

The American Health Care Act: What Does It Mean for the ADHD Community?

Executive Summary

The House of Representatives had been preparing to vote on the American Health Care Act (AHCA), which would repeal significant portions of the Affordable Care Act (ACA or “Obamacare”) and replace them with alternative coverage policies. At this time, the House is not moving forward with a vote on the AHCA.

The Congressional Budget Office (CBO) has released official estimates showing that the AHCA would reduce the deficit by \$150 billion over ten years. The CBO further estimates that elimination of the individual and employer mandates under the AHCA will result in 14 million fewer people having health care coverage in 2018. By 2026 this number would increase to about 24 million due to changes under the AHCA to the Medicaid program and to tax credits for individuals purchasing private market insurance. These estimates reflect changes included in an original “manager’s amendment” to the bill, but do not reflect additional changes to eliminate essential health benefit requirements.

Under the AHCA, a number of core elements of the ACA would be repealed, modified, or replaced—and many would be left alone. The AHCA would impact coverage under Medicaid, individual and small group markets, and to a lesser extent employer-sponsored insurance. This bill would have little impact on other governmental programs like Medicare for seniors, Veterans’ coverage, and TRICARE for active service members and their families.

This Executive Summary provides highlights of what the AHCA does. For a more complete explanation of the AHCA, look at the headings in the main text below to find what interests you.

- *Individual and employer “mandates”* – Current law requires individuals to maintain qualifying health insurance coverage (which includes coverage under government programs like Medicaid) or pay a penalty. Current law requires employers with 50 or more full-time employees to provide qualifying health insurance to their employees or pay a penalty per employee. The AHCA repeals both mandates.
- *Continuous coverage rule* – To achieve the goal of the individual mandate, the bill imposes a 30 percent penalty on insurance premiums for anyone who goes without coverage for 63 days or longer during the prior 12 months (the continuous coverage rule). Individuals with ADHD who obtain health insurance in the individual market will need to pay very close attention to deadlines to avoid coverage lapse.
- *Popular insurance market reforms* – Currently, health insurers cannot deny health insurance coverage or charge higher premiums based on having a “preexisting

condition,” like ADHD diagnosed before an individual buys health insurance. The AHCA does not impact these preexisting condition rules and other existing rules requiring insurers to offer dependent coverage until 26; prohibiting annual and lifetime limits on the amount of coverage offered; and prohibiting discrimination based on race, nationality, disability, age or sex.

- *Essential Health Benefits* – Currently, all plans sold on the individual and small group markets, as well as Medicaid plans, must cover essential health benefits (EHBs), which include treatments for mental health, behavioral health and substance use disorder. The AHCA repeals EHB requirements for both the private market and the Medicaid expansion population (defined below). The indirect effect of eliminating EHBs from the private market also weakens rules imposing on out-of-pocket maximums and prohibiting annual and lifetime caps on coverage. Individuals with ADHD who are covered by individual market plans or are on Medicaid, including Medicaid managed care plans, should pay close attention to the categories of care their plans cover to be sure they continue to cover mental health prescription drugs and services.
- *Actuarial Value* – The AHCA repeals the actuarial value (AV) metal levels—gold, silver, and bronze—for example, gold plans pay 80% of costs; enrollees pay 20%; so insurers would have more flexibility to charge higher co-pays and deductibles for EHBs. Many insurers will likely offer plans with lower monthly premiums but higher out-of-pocket expenses. Individuals with ADHD should pay close attention when comparing plans to evaluate coverage for items and services they need, such as particular branded medications, some of which are likely to increase in cost to enrollees.
- *Premium tax credits and cost-sharing reduction payments* – Currently, the federal government provides subsidies (called “premium tax credits”) to help low-income individuals pay for health insurance premiums. The AHCA repeals the individual premium tax credits based on income and replaces them with tax credits based primarily on age. However, this new premium tax credit is phased out based on income (above \$75,000 for individuals and above \$150,000 for joint filers). Individuals and families with higher household incomes will not be eligible for these new tax credits, and those with lower incomes will receive lower subsidies than under current law.
 - Under the AHCA, use of federal tax credits to subsidize health coverage would no longer be limited to “qualified health plans,” (plans meeting federal exchange regulations). Individuals could purchase a wider variety of plans but could unwittingly enroll in plans that lack the consumer protections in the qualified health plans, such as mandatory coverage for EHBs, maximum out-of-pocket limits, and prohibitions on annual and lifetime limits. Individuals with ADHD who require access to specific items and services, particularly mental and behavioral services, should pay attention to whether they are enrolling in qualified coverage.

