



## Summary of Senate Republicans' Obamacare Legislation

By Chris Jacobs, Senior Healthcare Policy Analyst, Texas Public Policy Foundation

On June 22, Senate leadership released a [discussion draft](#) of their Obamacare “repeal-and-replace” bill, the Better Care Reconciliation Act. A detailed summary of the bill is below, along with possible conservative concerns where applicable. Where provisions in the bill were also included in the reconciliation bill passed by Congress early in 2016 (H.R. 3762, text available [here](#)), differences between the two versions, if any, are noted.

Of particular note: It is unclear whether this legislative language has been fully vetted with the Senate Parliamentarian. When the Senate considers budget reconciliation legislation—as it plans to do with the Obamacare “repeal-and-replace” bill—the Parliamentarian advises whether provisions are budgetary in nature and can be included in the bill (which can pass with a 51-vote simple majority), and which provisions are not budgetary in nature and must be considered separately (i.e., require 60 votes to pass).

In the absence of a complete bill and CBO score, it is entirely possible the Parliamentarian has not fully vetted this draft—which means provisions could change substantially, or even get stricken from the bill, due to procedural concerns as the process moves forward.

### Full Analysis

#### Title I

**Revisions to Obamacare Subsidies:** Modifies eligibility thresholds for the current regime of Obamacare subsidies. Under current law, households with incomes of between 100-400 percent of the federal poverty level (FPL, \$24,600 for a family of four in 2017) qualify for subsidies. This provision would change eligibility to include all households with income under 350% FPL—effectively eliminating the Medicaid “coverage gap,” whereby low-income individuals (those with incomes under 100% FPL) in states that did not expand Medicaid do not qualify for subsidized insurance.

Clarifies the definition of eligibility by substituting “qualified alien” for the current-law term “an alien lawfully present in the United States” with respect to the five-year waiting period for said aliens to receive taxpayer-funded benefits, per the welfare reform law enacted in 1996.

Changes the bidding structure for insurance subsidies. Under current law, subsidy amounts are based on the second-lowest silver plan bid in a given area—with silver plans based upon an actuarial value (the average percentage of annual health expenses covered) of 70

## Summary of Senate Republicans' Obamacare Legislation

percent. This provision would base subsidies upon the “median cost benchmark plan,” which would be based upon an average actuarial value of 58 percent.

Modifies the existing Obamacare subsidy regime, by including age as an additional factor for determining subsidy amounts. Younger individuals would have to spend a smaller percentage of income on health insurance than under current law, while older individuals would spend a higher percentage of income. For instance, an individual under age 29, making just under 350% FPL, would pay 6.4% of income on health insurance, whereas an individual between ages 60-64 at the same income level would pay 16.2% of income on health insurance. (Current law limits individuals to paying 9.69% of income on insurance, at all age brackets, for those with income just below 400% FPL.)

Lowers the “failsafe” at which secondary indexing provisions under Obamacare would apply. Under current law, if total spending on premium subsidies exceeds 0.504% of gross domestic product annually in years after 2018, the premium subsidies would grow more slowly. (Additional information available [here](#), and a Congressional Budget Office analysis available [here](#).) This provision would reduce the overall cap at which the “failsafe” would apply to 0.4% of GDP.

Eliminates subsidy eligibility for households eligible for employer-subsidized health insurance. Also modifies definitions regarding eligibility for subsidies for employees participating in small businesses' health reimbursement arrangements (HRAs).

Increases penalties on erroneous claims of the credit from 20 percent to 25 percent. Applies most of the above changes beginning in calendar year 2020.

Beginning in 2018, changes the definition of a qualified health plan, to prohibit plans from covering abortion other than in cases of rape, incest, or to save the life of the mother. Some conservatives may be concerned that this provision may eventually be eliminated under the provisions of the Senate's “Byrd rule,” therefore continuing taxpayer funding of plans that cover abortion. (For more information, see these [two articles](#).)

Eliminates provisions that limit repayment of subsidies for years after 2017. Subsidy eligibility is based upon estimated income, with recipients required to reconcile their subsidies received with actual income during the year-end tax filing process. Current law limits the amount of excess subsidies households with incomes under 400% FPL must pay. This provision would eliminate that limitation on repayments, which may result in fewer individuals taking up subsidies in the first place.

