American Health Care Act

CMS Policy Analysis

MEMORANDUM

Date: March 20, 2017

To: CMS Board of Directors

From: Chet Seward

RE: Analysis of American Health Care Act

The following summary analysis of the American Health Care Act (ACHA) is for your use as you consider taking a position on the ACHA. It includes a top-line cross reference (see Appendix 1) to current Colorado Medical Society (CMS).

Background

It is important to note that this analysis refers to the bill as approved by the House Ways and Means and the Energy and Commerce Committees on March 9 to begin to fulfill the Republican campaign promise to repeal and replace the Affordable Care Act (ACA), otherwise known as Obamacare. The bill is being considered using the budget reconciliation process, which restricts its impact to components of the ACA that cost money or are implemented as taxes. As a result, many components of the ACA will remain intact until other legislation is passed including:

- Coverage for pre-existing conditions;
- Guaranteed availability and renewability of coverage;
- Maintaining ACA essential health benefit provisions (except in Medicaid);
- Covering adult children up to age 26 on their parent's plan;
- Capping out-of-pocket expenditures;
- Prohibiting health status underwriting;
- Banning lifetime and annual limits; and
- Discriminating on the basis of race, nationality, disability, age or sex.[i]

Immense political pressure is currently being applied to the bill, so future changes are likely.

CMS policy analysis

The attached appendix provides more detailed information on the AHCA, specifically noting where CMS policy is consistent or inconsistent. Highlights include:

- Elimination of the Medicaid expansion – The bill fundamentally changes the federal financing model for Medicaid by capping future outlays and eliminating enhanced federal funding for the ACA expansion that provided 400,000 Coloradans coverage through Medicaid and accounted for the largest component of the state's coverage gains and drop in uninsurance rates to a historically low level. The bill would reinstitute disproportionate share

hospital payments in Colorado. A new study shows that by 2030 a projected 600,000 Coloradans would lose their Medicaid eligibility and the state would cumulatively lose $14 billion given per capita allotments and eligibility restrictions.[ii] *CMS policy supports the Medicaid expansion.*

- Elimination of the individual and employer mandates – The bill effectively repeals both the individual and employer mandates in the ACA by zeroing out their tax penalties. In place of the individual mandate the ACHA creates a continuous coverage requirement that would place a 30% premium surcharge on those that have a gap in coverage over the past year for more than 63 days. The Congressional Budget Office and the Joint Committee on Taxation project that 14 million more people would be uninsured under the AHCA in 2018, and 52 million people would be uninsured by 2026 as compared with 28 million under the ACA. *CMS policy supports mandatory insurance coverage.*
- Modifies age-rating bands and changes premium and cost sharing subsidies for individuals – The bill changes the ACA 3:1 age-rating band to 5:1, allowing for older individuals to be charged five times the cost of the least generous plan for young individuals. Come 2020, the bill also repeals ACA tax credits and replaces them with advanceable, refundable, flat tax credits adjusted for age. These credits, which can be used on individual policies sold on or off the exchange, start at $2,000 for individuals up to age 29 and top out at $4,000 per person age 60 and older. The bill also repeals cost sharing subsidies within the ACA that help low-income individuals pay for out of pocket costs like high deductibles. About 180,000 Coloradans bought coverage through the state's health insurance exchange in 2016. Approximately 104,000 of them received federal subsidies to do so, with Western Slope counties having the highest proportion of residents that received ACA subsidies to buy insurance.[iii] *CMS policy does not support rate banding. The other proposed premium and cost sharing subsidy changes are inconsistent with CMS policy that emphasizes the use of sliding income scales to assist those most in need.*
- Creating the Patient and State Stability Fund – The bill creates a $100 billion fund over nine years for use by states for a number of purposes including financial assistance for high risk individuals, reinsurance to stabilize the individual market and promoting preventive care. *CMS policy supports innovative efforts to ensure coverage and encourage health and prevention. It is unclear what federal requirements would be included with such a fund, whether use of such funds could offset losses from federal funding of the Medicaid expansion and whether or not the state could raise the required 7% match starting in 2020 and phase up to 50% in 2026 to utilize this fund.*
- Eliminating the Prevention and Public Health Fund – The bill repeals the ACA's prevention and public health fund after 2018 and provides $422 million in supplemental funding for community health centers for 2017. These cuts are reported to decrease the budget for the Centers for Disease Control by 12%, in addition to eliminating $44.6 million of funding to Colorado over the next five years for use in battling epidemics and other prevention and wellness initiatives.[iv] *These cuts are inconsistent with CMS policy that emphasizes public health, prevention and wellness as critical health care cost containment strategies.*

The attached appendix file provides a more detailed summary of the American Health Care Act by the Henry J. Kaiser Family Foundation. Relevant CMS policy is noted and linked in the left hand margin in gray call out boxes.