- Currently, individuals below certain income levels who purchase a “silver plan” also receive cost-sharing reduction payments that help to reduce, or even totally eliminate, the deductible required by a health insurance plan. The AHCA would eliminate these payments beginning in 2020.
- *Expanded Health Savings Accounts (HSAs)* – The AHCA increases the maximum tax-subsidized amounts that can be contributed to HSAs, expands their use, and reduces the penalties for using HSA funds on non-health care expenses.
- *Medicaid expansion provisions* – Current law provides federal funding to states to expand eligibility for Medicaid from a state’s previous eligibility level to include individuals earning up to 138 percent of the federal poverty level. The AHCA would phase out this additional federal funding for “Medicaid expansion” by 2020. Under a manager’s amendment offered by the bill’s authors, the phase-out of Medicaid expansion would be accelerated to 2017, and no additional states would be permitted to expand their programs. It would also cap Medicaid eligibility for children at 100 percent of the federal poverty level.
- *Medicaid financing reform* – The biggest change to Medicaid under the AHCA—which is estimated to save the federal government \$880 billion over ten years—would replace the current mandatory federal matching funds for state Medicaid programs with one that imposes a flat cap per Medicaid enrollee based on 2016 spending. Under the manager’s amendment, states could also opt to receive “block grants” in lieu of per capita caps and establish their own rules for eligibility and coverage.
- *Medicare provisions* – The AHCA does not change Medicare, but is estimated to cause the Medicare Trust Fund to become insolvent sooner than current law.

As you are likely aware, Congress has recently been considering legislation to repeal and replace the Affordable Care Act (ACA). Because CHADD is an ADHD educational, not a political organization, we view our role as primarily to educate our members and the broader ADHD community about how different reform proposals could impact coverage and access to treatments for ADHD. If there are specific policy proposals that will improve the lives of our constituencies, CHADD will advocate for those changes.

In the current political environment, many Americans are feeling impassioned to take a stand and engage in federal policymaking debates. At CHADD, we think that is great and—when done in an informed and respectful way—should be encouraged. We believe it is CHADD’s job to provide you, our member, and the public with the ADHD-specific information to help you inform your own opinions and decide whether and how to engage in the political process.

Background on the Legislative Process

On March 6, 2017, the House Energy & Commerce Committee and the House Ways & Means Committee released bills, that, together repeal significant portions of the ACA and replace them with alternative provisions. The legislation, called the American Health Care Act (AHCA), was introduced pursuant to reconciliation instructions in the fiscal year (FY) 2017 budget bill. The committees marked up the legislation on March 8-9 and advanced the bills. The two bills were then combined at the House Budget Committee, which also advanced the bills. A “manager’s amendment” to the bill was adopted that would freeze Medicaid expansion at the end of 2017, allow states to impose work requirements for able-bodied adults on Medicaid, and allow states into block-grant financing of their Medicaid programs, among other programmatic changes. It would also accelerate repeal of the ACA’s various taxes, repealing many of them retroactively to the beginning of the year. On March 24, House leadership canceled a scheduled vote on the legislation and the outlook for ACA repeal and replace efforts remains uncertain.

