amendment exception for federal payment; and it received over \$350 million in federal and state Medicaid dollars in fiscal year 2014.

Subtitle B: Medicaid Program Enhancement

Section 111 – Repeal of Medicaid Provisions

Section (111) (a) and 111 (3)

- Sunsets States’ expanded authority to make presumptive eligibility determination on December 31, 2019. States would still be allowed to make presumptive eligibility determinations for children, pregnant women, and breast cancer and cervical cancer patients.

Section 111 (1) (b)

- Reverts the mandatory Medicaid income eligibility level for poverty-related children back to at or below 100 percent of federal poverty level on December 31, 2019 States could cover this population in their State Children’s Health Insurance Program (SCHIP).

Section 111 (2)

- Repeals the 6 percentage point bonus in the federal match rate for community-based attendant services and supports on December 31, 2019.

Section 112 – Repeal of Medicaid Expansion

- Terminates Obamacare’s mandatory requirement for States to expand Medicaid for certain childless non-disabled, non-elderly, non-pregnant adults up to 133% FPL. Also sunsets the optional ability for a State to cover adults above 133% FPL, effective December 31, 2017.
- Preserves the ability of States to cover Medicaid expansion enrollees (childless non-disabled, non-elderly, non-pregnant adults) at a State’s regular Federal Medical Assistance Percentage (FMAP) by designating a new optional category in Section 1902 (nn) of the *Social Security Act*.
- Medicaid expansion enrollees who were enrolled in Medicaid expansion prior to December 31, 2019 receive “grandfathered” status. States will receive the enhanced matching rate under current law (90 % in CY2020), for grandfathered enrollees as long as such individuals remain eligible and enrolled in the program.
- Changes Obamacare’s enhanced FMAP for Medicaid expansion by limiting the enhanced FMAP for Medicaid expansion States that already have expanded Medicaid to cover able-bodied adults as of March 1, 2017. Thus, any new State that might expand Medicaid to cover low non-disabled, non-elderly, non-pregnant, able-bodied adults up to 133% FPL would receive that State’s *regular* FMAP and would *not* receive the enhanced FMAP. Makes a conforming technical change to continue the policy in the base bill that freezes the Obamacare enhanced FMAP provided for certain States that covered low-income adults prior to Obamacare at the State’s regular FMAP.

Section 113 – Elimination of DSH Cuts

Repeals the Medicaid Disproportionate Share Hospital (DSH) cuts for non-expansion States in FY2018. States that expanded Medicaid would have their DSH cuts repealed in FY2020.

Section 114 – Reducing State Medicaid Costs

Section 114 (a)

- Eliminates an unintended consequence in the current statute and regulations by requiring States, for purposes of determining MAGI for Medicaid and CHIP eligibility, to consider monetary winnings from lotteries (and other lump sum payments) as if they were obtained over multiple months, even if obtained in a single month.
- Counts lottery winnings above \$80,000 over multiple months, thus preventing individuals with significant financial means from inappropriately shifting the cost of their care to the Medicaid program.
- Includes a hardship exemption by which States could continue to provide Medicaid coverage for an individual if the denial of coverage would cause an undue medical or financial hardship as determined based on criteria established by the Secretary of HHS.

Section 114 (b)

- Limits the effective date for retroactive coverage of Medicaid benefits to the month in which the applicant applied. This provision would apply to Medicaid applications made (or deemed to be made) on or after October 1, 2017.

Section 114 (c)

- Repeals the authority for States to elect to substitute a higher home equity limit that is above the statutory minimum in law. It would apply to Medicaid eligibility determinations that are made more than 180 days after enactment. In situations where the Secretary of HHS determines that State legislation would be required to amend the State plan, then States would have additional time to comply with these requirements.