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[i] Jost, Timothy. *Examining the House Republican ACA Repeal and Replace Legislation*. Accessed on 3/20/2017 at http://healthaffairs.org/blog/2017/03/07/examining-the-house-republican-aca-repeal-and-replace-legislation/

[ii] Colorado Health Institute. *ACHA Would Reduce Medicaid Rolls, Cut Billions in Funding for Colorado,* March 16, 2017.

[iii] Colorado Health Institute. *Impact of the Affordable Care Act.* March 2017 (update).

[iv] Trust for America's Health. *Colorado Could Lose More than $40 Million to Fight Health Epidemics over Five Years if the ACA and Prevention and Public Health Fund are Repealed*. Accessed on 3/20/2017 at https://www.healthyamericans.org/reports/prevention-fund-state-facts-2017/release.php?stateid=CO

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March 2017

Summary of the American Health Care Act

This summary describes key provisions of the American Health Care Act as approved by the House Ways and Means and Energy and Commerce Committees as a plan to repeal and replace the Affordable Care Act (ACA) through the Fiscal Year 2017 budget reconciliation process.

	American Health Care Act
Date plan announced	March 6, 2017
Overall approach	• Repeal ACA mandates (2016), standards for health plan actuarial values (2020), and, premium and cost sharing subsidies (2020). • Modify ACA premium tax credits for 2018-2019 to increase amount for younger adults and reduce for older adults, also to apply to coverage sold outside of exchanges and to catastrophic policies. In 2020, replace ACA income-based tax credits with flat tax credits adjusted for age. Eligibility for new tax credits phase at income levels between $75,000 and $115,000 • Retain private market rules, including requirement to guarantee issue coverage, prohibition on discriminatory premiums and pre-existing condition exclusions, requirement to extend dependent coverage to age 26. Modify age rating limit to permit variation of 5:1, unless states adopt different ratios, effective 2018. • Retain health insurance marketplaces, annual Open Enrollment periods (OE), and special enrollment periods (SEPs). • Impose late enrollment penalty for people who don't stay continuously covered. • Establish State Innovation Grants and Stability Program with federal funding of $100 billion over 9 years. States may use funds to provide financial help to high-risk individuals, promote access to preventive services, provide cost sharing subsidies, and for other purposes. In states that don't successfully apply for grants, funds will be used for reinsurance program. • Repeal funding for Prevention and Public Health Fund at the end of Fiscal Year 2018 and rescind any unobligated funds remaining at the end of FY2018. Provide supplemental funding for community health centers for $442 million for FY 2017 • Encourage use of Health Savings Accounts by increasing annual tax free contribution limit and through other changes • Eliminate enhanced FMAP for Medicaid expansion as of January 1, 2020 except for those enrolled as of December 31, 2019 who do not have a break in eligibility of more than one month • Convert federal Medicaid funding to a per capita allotment and limit growth beginning in 2020 using 2016 as base year • No change to Medicare benefit enhancements or provider/Medicare Advantage plan payment savings • Repeal Medicare HI tax increase and other ACA revenue provisions Prohibit federal Medicaid funding for Planned Parenthood clinics
Individual mandate 185.996 Health Systems Reform Evaluation Matrix-Inconsistent	• Tax penalty for not having minimum essential coverage is eliminated effective January 1, 2016 • Late enrollment penalty (30% of otherwise applicable premium) applies for individuals buying non-group coverage who have not maintained continuous coverage. Continuous coverage is assessed during a 12-month look back period prior to the date of enrollment in new coverage. If individual had a lapse in coverage of 63

consecutive days or longer during the look back period, late enrollment penalty applies during the plan year in which the individual enrolls in new non-group coverage. (For SEP, penalty applies for the remainder of the plan year). Late enrollment penalty is effective for special enrollments during the 2018 plan year, for all other enrollments beginning with the 2019 plan year. Private health plans continue to be required by law to provide certificates of creditable coverage; however, no requirement for governmental programs (e.g., Medicaid, CHIP, state high-risk pools) to provide such certificates.