The AHCA would not repeal the ACA in its entirety. Instead, given the procedural restraints of the budget reconciliation process, the AHCA would repeal or modify core revenue and spending provisions of the ACA, including income-based premium subsidies to assist with the purchase of insurance coverage, the Medicaid expansion, industry and excise taxes, and the individual and employer mandate penalties. ACA titles affecting Medicare, delivery systems reforms, program integrity and biosimilars are left in place. The bill also does not repeal key insurance reforms such as mandatory coverage of preexisting conditions, guaranteed availability and renewability of coverage, coverage of dependents up to age 26, and prohibitions against health status underwriting, lifetime and annual limits, discrimination and the essential health benefits.

Although the AHCA has suffered major political setbacks, there are still efforts underway to revive its consideration, albeit with significant changes. The Congressional Budget Office (CBO) released official estimates showing that the AHCA would reduce the deficit by \$150 billion over ten years. More specifically, the bill would reduce direct federal spending on health care programs by \$1,150 billion, which is largely offset by a reduction in \$999 billion in tax revenues. CBO further estimates that elimination of the individual and employer mandates will result in 14 million fewer people having health care coverage in 2018; and by 2026 this number would increase to about 24 million due to changes to the Medicaid program and to tax credits for individuals purchasing private market insurance.

What will change?

A number of the core elements of the ACA would be repealed or modified, some with “replacement” proposals, and there are many elements of the ACA that the AHCA leaves intact.

- *Individual and employer mandates* – The AHCA zeros out the penalties associated with the individual and employer mandates, effective for the 2016 tax year.
- *Cost-sharing reduction payments and premium tax credits* – In 2020, the AHCA repeals the ACA’s refundable tax credits that are provided by the federal government to help low-

income individuals pay for qualified coverage, as well as the cost-sharing reduction payments to insurers that were designed to reduce out-of-pocket costs (e.g., annual deductibles and co-pays) for lower-income enrollees.

- *Small-employer tax credit* – The AHCA repeals ACA tax credits for small businesses in 2020.
- *Federal actuarial value (AV) standards and age rating rules* – The AHCA ends the AV requirements beginning in 2020, allowing for greater flexibility in the amount of coverage an insurance plan must provide. The provisions also allow states to permit age ratios of 5 to 1 (instead of the ACA’s 3 to 1 limit) beginning in 2018. This means that plans could charge older enrollees up to five times as much as younger enrollees.
- *Essential Health Benefits (EHBs)* – Beginning in 2018, the AHCA eliminates federal rules requiring plans sold on the individual and small group markets offer EHBs—ten categories of benefits including maternity and newborn care, mental health services and addiction treatment, and prescription drugs—leaving these decisions to the states. A spillover effect of eliminating federal EHB rules is to undermine current prohibitions on insurers imposing annual and lifetime caps, as well as imposing out-of-pocket maximums, all of which are tied to the EHBs. The bill would also sunset the EHB requirement in Medicaid expansion in 2020.
- *Taxes on industry groups* – The AHCA repeals the ACA’s medical devices tax, prescription medications tax, tanning tax, net investment tax, over-the-counter medications tax (effective 2018), health insurance tax and the \$500,000 cap on deductions for insurance company executive pay. A manager’s amendment to the bill makes all these tax cuts effective retroactively to the beginning of 2017).
- *Medicare tax on higher-income individuals* – The AHCA repeals the tax imposed on unearned income of taxpayers earning more than \$200,000 (\$250,000 for joint filers) and the ACA’s Medicare 0.9% tax surcharge on taxpayers with incomes exceeding \$200,000 (\$250,000 for joint filers) beginning in 2023.
- *Medicaid expansion provisions* – The AHCA repeals the state option to expand Medicaid for newly eligible individuals and non-pregnant childless adults up to 138% of the Federal Poverty Level (FPL), and it modifies and repeals the enhanced match rate available for newly eligible individuals as of December 31, 2019. States can keep the enhanced match for newly eligible expenditures that occur before January 1, 2018, but, after that date, a state could enroll newly eligible individuals only at the state’s traditional Federal Medical Assistance Percentage (FMAP) matching rate for that individual. Under the manager’s amendment, the phase-out of Medicaid expansion was accelerated to the end of 2017, and no additional states would be permitted to expand their programs.
- *Traditional Medicaid funding formula* – Beginning in FY 2020, the federal government would fund state Medicaid programs under a per capita cap model. Each state’s targeted

amount is based on FY 2016 spending for each “1903A enrollee category,” which include: children under 19; adults age 65 and over; blind and disabled enrollees; expansion enrollees (non-pregnant adults); and other nonelderly, nondisabled, non-expansion adults.