Section 115 – Safety Net Funding for Non-Expansion States

Provides \$10 billion over five years to non-expansion States for safety net funding. For FY2018 through FY2022, each State that has not implemented the ACA Medicaid expansion as of July 1st of the preceding year may receive safety net funding to adjust payment amounts for Medicaid providers. For these payment adjustments using the safety net funding, non-expansion States would receive an increased matching rate of 100% for FY2018 through FY2021 and 95% for FY2022. Each non-expansion State's allotment from the \$2 billion would be determined according to the number of individuals in the State with income below 138% of FPL in 2015 relative to the total number of individuals with income below 138% of FPL for all the non-expansion States in 2015. The 2015 American Community Survey 1-year estimates as published by the Bureau of the Census would be used to determine the portion of each State's population that is below 138% of the FPL. If a non-expansion State for a year implements the ACA Medicaid expansion during the year, the State shall no longer be treated as a non-expansion State for safety net funding for subsequent years.

Section 116 – Providing Incentives for Increased Frequency of Eligibility Redeterminations

Requires States with Medicaid expansion populations to, as of October 1, 2017, redetermine expansion enrollees' eligibility every 6 months. This ensures individuals not eligible for the program are not remaining enrolled longer than they should, while also allowing eligible individuals to remain enrolled. This policy also provides a temporary five percent FMAP increase to States for activities directly related to complying with this section.

Section 117 – Permitting States to Apply A Work Requirement for Nondisabled, Nonelderly, Nonpregnant Adults Under Medicaid

Creates a new section of the Social Security Act to give States the option of instituting a work requirement in Medicaid for nondisabled, nonelderly, non-pregnant adults as a condition of receiving coverage under Medicaid. The amendment adopts the language from Mr. Griffith's bill, H.R. 1381, which was modeled after the requirements and exemptions that exist in TANF under current law. States could begin using this new option on October 1, 2017.

The amendment grants broad flexibility to states to implement the requirement as they see fit. However, a few requirements are imposed. For example, the amendment defines what a work requirement entails by using the countable TANF activities defined in section 407(d) in the *Social Security Act*. Countable work activities include the following, in addition to unsubsidized employment:

- Subsidized private sector employment;
- Subsidized public sector employment;
- Work experience;
- On-the-job training (OJT);
- Job search and job readiness assistance;
- Community service programs;
- Vocational educational training;
- Job skills training related to employment;
- Education directly related to employment, in the case of a recipient who has not received a high school diploma or a certificate of high school equivalency;
- Satisfactory attendance at secondary school or in a course of study leading to a certificate of general equivalence, if a recipient has not completed secondary school or received such a certificate; and
- Providing childcare services to an individual who is participating in a community service program.

Under the amendment, a state may not impose a work requirement as a condition of receiving medical assistance under Medicaid on:

- Pregnant women;
- Children under the age of 19;
- An individual who is the only parent or caretaker of a child under the age of 6 or who is the only parent or caretaker of a child with a disability; and,

- An individual under the age of 20 who is married or is the head of the household and maintains satisfactory attendance at school or participates in education directly related to employment.

To ensure that states have the tools capable to implement the work requirement, the amendment provides a 5% administrative FMAP bump to states who choose to implement a work requirement.

Subtitle C: Per Capita Allotment for Medical Assistance

Section 121 – Per Capita Allotment for Medical Assistance

Reforms federal Medicaid financing by creating a per capita cap model (i.e., per enrollee limits on federal payments to States) starting in FY2020. Section 121 would use each State’s spending in FY2016—including non-DSH supplemental payments—as the base year to set targeted spending for each enrollee category (elderly, blind and disabled, children, non-expansion adults, and expansion adults) in FY2019 and subsequent years for that State. Each State’s targeted spending amount for children, non-expansion adults, and expansion adults would increase by the percentage increase in the medical care component of the consumer price index for all urban consumers from September 2019 to September of the next fiscal year. Each State’s targeted spending amount for elderly and blind and disabled would increase by the percentage increase in the medical care component of the consumer price index for all urban consumers from September 2019 to September of the next fiscal year plus 1 percentage point. Starting in FY2020, any State with spending higher than their specified targeted aggregate amount would receive reductions to their Medicaid funding for the following fiscal year.