Premium subsidies to individuals

185.998 Health System Reform
Inconsistent

- For 2018-2019, modify premium tax credits as follows:
  - Increase credit amounts for young adults with income above 150% FPL and decrease amounts for adults 50 and older above that income level.
  - For end of year reconciliation of advance credits, the cap on repayment of excess advance payments does not apply.
  - Tax credits cannot be used for plans that cover abortion.
  - Premium tax credits can be used to purchase catastrophic plans.
  - Premium tax credits can be used to purchase qualified health plans (i.e., covering essential health benefits) sold outside of the exchange, but are not advance-payable for such plans. Premium tax credits cannot be used to purchase grandfathered or grandmothered individual health insurance policies sold outside of the exchange.

185.993 Matrix Reform Plan
Inconsistent

- Starting in 2020, replace ACA income-based tax credits with flat tax credit adjusted for age. Credits are payable monthly; annual credit amounts are:
  - $2,000 per individual up to age 29
  - $2,500 per individual age 30-39
  - $3,000 per individual age 40-49
  - $3,500 per individual age 50-59
  - $4,000 per individual age 60 and older

  Families can claim credits for up to 5 oldest members, up to limit of $14,000 per year.

  Amounts are indexed annually to CPI plus 1 percentage point.

  U.S. citizens and legal immigrants who are not incarcerated and who are not eligible for coverage through an employer plan, Medicare, Medicaid or CHIP, or TRICARE, are eligible for tax credit. Married couples must file jointly to claim the credit. In addition, eligibility for the tax credit phases out starting at income above $75,000 (credit is reduced, but not below zero, by 10 cents for every dollar of income above this threshold; tax credit reduced to zero at income of $95,000 for single individuals up to age 29, $115,000 for individuals age 60 and older. For joint filers, credits begin to phase out at income of $150,000; tax credit reduced to zero at income of $190,000 for couples up to age 29; tax credit reduced to zero at income $230,000 for couples age 60 or older; tax credit reduced to zero at income of $290,000 for couples claiming the maximum family credit amount.)

  Taxpayers who are also enrolled in qualified small employer health reimbursement arrangements (HRA) that apply to non-group coverage will have tax credit reduced, but not below zero, by the amount of the HRA benefit.
- Premium tax credit can be applied to any eligible individual health insurance policy (but not grandfathered or grandmothered policies) sold on or off the exchange. In addition, credit can be applied to unsubsidized COBRA premiums. Eligible policies do not include those for which substantially all coverage is for excepted benefits; policies that cover abortion (with Hyde exceptions) are not eligible policies. States shall certify plans eligible for the credit; employer group health plan sponsors shall certify COBRA coverage eligible for the credit. The federal government must establish a program for making advance payment of tax credits no later than January 1, 2020; to

185.998 Health System Reform Inconsistent, 185.993 Matrix Reform Plan, Inconsistent, 185.996 Health Systems Reform Evaluation Matrix- Inconsistent