- *Optional Block Grants* – Under the manager’s amendment, states could also opt to receive “block grants” in lieu of per capita caps for two subpopulations of their Medicaid programs: children and non-disabled, non-elderly adults. The formula for determining the amount of funding the state receives from the federal government would be the same as under the per capita formula, but states would have greater flexibility to set eligibility rules and determine what items and services will be covered under Medicaid. To avoid political wavering, states would have to accept block grants for 10 years at a time.
- *Presumptive eligibility* – The AHCA repeals state authority to make presumptive Medicaid eligibility determinations, except in cases of children, pregnant women, and breast and cervical cancer patients. States with Medicaid expansion populations would also be required to re-determine the eligibility of those enrollees every 6 months beginning on October 1, 2017, and would receive additional federal funding in connection with these efforts.
- *Medicaid work requirements* – Under the manager’s amendment, states would be permitted to impose requirements on able-bodied Medicaid applicants and enrollees age 19 to 64 to provide proof of maintaining or seeking employment or certain types of work-related training, but not post-secondary education (e.g., community college). States would receive a 5 percent increase in federal funding to their Medicaid program (for one year) to implement the work requirement.
- *Prevention fund* – The AHCA cuts off funding for the Prevention and Public Health fund after 2017.

What are the “replacement” elements?

- *Continuous coverage incentive* – Beginning in open enrollment for benefit year 2019 (and in 2018 for special enrollment period applicants), the AHCA calls for a flat 30% late-enrollment surcharge that issuers will assess on applicants who went without coverage for longer than 63 days during a 12-month lookback period.
- *Expanded Health Savings Accounts (HSAs)* – Effective for 2018, the AHCA increases the maximum tax-subsidized amounts that can be contributed to HSAs to the amount of the out-of-pocket limits, allows both spouses to make catch-up contributions to the same HSA, and allows HSAs to cover medical expenses incurred up to 60 days before HSA coverage begins.
- *Age-based tax credits* – The AHCA repeals the ACA’s individual means-based premium tax credits in 2019 and replaces them with new age-adjusted tax credits. Beginning in 2020, the credits are available for individuals purchasing insurance in the individual

market. The amount of the monthly credit is based on age, and it is refundable and advanceable. If an individual's monthly premiums are less than the total allowed amount, the excess may be paid into an HSA. In response to pushback on the leaked February 10 draft, the drafters added a provision that phases out the credit above a certain income (\$75,000 for individuals and \$150,000 for joint filers). This means that wealthier Americans will not be eligible for the credit. The manager's amendment also includes \$1 billion for an "American Health Care Implementation Fund" to allow for additional modifications to the premium tax credit to help certain individuals afford coverage.

What would stay?

- *Popular insurance market reforms* – The AHCA maintains rules requiring issuers to offer dependent coverage until 26; pre-existing conditions protections; prohibitions on annual and lifetime limits; and the prohibition of discrimination based on race, nationality, disability, age or sex.
- *Cadillac tax* – The AHCA does not fully repeal the so-called "Cadillac tax" on high-cost group health plans, but delays implementation until January 1, 2026. Under current law, employers and insurers whose coverage exceeds a statutory amount (currently \$10,200 for an individual; \$27,500 for a family) must pay a 40% excise tax for every dollar above those thresholds.
- *Medicare provisions* – The AHCA leaves the Medicare title of the ACA untouched, meaning that the cuts impacting certain providers and Medicare Advantage plans, as well as the Center for Medicare and Medicaid Innovation and value-based payment programs, would remain in effect. The repeal of the Medicare payroll tax on higher-income earners is estimated to shorten the solvency of the Medicare Trust Fund.