Some conservatives may be concerned first that, rather than repealing Obamacare, these provisions actually expand Obamacare—for instance, extending subsidies to some individuals currently not eligible, and fixing the so-called “family glitch.” Some conservatives may also be concerned that, as with Obamacare, these provisions will create disincentives to work that would [reduce the labor supply](#) by the equivalent of millions of jobs. Finally, as noted above, some conservatives may believe that, as with Obamacare

## Summary of Senate Republicans' Obamacare Legislation

itself, enacting these policy changes through the budget reconciliation process will prevent the inclusion of strong pro-life protections, thus ensuring continued taxpayer funding of plans that cover abortion.

**Small Business Tax Credit:** Repeals Obamacare's small business tax credit, effective in 2020. Disallows the small business tax credit beginning in 2018 for any plan that offers coverage of abortion, except in the case of rape, incest, or to protect the life of the mother—which, as noted above, some conservatives may believe will be stricken during the Senate's "[Byrd rule](#)" review. *This language is substantially similar to Section 203 of the 2015/2016 reconciliation bill, with the exception of the new pro-life language.*

**Individual and Employer Mandates:** Sets the individual and employer mandate penalties to zero, for all years after December 31, 2015. *This language is similar to Sections 204 and 205 of the 2015/2016 reconciliation bill.*

**Stability Funds:** Creates two stability funds intended to stabilize insurance markets—the first giving funds directly to insurers, and the second giving funds to states. The first would appropriate \$15 billion each for 2018 and 2019, and \$10 billion each for 2020 and 2021, (\$50 billion total) to the Centers for Medicare and Medicaid Services (CMS) to “fund arrangements with health insurance issuers to address coverage and access disruption and respond to urgent health care needs within States.” Instructs the CMS Administrator to “determine an appropriate procedure for providing and distributing funds.” Does not require a state match for receipt of stability funds.

Creates a longer term stability fund with a total of \$62 billion in federal funding—\$8 billion in 2019, \$14 billion in 2020 and 2021, \$6 billion in 2022 and 2023, \$5 billion in 2024 and 2025, and \$4 billion in 2026. Requires a state match beginning in 2022—7 percent that year, followed by 14 percent in 2023, 21 percent in 2024, 28 percent in 2025, and 35 percent in 2026. Allows the Administrator to determine each state's allotment from the fund; states could keep their allotments for two years, but unspent funds after that point could be re-allocated to other states.

Long-term fund dollars could be used to provide financial assistance to high-risk individuals, including by reducing premium costs, “help stabilize premiums and promote state health insurance market participation and choice,” provide payments to health care providers, or reduce cost-sharing. However, all of the \$50 billion in short-term stability funds—and \$15 billion of the long-term funds (\$5 billion each in 2019, 2020, and 2021)—must be used to stabilize premiums and insurance markets. The short-term stability fund requires applications from insurers; the long-term stability fund would require a one-time application from states.

Both stability funds are placed within Title XXI of the Social Security Act, which governs the State Children's Health Insurance Program (SCHIP). While SCHIP has a statutory prohibition on the use of federal funds to pay for abortion in state SCHIP programs, it is unclear at best whether this restriction would provide sufficient pro-life protections to

## Summary of Senate Republicans' Obamacare Legislation

ensure that Obamacare plans do not provide coverage of abortion. It is unclear whether and how federal reinsurance funds provided *after-the-fact* (i.e., covering some high-cost claims that *already occurred*) can *prospectively* prevent coverage of abortions.

Some conservatives may be concerned first that the stability funds would amount to over \$100 billion in corporate welfare payments to insurance companies; second that the funds give nearly-unilateral authority to the CMS Administrator to determine how to allocate payments among states; third that, in giving so much authority to CMS, the funds further undermine the principle of state regulation of health insurance; fourth that the funds represent a short-term budgetary gimmick—essentially, throwing taxpayer dollars at insurers to keep premiums low between now and the 2020 presidential election—that cannot or should not be sustained in the longer term; and finally that placing the funds within the SCHIP program will prove insufficient to prevent federal funding of plans that cover abortion.