Section 121 would also modernize Medicaid’s data and reporting systems. The additional reporting requirements would include data on medical assistance expenditures within categories of services and categories of all enrollees on Medicaid. Providing a full picture of spending in the program for the first time in the program’s history and helping to make the transition to a per capita model smooth and efficient. To help States prepare for these new reporting requirements, section 121 would provide a temporary increase to the federal matching percentage to improve data reporting systems. The temporary increases would impact expenditures on or after October 1, 2017, and before October 1, 2019.

Certain payments are exempt from the caps. For example, DSH payments operate outside of the caps since they are already a capped allotment. Administrative payments and funding for childhood vaccines are also exempt. In addition, certain populations would be exempt:

- Individuals covered under a CHIP Medicaid expansion program;
- Individuals who receive medical assistance through an Indian Health Service facility;
- Individuals entitled to medical assistance coverage of breast and cervical cancer treatment due to screening under the Breast and Cervical Cancer Early Detection Program;
- The following partial-benefit enrollees:

- Unauthorized aliens eligible for Medicaid emergency medical care;
- Individuals eligible for Medicaid family planning options;
- Dual-eligible individuals eligible for coverage of Medicare cost sharing;
- Individuals eligible for premium assistance;
- Coverage of tuberculosis-related services for individuals infected with TB.

For any state that in 2016 had a DSH allotment that was more than six times the national average and requires political subdivisions within the State to contribute funds toward Medicaid, the amount of allowable medical assistance expenditures under the per capita allotment reform is reduced by the amount required to be raised from the political subdivisions. The provision also provides an exception allowing a State to require such funds from political subdivisions with a population that exceeds 5 million.

Consistent with the vision outlined in the House Republican health care proposal, *A Better Way*, the amendment creates a new option for States to opt to receive, starting Fiscal Year 2020, a flexible block grant of funds for providing health care for their traditional adult and children populations served in the per capita allotment.

- Funding for the block grant would be determined using the same a base year calculation for the per capita allotment reforms.
- States may choose to provide care for certain populations by receiving a block of funds for a period of 10 years, rather than providing care through the per capita allotment.
- States choosing the block grant are required to submit a report that identifies the conditions for eligibility under the block grant which are in lieu of eligibility in current law, except in the case of certain low-income pregnant women and children in poverty.
- States choosing the block grant are also required to, in the submitted report, outline the types of items and services; the amount, duration, and scope of such services; the cost-sharing with respect to such services; and the method for delivering care. These items and services are in lieu of those requirements in current law, except that the block grant must provide medical assistance for hospital care; surgical care and treatment; medical care and treatment; obstetrical and prenatal care and treatment; prescribed drugs, medicines and prosthetics; other medical supplies and services; and health care for children under 18 years of age.
- A plan shall be deemed approved by the Secretary of HHS unless the Secretary finds within 30 days that the plan is incomplete or actuarially unsound.
- The amount of block grant funding shall be calculated by computing the per capita cost for the eligible population, multiplied by the number of enrollees in the year prior to adopting a block grant. The funding will increase by the growth in the consumer price index but will not adjust for changes in population. Unused funds rollover and remain available for expenditure so long as a State has a block grant.

- A State may choose to provide health care to either non-expansion adults and children, or just non-expansion adults.
- States adopting the block grant are required to contract with an independent entity to ensure the State is in compliance with the requirements for a block grant. Such audit reports are required to be made available to HHS upon request.

Finally, to ensure that gaming does not take place the Secretary of HHS would conduct audits of each State's enrollment and expenditures reported on the Form CMS-64 for FY2016, FY2019, and subsequent years.

Subtitle D: Patient Relief and Health Insurance Market Stability

Section 131 – Repeal of Cost-Sharing Subsidy

Section 1402, the cost-sharing subsidy program, of the *Patient Protection and Affordable Care Act* is repealed in 2020 by this section. The program is designed to lower out-of-pocket costs for those who purchase Silver plans through an exchange established by the law. The Obama administration executed this program without an appropriation, leading to a lawsuit from House Republicans arguing that Congress – and in particular, the House of Representatives – alone holds the constitutional power of the purse. The lawsuit, now entitled *House v. Price*, is being held in abeyance. The next filing date in the case for both parties is May 22, 2017.