How could these changes impact coverage for ADHD-related care?

Several provisions of the AHCA could impact access to ADHD-related care, so if the law passes, individuals and families with ADHD should be cognizant of these issues:

- The AHCA eliminates the AV metal levels (e.g., gold plans cover 80 percent of costs) to create greater flexibility for insurers who want to charge higher co-pays and deductibles than permitted under the ACA. It is unknown exactly how insurers will respond to these newfound flexibilities, but it is likely many will offer plans with lower monthly premiums but higher out-of-pocket expenses. Therefore, individuals should pay close attention when comparing plans to evaluate coverage for items and services, some of which are likely to increase in cost to enrollees. Those who need coverage for specific items, such as particular branded medications, should pay careful attention to the different cost-sharing tiers of pharmacy benefits for example.
- The use of federal tax credits to subsidize health coverage is no longer limited to "qualified health plans," or those meeting the insurance regulations of the ACA. This will

give individuals the flexibility to purchase a wider variety of plans, but also means that individuals could unwittingly end up enrolled in plans that lack these consumer protections, such as mandatory coverage for essential health benefits and prohibitions on annual and lifetime limits. Individuals who require access to specific items and services, particularly mental and behavioral services, should pay attention to whether they are enrolling in qualified coverage.

- The AHCA's continuous coverage rule imposes an extra 30 percent surcharge on insurance premiums in the individual market for anyone who has a lapse in health insurance coverage of 63 days or longer. While this replaces the ACA's individual mandate, the amount of the government-mandated penalty for failing to maintain continuous coverage will actually be higher for most enrollees. Thus, individuals with ADHD securing commercial health insurance should pay very close attention to deadlines to ensure their coverage does not lapse.
- The AHCA repeals EHBs for individual market and Medicaid plans. It is likely that a number of commercial market and Medicaid managed care plans will opt not to cover certain EHBs, and therefore cease covering mental health prescription drugs and services. Additionally, elimination of federal EHB rules could also result in much higher out-of-pocket costs associated with certain categories of items and services. Therefore, individuals with ADHD should pay close attention to the categories of care their plans cover, as well as any caps on the amount of coverage for different categories of care.

How could the AHCA impact coverage for my family?

Like the ACA, how this bill will impact coverage for individuals and families depends foremost on the type of coverage you currently have. The AHCA's changes have the greatest impact on the individual and small group markets for private health insurance and, after that, on low-income families on Medicaid and CHIP. The bill will have much less of an impact on employer-sponsored coverage and almost no impact on other governmental programs like Medicare for seniors, Veterans' coverage, and TRICARE for active service members and their families.

Below is a preliminary assessment of how the AHCA could impact eligibility and enrollment in different types of coverage.

- *Commercial Insurance (Individual and Small Group Markets)*

The AHCA repeals the premium subsidies and small business tax credits that the ACA included to make health insurance more affordable for low-income people and others not obtaining coverage through their employer. In place of these subsidies, AHCA creates a flexible-use tax credit that allows consumers to purchase any state-approved health insurance coverage. The tax credit is refundable (meaning you do not need to owe taxes to receive it) and advanceable (meaning it can be paid directly to the insurance company on a monthly basis to reduce the amount of insurance premiums) for US citizens or

nationals enrolled in state-approved individual health insurance and not eligible for employer coverage or government programs. Unlike the ACA’s income-based subsidies, which went up to 400% of the federal poverty level (FPL) the AHCA tax credits vary based on age (*see* Table 1):

The full amount of the tax credits will be available to eligible individuals earning less than \$75,000 and households earning less than \$150,000, but are phased out for higher earners—for each \$1,000 in additional income above the threshold, a person would be entitled to \$100 less in credit. Additionally, the ACA’s cost-sharing subsidies for low-income enrollees up to 250% FPL are repealed in 2020, so all co-pays and deductibles must be covered out-of-pocket.