**Implementation Fund:** Provides \$500 million to implement programs under the bill.

**Repeal of Some Obamacare Taxes:** Repeals some Obamacare taxes:

- Tax on high-cost health plans (also known as the “Cadillac tax”)—but only through 2025;
- Restrictions on use of Health Savings Accounts and Flexible Spending Arrangements to pay for over-the-counter medications, effective January 1, 2017;
- Increased penalties on non-health care uses of Health Savings Account dollars, effective January 1, 2017;
- Limits on Flexible Spending Arrangement contributions, effective January 1, 2018;
- Tax on pharmaceuticals, effective January 1, 2018;
- Medical device tax, effective January 1, 2018;
- Health insurer tax (currently being suspended);
- Elimination of deduction for employers who receive a subsidy from Medicare for offering retiree prescription drug coverage, effective January 1, 2017;
- Limitation on medical expenses as an itemized deduction, effective January 1, 2017;
- Medicare tax on “high-income” individuals, effective January 1, 2023;
- Tax on tanning services, effective September 30, 2017;
- Net investment tax, effective January 1, 2017;
- Limitation on deductibility of salaries to insurance industry executives, effective January 1, 2017.

*These provisions are generally similar to Sections 209 through 221 of the 2015/2016 reconciliation bill. However, the bill does NOT repeal the economic substance tax, which WAS repealed in Section 222 of the 2015/2016 bill. Moreover, the bill delays repeal of the Medicare “high-income” tax (which is not indexed to inflation) for an additional six years, until 2023.*

**Health Savings Accounts:** Increases contribution limits to HSAs, raising them from the current \$3,400 for individuals and \$6,750 for families in 2017 to the out-of-pocket maximum amounts (currently \$6,550 for an individual and \$13,100 for a family), effective

## Summary of Senate Republicans' Obamacare Legislation

January 2018. Allows both spouses to make catch-up contributions to the same Health Savings Account. Permits individuals who take up to 60 days to establish an HSA upon enrolling in HSA-eligible coverage to be reimbursed from their account for medical expenses.

**Federal Payments to States:** Imposes a one-year ban on federal funds flowing to certain entities. This provision would have the effect of preventing Medicaid funding of certain medical providers, including Planned Parenthood, so long as Planned Parenthood provides for abortions (except in cases of rape, incest, or to save the life of the mother). *This language is virtually identical to Section 206 of the 2015/2016 reconciliation bill.*

**Medicaid Expansion:** *The discussion draft varies significantly from the repeal of Medicaid expansion included in Section 207 of the 2015/2016 reconciliation bill.* The 2015/2016 reconciliation bill repealed both elements of the Medicaid expansion—the change in eligibility allowing able-bodied adults to join the program, and the enhanced (90-100%) federal match that states received for covering them.

By contrast, the discussion draft retains eligibility for the able-bodied adult population—making this population optional for states to cover, rather than mandatory. (The Supreme Court's 2012 ruling in [NFIB v. Sebelius](#) made Medicaid expansion optional for states.) Some conservatives may be concerned that this change represents a marked weakening of the 2015/2016 reconciliation bill language, one that will entrench a [massive expansion of Medicaid](#) beyond its original focus on the most vulnerable in society.

With respect to the Medicaid match rate, the discussion draft reduces the enhanced federal match to states—scheduled under current law as 90 percent in 2020—to 85 percent in 2021, 80 percent in 2022, and 75 percent in 2023. The regular federal match rates would apply for expansion states—defined as those that expanded Medicaid prior to March 1, 2017—beginning in 2024, and to all other states effective immediately. (In the case of states that already expanded Medicaid to able-bodied adults prior to Obamacare's enactment, the bill provides for an 80 percent federal match for 2017 through 2023.)

The bill also repeals the requirement that Medicaid “benchmark” plans comply with Obamacare's essential health benefits, also effective December 31, 2019.

Finally, the bill repeals provisions regarding presumptive eligibility and the Community First Choice Option, eliminating a six percent increase in the Medicaid match rate for some home and community-based services.

Some conservatives may be concerned that the language in this bill would give expansion states a strong incentive to sign up many more individuals for Medicaid over the next seven years. Some conservatives may also be concerned that, by extending the Medicaid transition for such a long period, it will [never in fact go into effect](#).

## Summary of Senate Republicans' Obamacare Legislation

**Disproportionate Share Hospital (DSH) Allotments:** Exempts non-expansion states from scheduled reductions in DSH payments in fiscal years 2021 through 2024, and provides an increase in DSH payments for non-expansion states in fiscal year 2020, based on a state's Medicaid enrollment.

**Retroactive Eligibility:** Effective October 2017, restricts retroactive eligibility in Medicaid to the month in which the individual applied for the program; current law requires three months of retroactive eligibility.

**Non-Expansion State Funding:** Includes \$10 billion (\$2 billion per year) in funding for Medicaid non-expansion states, for calendar years 2018 through 2022. States can receive a 100 percent federal match (95 percent in 2022), up to their share of the allotment. A non-expansion state's share of the \$2 billion in annual allotments would be determined by its share of individuals below 138% of the federal poverty level (FPL) when compared to non-expansion states. This funding would be excluded from the Medicaid *per capita* spending caps discussed in greater detail below.