Section 132 – Patient and State Stability Fund

This section establishes the Patient and State Stability Fund, which is designed to lower patient costs and stabilize State markets. Under the use of funds, a State may use the resources for any of the following purposes:

- Helping, through the provision of financial assistance, high-risk individuals who do not have access to health insurance coverage offered through an employer enroll in health insurance coverage in the individual market in the State, as such market is defined by the State (whether through the establishment of a new mechanism or maintenance of an existing mechanism for such purpose).
- Providing incentives to appropriate entities to enter into arrangements with the State to help stabilize premiums for health insurance coverage in the individual, as such markets are defined by the State.
- Reducing the cost of providing health insurance coverage in the individual market and small group market, as such markets are defined by the State, to individuals who have, or are projected to have, a high rate of utilization of health services (as measured by cost) and to individuals who have high costs of health insurance coverage due to the low density population of the State in which they reside.
- Promoting participation in the individual market and small group market in the State and increasing health insurance options available through such market.

- Promoting access to preventive services, dental care services (whether preventive or medically necessary), vision care services (whether preventive or medically necessary), or any combination of such services.
- Maternity coverage and newborn care.
- Prevention, treatment, or recovery support services for individuals with mental or substance use disorders, focused on either or both of the following:
 - Direct inpatient or outpatient clinical care for treatment of addiction and mental illness.
 - Early identification and intervention for children and young adults with serious mental illness.
- Providing payments, directly or indirectly, to health care providers for the provision of such health care services as are specified by the Administrator.
- Providing assistance to reduce out-of-pocket costs, such as copayments, coinsurance, premiums, and deductibles, of individuals enrolled in health insurance coverage in the State.

If a State chooses not to use the funding for their own program, the resources will be available to the Administrator of the Centers for Medicare & Medicaid Services (CMS) to help stabilize premiums for patients.

The formula used to calculate a State's allotment for years 2018 and 2019 uses two criteria. The first is for 85 percent of the annual funding and is based off of incurred claims for benefit year 2015, and subsequently 2016, which provides for the latest medical loss ratio (MLR) data available that reflects total costs for the on-exchange individual market. The second is for States to access a proportion of the remaining 15 percent. In order to receive this funding, a State must meet one of two triggers: their uninsured population for individuals below 100 percent of federal poverty level (FPL) increased from 2013-2015; or, fewer than three plans are offering coverage on the on-exchange individual market in 2017.

Beginning in 2020, the Administrator will set an allocation methodology to reflect cost, risk, low-income uninsured population, and issuer competition. To determine this methodology, the Administrator will consult with health care consumers, health insurance issuers, State insurance commissioners, and other stakeholders and after taking into consideration additional cost and risk factors that may inhibit health care consumer and health insurance issuer participation.

This section annually appropriates \$15 billion for State use for 2018 and 2019. For years 2020 through 2026, \$10 billion is appropriated annually. A State match is phased in beginning 2020 at a different schedule, depending on if a State chooses to use the money for their own program or utilizes the federal default program administered through CMS. The section also includes \$15 billion explicitly for maternity coverage and newborn care, as well as the prevention, treatment, or recovery support services for individuals with mental or substance use disorders.

This section empowers the Administrator of CMS to create a Federal Invisible High Risk Pool and appropriates \$15 billion for calendar years 2018 through 2026 for that purpose. In addition to the \$15 billion appropriation, unallocated funds from the federal fallback within the

underlying Patient and State Stability Fund would be available for the purposes of carrying out this program. Beginning calendar year 2020, a State can take over the operations of the program.

Finally, this section allows states that elect to pursue a waiver under section 2701(b) of the Public Health Service Act to provide financial support to lower costs for those who face higher premiums as a result of such a waiver and appropriates \$8 billion in calendar years 2018 through 2023 for that purpose.