	the greatest extent practicable the program will use methods and procedures used for the ACA advance payable premium tax credit. • Excess credit amounts (above the actual cost of individual coverage or COBRA policy) are payable to health savings accounts.
Cost sharing subsidies to individuals	▪ ACA cost sharing subsidies are repealed effective January 1, 2020.
Individual health insurance market rules	• Require guaranteed issue of all non-group health plans during annual open enrollment. Insurers also must offer 60-day special enrollment periods (SEP) for individuals after qualifying events. Short-term non-renewable policies can continue to be sold using medical underwriting. • Continue ACA rating rules, except age rating of 5:1 is permitted starting January 1, 2018, unless states adopt a different ratio. Short-term non-renewable policies can continue to set premiums based on health status. • Prohibition on pre-existing condition exclusion periods is not changed. Short term non-renewable policies can continue to exclude pre-existing conditions
Benefit design	• ACA requirement to cover 10 essential health benefit categories is not changed. ACA requirement for maximum out of pocket limit on cost sharing is not changed. ACA requirement for plans to be offered at specified actuarial values/metal levels sunsets on 12/31/2019. • Prohibition on lifetime and annual dollar limits is not changed • Requirement for individual and group plans to cover preventive benefits with no cost sharing is not changed. • Requirement for all plans to apply in-network level of cost sharing for out-of-network emergency services is not changed • Prohibit abortion coverage from being required. Federal premium tax credits cannot be applied to plans that cover abortion services, beyond those for saving the life of the woman or in cases of rape or incest (Hyde amendment). Nothing prevents an insurer from offering or an individual from buying separate policies to cover abortion as long as no premium tax credits are applied.
Women's health	• ACA essential health benefit requirement for individual and small group health insurance policies is not changed, including requirement to cover maternity care as an essential health benefit. • Requirement for individual and group plans to cover preventive benefits, such as contraception and cancer screenings, with no cost sharing is not changed. • Prohibition on gender rating is not changed • Prohibition on pre-existing conditions exclusions, including for pregnancy, prior C-section, and history of domestic violence, is not changed. • Prohibit federal Medicaid funding for Planned Parenthood clinics for one year, effective upon date of enactment. Specifies that federal funds to states including those used by managed care organizations under state contract are prohibited from going to such entity. • Redefine qualified health plan to exclude any plan that covers abortion services, beyond those for saving the life of the woman or in cases of rape or incest (Hyde amendment), effective in 2018 • Prohibit federal premium tax credits from being applied to plans that cover abortion services, beyond Hyde limitations. Disqualify small employers from receiving tax credits if their plans include abortion coverage beyond Hyde limitations, effective in 2018. Does not prevent an insurer from offering or an individual from buying separate policies to cover abortion as long as no tax credits are applied.
Health Savings Accounts	• Modify certain rules for HSAs, changes take effect January 1, 2018: • Increase annual tax free contribution limit to equal the limit on out-of-pocket cost sharing under qualified high deductible health plans ($6,550 for self only coverage, $13,100 for family coverage in 2017, indexed for inflation). Excess premium tax credit amounts contributed to an HSA do not count against the contribution limit.

185.998 Health System Reform Inconsistent

185.998 Health System Reform - Consistent

185.996 Health Systems Reform Evaluation Matrix- Consistent

185.997 Ind Selected, Ind Owned Health Insurance- Consistent

	• Additional catch up contribution of up to $1,000 may be made by persons over age 55. Both spouses can make catch up contributions to the same HSA. • Amounts withdrawn for qualified medical expenses are not subject to income tax. Qualified medical expense definition expanded to include over-the-counter medications and expenses incurred up to 60 days prior to date HSA was established • Tax penalty for HSA withdrawals used for non-qualified expenses is reduced from 20% to 10%.
High-risk pools	• States may use Innovation and Stability Program grants to fund high-risk pools, and for other purposes
Selling insurance across state lines	• No provision
Exchanges/ Insurance through associations	• State exchanges continue, though premium tax credits can be used for eligible non- group policies regardless of whether they are sold through an exchange. Through 2019, tax credits are only advance payable for policies purchased through an exchange. • Single risk pool rating requirement for plans first sold on or after January 1, 2014 is not changed.
Dependent coverage to age 26	• Requirement to provide dependent coverage for children up to age 26 for all individual and group policies is not changed.
Other private insurance standards	• Minimum medical loss ratio standards for all health plans are not changed. • Requirement for all health plans to offer independent external review is not changed. • Requirements for all plans to report transparency data, and to provide standard, easy- to-read summary of benefits and coverage are not changed.
Employer requirements and provisions 185.996 Evaluation Matrix- Inconsistent	• Tax penalty for large employers that do not provide health benefits is reduced to zero, retroactive to January 1, 2016 • Wellness incentives permitted under the ACA are not changed • Repeal tax credits for low-wage small employers, effective January 1, 2020. Requires that small business tax credits cannot be used to purchase plans that cover abortions, beyond Hyde limitations, effective in 2018