**Eligibility Re-Determinations:** Permits—but unlike the House bill, does not require—states, beginning October 1, 2017, to re-determine eligibility for individuals qualifying for Medicaid on the basis of income every six months, or at shorter intervals. Provides a five percentage point increase in the federal match rate for states that elect this option.

**Work Requirements:** Permits (but does not require) states to, beginning October 1, 2017, impose work requirements on “non-disabled, non-elderly, non-pregnant” beneficiaries. States can determine the length of time for such work requirements. Provides a five percentage point increase in the federal match for state expenses attributable to activities implementing the work requirements.

States may not impose requirements on pregnant women (through 60 days after birth); children under age 19; the sole parent of a child under age 6, or sole parent or caretaker of a child with disabilities; or a married individual or head of household under age 20 who “maintains satisfactory attendance at secondary school or equivalent,” or participates in vocational education.

**Provider Taxes:** Reduces permissible Medicaid provider taxes from 6 percent under current law to 5.8 percent in fiscal year 2021, 5.6 percent in fiscal year 2022, 5.4 percent in fiscal year 2023, 5.2 percent in fiscal year 2024, and 5 percent in fiscal year 2025 and future fiscal years. Some conservatives may view provider taxes as essentially “money laundering”—a game in which states engage in shell transactions solely designed to increase the federal share of Medicaid funding and reduce states' share. More information can be found [here](#).

## Summary of Senate Republicans' Obamacare Legislation

**Medicaid *Per Capita* Caps:** Creates a system of *per capita* spending caps for federal spending on Medicaid, beginning in fiscal year 2020. States that exceed their caps would have their federal match reduced in the following fiscal year.

The cap would include all spending on medical care provided through the Medicaid program, with the exception of DSH payments and Medicare cost-sharing paid for dual eligibles (individuals eligible for both Medicaid and Medicare). The cap would rise by medical CPI plus one percentage point annually.

While the cap would take effect in fiscal year 2020, states could choose their “base period” based on any eight consecutive quarters of expenditures between October 1, 2013 and June 30, 2017. The CMS Administrator would have authority to make adjustments to relevant data if she believes a state attempted to “game” the look-back period.

Creates five classes of beneficiaries for whom the caps would apply: 1) elderly individuals over age 65; 2) blind and disabled beneficiaries; 3) children under age 19; 4) expansion enrollees (i.e., able-bodied adults enrolled under Obamacare); and 5) all other non-disabled, non-elderly, non-expansion adults (e.g., pregnant women, parents, etc.). Excludes State Children’s Health Insurance Plan enrollees, Indian Health Service participants, breast and cervical cancer services eligible individuals, and certain other partial benefit enrollees from the *per capita* caps.

For years before fiscal year 2025, indexes the caps to medical inflation for children, expansion enrollees, and all other non-expansion enrollees, with the caps rising by medical inflation plus one percentage point for aged, blind, and disabled beneficiaries. Beginning in fiscal year 2025, indexes the caps to overall inflation.

Includes provisions in the House bill regarding “required expenditures by certain political subdivisions.” Some conservatives may question the need to insert a [parochial New York-related provision](#) into the bill.

Provides a provision—not included in the House bill—for effectively re-basing the *per capita* caps. Allows the Secretary of Health and Human Services to increase the caps by between 0.5% and 2% for low-spending states (defined as having *per capita* expenditures 25% below the national median), and lower the caps by between 0.5% and 2% for high-spending states (with *per capita* expenditures 25% above the national median). The Secretary may only implement this provision in a budget-neutral manner, i.e., one that does not increase the deficit. However, this re-basing provision shall NOT apply to any state with a population density of under 15 individuals per square mile.

Requires the Department of Health and Human Services (HHS) to reduce states’ annual growth rate by one percent for any year in which that state “fails to satisfactorily submit data” regarding its Medicaid program. Permits HHS to adjust cap amounts to reflect data errors, based on an appeal by the state, increasing cap levels by no more than two percent. Requires new state reporting on inpatient psychiatric hospital services and children with

## Summary of Senate Republicans' Obamacare Legislation

complex medical conditions. Requires the HHS Inspector General to audit each state's spending at least every three years.