Section 133 – Continuous Health Insurance Coverage Incentive

The continuous coverage incentive is designed to limit adverse selection in individual health insurance markets. Beginning in open enrollment for benefit year 2019, there will be a 12-month lookback period to determine if the applicant went longer than 63 days without continuous health insurance coverage. If the applicant had a lapse in coverage for greater than 63 days, issuers will assess a flat 30 percent late-enrollment surcharge on top of their base premium based on their decision to forgo coverage. This late-enrollment surcharge would be the same for all market entrants, regardless of health status, and discontinued after 12 months, incentivizing enrollees to remain covered. This process would be for special enrollment period applicants in benefit year 2018.

Section 134 – Increasing Coverage Options

Under the Affordable Care Act, plan issuers are required to label their offerings by metal tier: Bronze, Silver, Gold, and Platinum. These metal tiers are determined by a calculation known as actuarial value (AV). In an attempt to improve plan choice, this section repeals the AV standards, which helps improve benefit design flexibility.

Section 135 – Change in Permissible Age Variation in Health Insurance Premium Rates

Current law limits the cost of the most generous plan for older Americans to three times the cost of the least generous plan for younger Americans. The true cost of care is 4.8-to-one, according to health economists. This provision loosens the ratio to five-to-one and gives States the flexibility to set their own ratio.

Section 136– Permitting States to Waiver Certain ACA Requirements to Encourage Fair Health Insurance Premiums

This section allows States to submit a waiver application to the Secretary of the U.S. Department of Health and Human Services (HHS) to:

- Increase the age rating ratio above the underlying bill's 5:1 ratio beginning 2018;
- Specify their own essential health benefits beginning 2020; and,
- Replace the underlying bill's continuous coverage incentive's late-enrollment penalty with health status rating beginning 2019, conditional upon the State operating a risk mitigation program or participating in a Federal Invisible Risk Sharing Program (FIRSP). Health status rating may not be waived for individuals who maintain continuous coverage.

The section further provides a default approval process for States, making all applications automatically approved within 60 days unless the HHS Secretary notifies a State of the reasons for denial within the 60-day timeframe. It also specifies requirements of the application, including that States will explain how the waiver will provide one or more of the following:

- Reducing average premiums for health insurance coverage in the State;
- Increasing enrollment in health insurance coverage in the State;
- Stabilizing the market for health insurance coverage in the State;
- Stabilizing premiums for individuals with pre-existing conditions; or
- Increasing the choice of health plans in the State.

Waivers may be in effect for up to 10 years, but can become void if, during any point during an approved waiver, a state ends its risk-sharing program. The section specifies certain non-application provisions to comply with Senate procedure concerning reconciliation, protecting the amendment's privilege status, and incorporates rules of construction stating that nothing in this Act shall be construed as permitting health insurance issuers to discriminate in rates for health insurance by gender or limit access to health coverage for individuals with preexisting conditions.

Subtitle E: Implementation Funding

Section 141 – American Health Care Implementation Fund

Establishes Section 141 of the Social Security Act creating an American Health Care Implementation Fund within the U.S. Department of Health and Human Services (HHS) to carry out:

- Sec. 121. Per capita allotment for medical assistance;
- Sec. 132. Patient and State Stability Fund;
- Sec. 202. Additional modifications to premium tax credit; and,
- Sec. 214. Refundable tax credit for health insurance coverage.

A \$1billion appropriation is made to the fund.

Title II— Ways and Means

Subtitle A: Repeal and Replace of Health-Related Tax Policy

Section 201 – Recapture Excess Advance Payments of Premium Tax Credits

The amount a household is required to pay towards their premiums is based on income. If a household's income increases during the tax year, excess premium tax credits may result. Under current law, for households with incomes less than 400 percent of the federal poverty level there

are certain limits on the amount the household is required to repay the federal government for the excess premium tax credits. For tax years 2018 and 2019, this section requires any individual who was overpaid in premium tax credits to repay the entire excess amount, regardless of income.

Section 202 – Additional Modifications to Premium Tax Credit

Under current law, qualified health plans must meet certain requirements for households to be eligible for the premium tax credit. This section amends those requirements to make available premium tax credits for the purchase of “catastrophic-only” qualified health plans and certain qualified plans not offered through an Exchange. Additionally, this section prohibits premium tax credits from being used to purchase plans that offer elective abortion coverage. Lastly, this section revises the schedule under which an individual’s or family’s share of premiums is determined by adjusting for household income and the age of the individual or family members.

