



U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON ENERGY AND COMMERCE

March 6, 2017

TO: Members, Committee on Energy and Commerce
FROM: Committee Majority Staff
RE: Full Committee Markup

I. INTRODUCTION

The Committee on Energy and Commerce will meet in open markup session on March 8, 2017, at 10:00 a.m. in 2123 Rayburn House Office Building to consider the following:

- Committee Print: Budget Reconciliation Legislative Recommendations Relating to Repeal and Replace of the Patient Protection and Affordable Care Act; and
- H. Res. 154, Requesting the President of the United States and directing the Secretary of Health and Human Services to transmit certain information to the House of Representatives relating to plans to repeal or replace the Patient Protection and Affordable Care Act and the health-related measures of the Health Care and Education Reconciliation Act of 2010.

In keeping with Chairman Walden's announced policy, Members must submit any amendments they may have two hours before they are offered during this markup. Members may submit amendments by email to peter.kielty@mail.house.gov. Any information with respect to an amendment's parliamentary standing (e.g., its germaneness) should be submitted at this time as well.

II. LEGISLATION

A. **Committee Print: Budget Reconciliation Legislative Recommendations Relating to Repeal and Replace of the Patient Protection and Affordable Care Act**

Subtitle A: Patient Access to Public Health Programs

Section 101 – The Prevention and Public Health Fund: This section repeals Section 4002 of the Patient Protection and Affordable Care Act. Section 4002 established the Prevention and Public Health Fund (PPHF) as a permanent advanced appropriation for prevention, wellness, and public health initiatives to be administered Department of Health and Human Services (HHS). This section repeals PPHF appropriations for fiscal year (FY) 2019 onwards and rescinds unobligated funds at the end of FY 2018.

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).

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. 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: This section repeals States' expanded authority to make presumptive eligibility determinations for certain populations and alter mandatory Medicaid income eligibility level for poverty-related children back to 100 percent of federal poverty level. In addition, this section repeals the 6-percentage point bonus in the federal match rate for community-based attendant services.

Section 112 – Repeal of Medicaid Expansion: This section codifies *NFIB v. Sebelius* by making Medicaid expansion optional for States. This section also repeals the State option to extend coverage to adults above 133 percent of federal poverty by December 31, 2019, and ends the enhanced match rate for newly eligible beneficiaries after December 31, 2019. States can keep the enhanced match for *newly eligible* expenditures that occur before January 1, 2020. However, for expenditures after January 1, 2020, the *newly eligible* matching rate would only apply to expenditures for newly eligible individuals who were enrolled in Medicaid (under the State plan or a waiver) as of December 31, 2019 and do not have a break in eligibility for more than one month after that date. After January 1, 2020, the State could only enroll newly eligible individuals at the State's traditional FMAP for that individual. This section also amends the formula for the *expansion State* matching rate so that the matching rate stops phasing up after calendar year (CY) 2017 and the transition percentage would remain at the CY 2017 level for each subsequent year. In addition, for expenditures after January 1, 2020, the *expansion State* matching rate would only apply to expenditures for individuals who are eligible for the *expansion State* matching rate and were enrolled in Medicaid (under the State plan or a waiver) as of December 31, 2019, and do not have a break in eligibility for more than one month after that date. After January 1, 2020, the State would have the option to enroll newly eligible individuals, but the State would receive the State's traditional federal medical assistance program (FMAP) for that individual.

The section also repeals the requirement that State Medicaid plans must provide the same "essential health benefits" that are required by plans on the exchanges, returning flexibility to the States on December 31, 2019.

Section 113 – Elimination of DSH Cuts: This section repeals the Medicaid Disproportionate Share Hospital (DSH) cuts for non-expansion States in 2018. States that expanded Medicaid would have their DSH cuts repealed in 2020.

Section 114 – Reducing State Medicaid Costs: This section would eliminate an unintended consequence in the current statute and regulations by requiring States, for purposes of determining modified adjusted gross income (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.

This section would close the loophole by requiring individuals to provide documentation of citizenship or lawful presence before obtaining coverage.

This section would repeal 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: This section provides \$10 billion over five years to non-expansion States for safety net funding, for CY 2018 through CY 2022.

Section 116 – Providing Incentives for Increased Frequency of Eligibility Redetermination: This section requires States with Medicaid expansion populations to re-determine expansion enrollees' eligibility every 6 months. This policy also provides a temporary five percent FMAP increase to States for activities directly related to complying with this section.

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 FY 2020. Section 108 would use each State's spending in FY 2016 as the base year to set targeted spending for each enrollee category (elderly, blind and disabled, children, non-expansion adults, and expansion adults) in FY 2019 and subsequent years for that State. Each State's targeted spending amount 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. Starting in FY 2020, any State with spending higher than their specified targeted aggregate amount would receive reductions to their Medicaid funding for the following fiscal year.

Section 108 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.

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 are also exempt. In addition, certain populations would be exempt.

Finally, to ensure that gaming does not take place, the Secretary of Health and Human Services (HHS) would conduct audits of each State's enrollment and expenditures reported on the Form CMS-64 for FY 2016, FY 2019, and subsequent years.

Subtitle D: Patient Relief and Health Insurance Market Stability

Section 131 – Repeal of Cost-Sharing Subsidy: This section repeals the Affordable Care Act (ACA) cost-sharing subsidy program at the end of 2019. The Obama administration made payments through 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 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.

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 and Medicaid Services (CMS) to help stabilize premiums for patients.

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 in 2020 at a different schedule, depending if a State chooses to use the money for their own program or utilizes the federal default program administered through CMS.

Section 133 – Continuous Health Insurance Coverage Incentive: The continuous coverage incentive would limit adverse selection in health care 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 begin for special enrollment period applicants in benefit year 2018.

Section 134 – Increasing Coverage Options: Under the ACA, 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). This section repeals the AV standards.

Section 135 – Change in Permissible Age Variation in Health Insurance Premium Rate: 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.

B. H. Res. 154, Requesting the President of the United States and directing the Secretary of Health and Human Services to transmit certain information to the House of Representatives relating to plans to repeal or replace the Patient Protection and Affordable Care Act and the health-related measures of the Health Care and Education Reconciliation Act of 2010

H.Res. 154 requests the President, and directs the Secretary of Health and Human Services, to transmit to the House of Representatives, not later than 14 days after the date of the adoption of the resolution, records relating to plans to repeal or replace the Patient Protection and Affordable Care Act and the health-related measures of the Health Care and Education Reconciliation Act of 2010.

III. STAFF CONTACTS

If you have any questions regarding H. Res. 154 or the Committee Print, please contact Paul Edattel, Adam Buckalew, Josh Trent or Caleb Graff of the Committee staff at (202) 225-2927.