For the period including calendar quarters beginning on October 1, 2017 through October 1, 2019, increases the federal Medicaid match for certain state expenditures to improve data recording, including a 100 percent match in some instances.

Some conservatives may note that the use of the past several years as the "base period" for the *per capita* caps, benefits states who expanded Medicaid to able-bodied adults under Obamacare. The most recent [actuarial report](#) on Medicaid noted that, while the actuary originally predicted that adults in the expansion population would cost less than existing populations, in reality each newly eligible enrollee cost 13.6% more than existing populations in 2016. Some states have used the 100% federal match for their expansion populations—i.e., "free money from Washington"—to raise provider reimbursement levels.

Some conservatives may therefore be concerned that the draft bill would retain the increased spending on adults in expansion states—extending the inequities caused by states that have used Obamacare's "free money" to raise Medicaid spending while sending Washington the tab.

**Medicaid Block Grants:** Creates a Medicaid block grant, called the "Medicaid Flexibility Program," beginning in Fiscal Year 2020. Requires interested states to submit an application providing a proposed packet of services, a commitment to submit relevant data (including health quality measures and clinical data), and a statement of program goals. Requires public notice-and-comment periods at both the state and federal levels.

The amount of the block grant would total the regular federal match rate, multiplied by the target *per capita* spending amounts (as calculated above), multiplied by the number of expected enrollees (adjusted forward based on the estimated increase in population for the state, per Census Bureau estimates). In future years, the block grant would be increased by general inflation.

Prohibits states from increasing their base year block grant population beyond 2016 levels, adjusted for population growth, plus an additional three percentage points. This provision is likely designed to prevent states from "packing" their Medicaid programs full of beneficiaries immediately prior to a block grant's implementation, solely to achieve higher federal payments.

Permits states to roll over block grant payments from year to year, provided that they comply with maintenance of effort requirements. Reduces federal payments for the following year in the case of states that fail to meet their maintenance of effort spending requirements, and permits the HHS Secretary to make reductions in the case of a state's non-compliance. Requires the Secretary to publish block grant amounts for every state every year, regardless of whether or not the state elects the block grant option.

## Summary of Senate Republicans' Obamacare Legislation

Permits block grants for a program period of five fiscal years, subject to renewal; plans with “no significant changes” would not have to re-submit an application for their block grants. Permits a state to terminate the block grant, but only if the state “has in place an appropriate transition plan approved by the Secretary.”

Imposes a series of conditions on Medicaid block grants, requiring coverage for all mandatory populations identified in the Medicaid statute, and use of the Modified Adjusted Gross Income (MAGI) standard for determining eligibility. Includes 14 separate categories of services that states must cover for mandatory populations under the block grant. Requires benefits to have an actuarial value (coverage of average health expenses) of at least 95 percent of the benchmark coverage options in place prior to Obamacare. Permits states to determine the amount, duration, and scope of benefits within the parameters listed above.

Applies mental health parity provisions to the Medicaid block grant, and extends the Medicaid rebate program to any outpatient drugs covered under same. Permits states to impose premiums, deductibles, or other cost-sharing, provided such efforts do not exceed 5 percent of a family's income in any given year.

Requires participating states to have simplified enrollment processes, coordinate with insurance Exchanges, and “establish a fair process” for individuals to appeal adverse eligibility determinations.

Exempts states from *per capita* caps, waivers, state plan amendments, and other provisions of Title XIX of the Social Security Act while participating in Medicaid block grants.

**Performance Bonus Payments:** Provides an \$8 billion pool for bonus payments to state Medicaid and SCHIP programs for Fiscal Years 2023 through 2026. Allows the Secretary to increase federal matching rates for states that 1) have lower than expected expenses under the *per capita* caps and 2) report applicable quality measures, and have a plan to use the additional funds on quality improvement. While noting the goal of reducing health costs through quality improvement, and incentives for same, some conservatives may be concerned that this provision—as with others in the bill—gives near-blanket authority to the HHS Secretary to control the program's parameters, power that conservatives believe properly resides outside Washington—and power that a future Democratic Administration could use to contravene conservative objectives.

**Medicaid Waivers:** Permits states to extend Medicaid managed care waivers (those approved prior to January 1, 2017, and renewed at least once) in perpetuity through a state plan amendment, with an expedited/guaranteed approval process by CMS. Requires HHS to adopt processes “encouraging States to adopt or extend waivers” regarding home and community-based services, if those waivers would improve patient access.