Most low-income families will find these tax credits far less generous than the ACA’s subsidies, and some may find them wholly inadequate to afford coverage. Higher-income families earning under about \$200,000 (depending on the number of eligible household members) will find the tax credit more generous than the ACA, and be able to afford insurance premiums more easily as a result.

TABLE 1: AHCA TAX CREDITS	
Age Range	Amount of Tax Credit
Under 30	\$2,000
30 – 39	\$2,500
40 – 49	\$3,000
50 – 59	\$3,500
Over 60	\$4,000

➤ *Medicaid*

Under the AHCA, states may retain ACA’s expanded eligibility for Medicaid only until the end of 2019 (and, as noted above, there is an effort to amend this provision to sunset Medicaid expansion at the end of 2017), meaning that childless adults and other families earning above 100% FPL will no longer be eligible for Medicaid in any state, and may remain on Medicaid only if they maintain continuous coverage. States will also be incentivized to re-verify Medicaid eligibility every 6 months. For children under age 19, the AHCA reverts the mandatory income eligibility level back to the pre-ACA level of 100% FPL, meaning that states would need to cover children above this income level through CHIP. Additionally, the AHCA replaces the current financing system with a new “per capita cap” structure that would limit federal matching payments to states that spend more than their targeted amounts in a given year. Under the manager’s amendment, states

could also opt to receive block-grant funding in lieu of per capita caps for ten years at a time for children and non-disabled, non-elderly adults on Medicaid. States would have greater flexibility to set eligibility rules and determine what items and services will be covered under Medicaid. The amendment also incentivizes states to impose work requirements on able-bodied adults receiving Medicaid.

Individuals in this income range (*see* Table 2) should carefully track how states respond to these tightened eligibility requirements and reduced federal funding. Individuals earning above 100% FPL should either ensure they do not lapse in their Medicaid coverage or prepare to seek private insurance. Families earning above 100% FPL should explore other coverage options for their minor children, including CHIP or private coverage.

TABLE 2: FEDERAL POVERTY LEVEL (2017)			
Size of Household	Percent FPL		
	100%	250%	400%
1	\$11,880	\$29,700	\$47,550
2	\$16,020	\$40,050	\$64,100
3	\$20,160	\$50,400	\$84,650
4	\$24,300	\$60,750	\$97,200
5	\$28,440	\$71,100	\$113,800

➤ *Employer-Sponsored Coverage*

Health insurance coverage provided through employment is only indirectly affected by the AHCA. Although some in Congress want to enact additional flexibilities for work-based coverage, these reforms are largely beyond the scope of the AHCA. Most notably, the bill repeals the ACA’s employer mandate, which requires that large employers either provide their full-time employees with health insurance or pay a per-employee tax to the government. Separately, the bill delays the Cadillac tax by 6 years, which will provide reprieve to many employers whose plans were quickly approaching the maximum dollar-limit imposed under the ACA. A prior leaked draft of the AHCA would have imposed a cap on the exclusion from taxable income for employer-sponsored coverage. This provision was removed from the current bill as Congressional Leaders have indicated their intention to deal with this exclusion through comprehensive tax reform.

Individuals in employer coverage need not do anything different under the AHCA, but those who work for large employers may see differences in the coverage options offered through work. The delay of the Cadillac tax will help employers provide more options that do not shift costs onto the individual employees. Conversely, the repeal of the employer mandate will prompt some employers to stop providing health insurance benefits altogether.

A final core element of the AHCA is aimed at making coverage more flexible through the use of health savings accounts (HSAs). The AHCA expands the ways that HSAs can be used and would allow individuals to contribute substantially more money into their HSAs (approximately doubling the current limits for individuals to \$6,550 and for families to \$13,100 in 2018).