Section 203 – Small Business Tax Credit

This section repeals Obamacare’s small business tax credit beginning in 2020. Between 2018 and 2020, under the proposal, the small business tax credit generally is not available with respect to a qualified health plan that provides coverage relating to elective abortions.

Section 204 – Individual Mandate

Under current law, most individuals are required to purchase health insurance or pay a penalty. This section would reduce the penalty to zero for failure to maintain minimum essential coverage; effectively repealing the individual mandate. The effective date would apply for months beginning after December 31, 2015, providing retroactive relief to those impacted by the penalty in 2016.

Section 205 – Employer Mandate

Under current law, certain employers are required to provide health insurance or pay a penalty. This section would reduce the penalty to zero for failure to provide minimum essential coverage; effectively repealing the employer mandate. The effective date would apply for months beginning after December 31, 2015, providing retroactive relief to those impacted by the penalty in 2016.

Section 206 – Repeal of the Tax on Employee Health Insurance Premiums and Health Plan Benefits

Obamacare imposed a 40 percent excise tax on high cost employer-sponsored health coverage, also known as Cadillac plans. Under current law, the tax will go into effect in 2020. This section changes the effective date of the tax. It will not apply for any taxable period beginning after December 31, 2019, and before January 1, 2026. Thus, the tax will apply only for taxable periods beginning after December 31, 2025.

Section 207 – Repeal of the Tax on Over-the-Counter Medications

Under current law, taxpayers may use several different types of tax-advantaged health savings accounts to help pay or be reimbursed for qualified medical expenses. Obamacare excluded over-the-counter medications from the definition of qualified medical expenses. This section effectively repeals the Obamacare tax on over-the-counter medications. The effective date begins tax year 2017.

Section 208 – Repeal of Increase of Tax on Health Savings Accounts

Distributions from an HSA or Archer MSA that are used for qualified medical expenses are excludible from gross income. Distributions that are not used for qualified medical expenses are includible in income and are generally subject to an additional tax. Obamacare increased the percentage of the tax on distributions that are not used for qualified medical expenses to 20 percent. This section lowers the rate to pre-Obamacare percentages. This change is effective for distributions after December 31, 2016.

Section 209 – Repeal of Limitations on Contributions to Flexible Savings Accounts

Obamacare limits the amount an employer or individual may contribute to a health Flexible Spending Account (FSA) to \$2,500, indexed for cost-of-living adjustments. This section repeals the limitation on health FSA contributions for taxable years beginning after December 31, 2016.

Section 210 – Repeal of Medical Device Tax

Obamacare created a new 2.3 percent excise tax on the sale of certain medical devices. This section repeals the medical device tax beginning after December 31, 2016.

Section 211 – Repeal of Elimination of Deduction for Expenses Allocable to Medicare Part D Subsidy

Prior to Obamacare, as an incentive for employers to offer retiree drug coverage, employers who offered sufficient prescription drug coverage to their employees qualified for the Retiree Drug Subsidy to help cover actual spending for prescription drug costs. Obamacare eliminated the ability for employers to take a tax deduction on the value of this subsidy. This section repeals this Obamacare change and re-instates the business-expense deduction for retiree prescription drug costs without reduction by the amount of any federal subsidy. This section applies to taxable years beginning after December 31, 2016.

Section 212 – Reduction of Increase in Income Threshold for Medical Expense Deduction

Taxpayers who itemize their deductions may deduct qualifying medical expenses. The medical-expense deduction may be claimed only for expenses that exceed a certain percentage of the taxpayer's adjustment gross income (AGI). Obamacare increased the AGI percentage threshold from 7.5 percent to 10 percent. This section reduces the AGI percentage threshold to 5.8-percent to provide additional support for Americans with high health costs, including low- and middle-income seniors. This section applies for taxable years beginning after December 31, 2016.