**Coordination with States:** After January 1, 2018, prohibits CMS from finalizing any Medicaid rule unless CMS and HHS 1) provide an ongoing regular process for soliciting

## Summary of Senate Republicans' Obamacare Legislation

comments from state Medicaid agencies and Medicaid directors; 2) solicit oral and written comments in advance of any proposed rule on Medicaid; and 3) respond to said comments in the preamble of the proposed rule.

**Inpatient Psychiatric Services:** Provides for optional state Medicaid coverage of inpatient psychiatric services for individuals over 21 and under 65 years of age. (Current law permits coverage of such services for individuals under age 21.) Such coverage would not exceed 30 days in any month or 90 days in any calendar year. In order to receive such assistance, the state must maintain its number of licensed psychiatric beds as of the date of enactment, and maintain current levels of funding for inpatient services and outpatient psychiatric services. Provides a lower (i.e., 50 percent) match for such services, furnished on or after October 1, 2018.

**Small Business Health Plans:** Amends the Employee Retirement Income Security Act of 1974 (ERISA) to allow for creation of small business health plans. Some may question whether or not this provision will meet the "[Byrd rule](#)" test for inclusion on a budget reconciliation measure.

### Title II

**Prevention and Public Health Fund:** Eliminates funding for the Obamacare prevention "slush fund," and rescinds all unobligated balances. *This language is substantially similar to Section 101 of the 2015/2016 reconciliation bill.*

**Opioid Funding:** Appropriates \$2 billion for Fiscal Year 2018 for the HHS Secretary to distribute "grants to states to support substance use disorder treatment and recovery support services."

**Community Health Centers:** Increases funding for community health centers by \$422 million for Fiscal Year 2018—money intended to offset reductions in spending on Planned Parenthood affiliates (see "Federal Payments to States" above). *Language regarding community health centers was included in Section 102 of the 2015/2016 reconciliation bill.*

**Age Rating:** Changes the maximum variation in insurance markets from 3-to-1 (i.e., insurers can charge older applicants no more than three times younger applicants) to 5-to-1 effective January 1, 2019, with the option for states to provide for other age rating requirements. Some conservatives may be concerned that, despite the ability for states to opt out, this provision, by setting a default federal standard, maintains the intrusion over insurance markets exacerbated by Obamacare.

**Medical Loss Ratios:** Permits states to determine their own medical loss ratios, beginning for plan years on or after January 1, 2019.

## Summary of Senate Republicans' Obamacare Legislation

**State Innovation Waivers:** Amends Section 1332 of Obamacare regarding state innovation waivers. Eliminates the requirement that states codify their waivers in state law, by allowing a Governor or State Insurance Commissioner to provide authority for said waivers. Appropriates \$2 billion for Fiscal Years 2017 through 2019 to allow states to submit waiver applications, and allows states to use the long-term stability fund to carry out the plan. Allows for an expedited approval process “if the Secretary determines that such expedited process is necessary to respond to an urgent or emergency situation with respect to health insurance coverage within a State.”

Requires the HHS Secretary to approve all waivers, unless they will increase the federal budget deficit—a significant change from the Obamacare parameters, which many conservatives viewed as unduly restrictive. (For more background on Section 1332 waivers, see [this article](#).)

Provides for a standard eight-year waiver (unless a state requests a shorter period), with automatic renewals upon application by the state, and may not be cancelled by the Secretary before the expiration of the eight-year period.

Provides that Section 1332 waivers approved prior to enactment shall be governed under the “old” (i.e., Obamacare) parameters, that waiver applications submitted after enactment shall be governed under the “new” parameters, and that states with pending (but not yet approved) applications at the time of enactment can choose to have their waivers governed under the “old” or the “new” parameters.

**Cost-Sharing Subsidies:** Repeals Obamacare’s cost-sharing subsidies, effective December 31, 2019. Appropriates funds for cost-sharing subsidy claims for plan years through 2019—a provision not included in the House bill. The House of Representatives filed suit against the Obama Administration (*House v. Burwell*) alleging the Administration acted unconstitutionally in spending funds on the cost-sharing subsidies without an explicit appropriation from Congress. The case is currently on hold pending settlement discussions between the Trump Administration and the House. Some conservatives may view the appropriation first as likely to get stricken under the “[Byrd rule](#),” and second as a budget gimmick—acknowledging that Obamacare did NOT appropriate funds for the payments by including an appropriation for 2017 through 2019, but then relying on nearly \$100 billion in phantom “savings” from repealing the non-existent “appropriation” for years after 2020.

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