Medicaid
 	
240.993 Medicaid Expansion- Inconsistent
 	
For reference see also 240.996 Medicaid Guiding Principles and 3/10/2017 CMS BOD policy on Medicaid Block Grants
	Financing
	• Codify that the Medicaid expansion is a state option upon enactment; eliminate option to extend coverage to adults above 133% FPL effective January 1, 2020; eliminate the enhanced match for the Medicaid expansion as of January 1, 2020 (except for individuals who were enrolled through the Medicaid expansion as of December 31, 2019 and who do not have a break in eligibility of more than one month).
	  ○ Limits the "expansion state" enhanced match rate transition percentage to CY 2017 levels of 80% (instead of phasing up the match to equal the ACA enhanced match rate by 2020).
	• Convert federal Medicaid financing to a per capita cap beginning in FY 2020.
	  ○ Per enrollee caps for five enrollment groups—elderly, blind and disabled, children, expansion adults, and other adults—are based on 2016 expenditures (excluding administrative costs, DSH, Medicare cost-sharing, and safety net provider payment adjustments in non-expansion states, and certain categories of individuals, including CHIP, those receiving services through Indian Health Services, those eligible for Breast and Cervical Cancer services, and partial- benefit enrollees) divided by full-year equivalent enrollees in each category and trended forward to 2019 by medical CPI.
	  ○ For states opting to adopt the Medicaid expansion after 2016, the per enrollee amount for this group would be the same as the other adult group under the per capita cap.

  - Per enrollee amounts are adjusted to exclude non-DSH supplemental payments
  - The target expenditures in 2020 are calculated based on the 2019 per enrollee amounts for each enrollment group adjusted for non-DSH supplemental payments and increased by medical CPI multiplied by the number of enrollees in each group. In 2021 and beyond, per enrollee amounts are based on the prior year amounts increased by medical CPI.
  - States with medical assistance expenditures exceeding the target amount for a fiscal year will have payments in the following fiscal year reduced by the amount of the excess payments.

- Provide 100% FMAP for MMIS and eligibility systems for FY 2018 and FY 2019 and increase other administrative matching to 60% for expenses related to implementing new data requirements.
- Repeal Medicaid DSH cuts for FY2020 - FY2025; exempt non-expansion states from DSH cuts for FY2018 - FY 2019
- Provide $10 billion over 5 years (CY2018 – CY 2022) to non-expansion states for safety-net funding (applies to states not adopting the expansion by July 1 of the previous year). Allotments based on 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. Payments 100% funded by the federal government in CY 2018-2021 and 95% in CY 2022. Payments to providers may not exceed providers' costs in providing health care services to Medicaid and uninsured patients. States receiving these funds in a year in which they also adopt expansion shall no longer be eligible to receive these funds in any subsequent year.

Other Changes

- Repeal the essential health benefits requirement for those receiving alternative benefit packages, including the expansion group, as of December 31, 2019.

240.993 Medicaid Expansion- Inconsistent

- Repeal increase in Medicaid eligibility to 138% FPL for children ages 6-19 as of December 31, 2019. The minimum federal income eligibility limit for these children will revert to 100% FPL.
- Repeal hospital presumptive eligibility provisions and presumptive eligibility for expansion adults, effective January 1, 2020
- Repeal enhanced FMAP for the Community First Choice Option to provide attendant care services effective January 1, 2020
- Prohibit federal Medicaid funding for Planned Parenthood for one year, effective upon date of enactment
- Require states to consider lottery winnings (and other lump sum payments including gambling winnings and liquid assets from an estate) as income over a period of months in determining Medicaid ineligibility for individual and spouse beginning, January 1, 2020. Secretary can establish hardship criteria and state can intercept lottery winnings for Medicaid recoupment.
- Eliminate 3-month retroactive coverage requirement (start eligibility "in or after" the month of application) beginning October 1, 2017.
- Eliminate reasonable opportunity period for citizenship/immigrant status verification and require documentation before enrolling in coverage and prohibit payments during reasonable opportunity periods with exceptions for people receiving Medicare, SSDI, SSI, foster care, born to a Medicaid eligible woman or other basis established by the Secretary for states that choose to offer reasonable opportunity periods, effective six months after enactment.