Section 213 – Repeal of Medicare Tax Increase

Obamacare imposed a Medicare Hospital Insurance (HI) surtax based on income at a rate equal to 0.9 percent of an employee’s wages or a self-employed individual’s self-employment income. This section repeals the additional 0.9 percent Medicare tax beginning in 2023.

Section 214 – Refundable Tax Credit for Health Insurance

This section repeals the current Obamacare tax subsidy and replaces it with an advanceable, refundable tax credit for the purchase of state-approved, major medical health insurance. To be eligible, generally, an individual must not have access to government health insurance programs or an offer from any employer; and be a citizen, national or qualified alien of the United States, and not incarcerated. The credits are adjusted by age:

- Under age 30: \$2,000
- Between 30 and 39: \$2,500
- Between 40 and 49: \$3,000
- Between 50 and 59: \$3,500
- Over age 60: \$4,000

The credits are additive for a family and capped at \$14,000. The credits grow over time by CPI+1. The credits are available in full to those making \$75,000 per year (\$150,000 joint filers). The credit phases out by \$100 for every \$1,000 in income higher than those thresholds.

The Secretaries of Health and Human Services and the Treasury are empowered to create a system— building upon already developed systems— to deliver the credit. Eligibility determinations will continue to be conducted by the federal government, while insurers and licensed agents and brokers will be able to do more of the consumer-facing actions currently performed in 39 states by healthcare.gov.

The program also calls for simplified reporting of an offer of coverage on the W-2 by employers. Reconciliation rules limit the ability of Congress to repeal the current reporting, but, when the current reporting becomes redundant and replaced by the reporting mechanism called for in the bill, then the Secretary of the Treasury can stop enforcing reporting that is not needed for taxable purposes.

Section 215 – Maximum Contribution Limit to Health Savings Account Increased to Amount of Deductible and Out-Of-Pocket Limitation

This section increases the basic limit on aggregate Health Savings Account (HSA) contributions for a year to equal the maximum on the sum of the annual deductible and out-of-pocket expenses permitted under a high deductible health plan. In 2017, those limits would \$6,550 in the case of self-only coverage and \$13,100 in the case of family coverage.

Section 216 – Allow Both Spouses to Make Catch-Up Contributions

This section would effectively allow both spouses to make catch-up contributions to one HSA beginning in 2018.

Section 217 – Special Rule for Certain Medical Expenses Incurred Before Establishment of HSA

This section sets forth certain circumstances under which HSA withdrawals can be used to pay qualified medical expenses incurred before the HSA was established. Starting in 2018, if an HSA is established during the 60-day period beginning on the date that an individual’s coverage under a high deductible health plan begins, then the HSA is treated as having been established on the date coverage under the high deductible health plan begins for purposes of determining if an expense incurred is a qualified medical expense.

Subtitle B: Repeal and Replace of Certain Consumer Taxes

Section 221 – Repeal of Tax on Prescription Medications

Obamacare imposed an annual fee on certain brand pharmaceutical manufacturers. This section repeals the tax on brand pharmaceutical manufacturers such that the it would not apply for years beginning after December 31, 2016.

Section 222 – Repeal of Health Insurance Tax

Obamacare imposed an annual fee on certain health insurers. The proposal repeals the health insurance tax beginning after December 31, 2016.

Subtitle C: Repeal of Tanning Tax

Section 231 – Repeal of Tanning Tax

Obamacare imposed a 10 percent sales tax on indoor tanning services. This section repeals the tanning tax starting after June 30, 2017.

Subtitle D: Remuneration from Certain Insurers

Section 241 – Remuneration from Certain Insurers

Generally, employers may deduct the remuneration paid to employees as “ordinary and necessary” business expenses. Obamacare added a limitation for certain health insurance providers that exceeds \$500,000 paid to an officer, director, or employee. This section repeals the limit on the deduction of a covered health insurance provider for compensation attributable to services performed by an applicable individual starting in 2017.

Subtitle E: Repeal of Net Investment Tax

Section 251 – Repeal of Net Investment Tax

Obamacare imposed a net investment tax, applying a rate of 3.8 percent to certain net investment income of individuals, estates, and trusts with income above certain amounts. This section repeals the net investment tax starting in 2017.