CHADD's Assessment of the AHCA

Like its membership, and the broader ADHD community, CHADD is a diverse organization that welcomes all different people with all different views—what unites us is our commitment to advancing the interests of children and adults with ADHD. CHADD's leadership, public policy team, and consultants have concerns with specific aspects of the AHCA. We are concerned that some provisions of the current bill could complicate access to treatment for ADHD among certain subsets of the population. Low-income communities, in particular, are likely to have a harder time finding affordable coverage options and more individuals are expected to end up uninsured. Per capita caps and block grants would put significant fiscal pressures on state Medicaid budgets and force them to find ways to reduce spending, including restricting access to branded medications. With EHBs eliminated, we are also concerned that it would be easier for insurance companies to discriminate against individuals with certain conditions, such as ADHD.

There are other aspects of the legislation, however, that give us encouragement that many individuals and families with ADHD may find additional flexibilities that meet their families' needs, and possibly at a lower price than their coverage today. It is too early to tell whether these new incentive will be effective at getting individuals to enroll in coverage.

It is important to keep in mind that the ACA, or Obamacare, did not solve all of the health insurance problems that people with ADHD experience. CHADD conducted a survey on health insurance experiences in 2016, and we found that many respondents continued to face major hurdles in accessing the ADHD treatments and services they or their family members desired. It is also worth keeping in mind that ACA did not create all of the problems that people experience in their health coverage, such as ever-increasing premiums.

On balance, we are not convinced that most individuals and families with ADHD will be better off under the AHCA than they are today, especially those with lower incomes, and therefore CHADD is not endorsing the legislation at this time. However, we believe that some people with ADHD may be better off and many will at least be no worse off, and therefore we are not working to prevent the bill's advancement through the legislative process. Given our concerns about the potential impact of certain provisions, we will continue to closely monitor

developments relating to the bill, if legislative efforts are revived, and will be prepared to provide our perspective to policymakers where we think we may have an opportunity to positively influence the legislation for our members and the broader ADHD community.

Need Additional Information?

- If you want to learn more about the bill, you can read the current version on the House Committee on Rules' website (<http://docs.house.gov/billsthisweek/20170320/BILLS-115hrPIH-AHCA.pdf>) and can view the Congressional Budget Office analysis on their website (<https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/americanhealthcareact.pdf>).
- If you want access to other summaries and analysis, we recommend the following sources known for objective information about health legislation: *Kaiser Family Foundation* (http://kff.org/tag/aca-repeal/?utm_source=web&utm_medium=trending&utm_campaign=ACA-repeal); *Modern Healthcare* (<http://www.modernhealthcare.com/>); *Politico* (<http://www.politico.com/health-care>); *Health Affairs* (<http://healthaffairs.org/blog/>).
- If you would like to make your own voice heard, you can look-up your House Representative by zip code here: www.house.gov, and your Senators by state here: www.senate.gov.
- If you would like more information about CHADD's public policy initiatives, please contact CHADD's Chief Operating Officer, April Gower-Getz, at april_gower@chadd.org.

* * * * *

TABLE 3: BRIEF SUMMARY OF MAJOR PROVISION CHANGES

Provision	Repeal/Change/Retain	Effective Date
Individual and Employer Mandates	Repealed and Replaced with incentives to maintain “continuous coverage”	On Enactment
Individual premium and small business tax credits	Changed to age-adjusted fixed dollar credits with income limitations	December 31, 2019
Taxes (incl. HIT, medical device, drug manufactures)	Repealed	December 31, 2017 and some in 2018
Cost-sharing reduction payments	Repealed	2020
Medicaid Coverage Expansion	Repealed state option to expand Medicaid	Dec. 31, 2019
Enhanced match funding to states that expanded Medicaid	Repealed and changed funding to a per capita cap structure	2020
Limits on HSAs	Changed by expanding flexibility	December 31, 2017
“Cadillac Tax”	Retained	Delay implementation until 2025
Essential Health Benefits	Retained (except for Medicaid expansion population)	For Medicaid population, sunset in 2019
Dependent coverage until 26	Retained	
Insurance Protections (prohibition on annual and lifetime limits, pre-existing conditions, and discrimination)	Retained	