	• Require states to limit home equity to federal minimum (removes the option to expand the limit from $500,000 to $750,000 (adjusted for CPI), effective six months after the bill is enacted or longer if states must pass legislation to change. • Require eligibility redeterminations every 6 months for expansion enrollees beginning October 1, 2017. Expands civil monetary penalties up to $20,000 per individual for intentionally claiming Medicaid matching funds for an individual not eligible for expansion. Provide a temporary (10/1/17 through 12/31/19) five percentage point FMAP increase for expenditures directly related to complying with this provision.
Medicare	*Revenues* • Repeals the HI payroll tax on high earners, beginning after December 31, 2017 • Repeals the annual fee paid by branded prescription drug manufacturers, beginning after December 31, 2017 • Reinstates the tax deduction for employers who receive Part D retiree drug subsidy (RDS) payments to provide creditable prescription drug coverage to Medicare beneficiaries, beginning after December 31, 2017. *Coverage enhancements* ▪ ACA benefit enhancements (no-cost preventive benefits; phased-in coverage in the Part D coverage gap) are not changed *Reductions to provider and plan payments* ▪ ACA reductions to Medicare provider payments and Medicare Advantage payments are not changed *Other ACA provisions related to Medicare are not changed, including:* ▪ Increase Medicare premiums (Parts B and D) for higher income beneficiaries (those with incomes above $85,000/individual and $170,000/couple). ▪ Authorize an Independent Payment Advisory Board to recommend ways to reduce Medicare spending if the rate of growth in Medicare spending exceeds a target growth rate. ▪ Establish various quality, payment and delivery system changes, including a new Center for Medicare and Medicaid Innovation to test, evaluate, and expand methods to control costs and promote quality of care; Medicare Shared Savings Accountable Care Organizations; and penalty programs for hospital readmissions and hospital-acquired conditions.
State role **Reference 185.996 Health Systems Reform Evaluation Matrix and 185.994 System of care policy – Potentially consistent, unclear if sufficient funding to make up for expansion and coverage shortfall**	• States may determine age rating ratio; otherwise federal standard of 5:1 applies. • Establish new Patient and State Stability Fund. Funds can be used by states for financial help for high-risk individuals, to stabilize private insurance premiums, promote access to preventive services, provide cost sharing subsidies, and for other purposes. $100 billion over 9 years appropriated ($15 billion per year for 2018-2019, $10 billion per year for 2020-2026). In states that do not successfully apply for grants, innovation funds will be used for a default reinsurance program, administered by CMS, that will pay 75% of claims between $50,000 and 350,000 (starting in 2020, CMS Administrator can establish different reinsurance rate and claims thresholds.) State matching funding of 7% required in 2020, phasing up to 50% in 2026. A different state matching schedule applies for the CMS-administered default reinsurance program (10% in 2020, phasing up to 50% in 2024.) Grants cannot be made to a state unless it agrees to make matching funds available. Any remaining funds at year end will be re-allocated the following year to states for which allocations were made.

	• State option to establish a state based health insurance exchange remains, but premium and cost sharing subsidies to fund this program are repealed, effective January 1, 2020. • State consumer assistance/ombudsman program is not changed, and is not funded. • State option to establish a Basic Health Program is not changed. State option to obtain a five-year waiver of certain new health insurance requirements (Section 1332 waiver) is not changed. • States continue to administer the Medicaid program with Federal matching funds available up to the federal cap.

Financing
 	
185.996 Health Systems Reform Evaluation Matrix- Reference principle #5
	• ACA taxes repealed, effective January 1, 2018, except where otherwise noted:
	  • Tax penalties associated with individual and large employer mandate, reduced to zero effective on January 1, 2016
	  • Cadillac tax on high-cost employer-sponsored group health plans is suspended for tax years 2020 through 2024, no revenues shall be collected during this period
	  • Increase in Medicare payroll tax (HI) rate on wages for high-wage individuals; also 3.8% tax on unearned income for high-income taxpayers
	  • Tax on tanning beds
	  • Tax on health insurers
	  • Tax on pharmaceutical manufacturers
	  • Excise tax on sale of medical devices
	  • Provision excluding costs for over-the-counter drugs from being reimbursed through a tax preferred health savings account (HSA)
	  • Provision increasing the tax (from 10% to 20%) on HSA distributions that are not used for qualified medical expenses.
	  • Chronic care tax
	  • Codification of economic substance doctrine and penalties
	• Annual limit on contributions to Flexible Spending Accounts (FSAs) repealed
	• Annual limit on deduction for salary in excess of $1 million paid to employees of publicly held corporations repealed
	• Federal Medicaid funding capped, effective FY 2020; enhanced match for Medicaid expansion population eliminated beginning January 1, 2020; and Medicaid DSH cuts repealed, effective FY 2020

Sources of information	https://waysandmeans.house.gov/event/markup-budget-reconciliation-recommendations-repeal- replace-obamacare/ http://docs.house.gov/meetings/IF/IF00/20170308/105679/BILLS-115-CommitteePrint-W000791-Amdt-1.pdf