Per Capita Cap for Medicaid

ACA	Did not implement a "per capita" cap on Medicaid expenditures.
AHCA	Implements a Medicaid per-capita allotment, which eliminates the federal guarantee of Medicaid matching funds by capping federal Medicaid funding through a per capita cap for five population groups, starting in 2020. Uses each state's spending in FY 2016 as the base year to set targeted spending for each enrollee category (elderly, blind and disabled, children, non-expansion adults, and expansion adults) in FY 2019 and subsequent years for that state. Each state's targeted spending amount would increase by the percentage increase in the medical care component of the consumer price index for all urban consumers (CPI-M) from September 2019 to September of the next fiscal year. Starting in FY 2020, any state with spending higher than their specified targeted aggregate amount would receive reductions to their Medicaid funding for the following fiscal year. Includes data and reporting provisions, with a temporary increase to the federal matching percentage for these purposes (October 1, 2017-October 1, 2019). Provides for audits in specified years.
CA Impact	A Medicaid per capita cap provides greater funding certainty to the federal government, and shifts the risk for health care cost increases to the states. For example, when new drugs and treatments are introduced, disease outbreaks occur, medical technology improves, chronic condition prevalence increases, or when people live longer and progressively require more medical care, states would be "on the hook" for cost increases. In addition, a per capita cap would lock in California's low payment rate structure. California is one of the lower state per capita spending states, mainly due to its provider rates being far below what other payors pay. A per capita cap would lock in this historical amount so that any provider or plan rate increases would come from reductions in Medi-Cal spending in other areas (such as eligibility or benefits) because the per capita amount is a capped amount of money. DHCS' preliminary fiscal analysis estimate of this provision of the AHCA is California will be responsible for a state share of approximately $680 million in 2020, growing to $5.3 billion by 2027. To the extent that state Medicaid programs are subject to an aggregate spending limit, DHCS indicates this will have a devastating and chilling effect on provider or plan rate increases or any future supplemental payments (including quality assurance fees) because these additional costs will almost always be guaranteed to exceed the allowed trend factors and require states to fund these additional costs at 100%. The Congressional Budget Office indicates the limit on federal reimbursement would reduce federal spending because (after the changes to the Medicaid expansion population have been accounted for) Medicaid spending would grow on a per-enrollee basis at a faster rate than the CPI-M, according to CBO's projections: at an average annual rate of 4.4% for Medicaid and 3.7% for the CPI-M over the 2017-2026 period.

Medicaid Eligibility Expansion for Adults

ACA	Requires Medicaid coverage of non-disabled, non-pregnant adults under age 65 who were previously ineligible for Medicaid with incomes at or below 138% of the federal poverty level (FPL), which was $16,395 for an individual in 2016. In California, the two principle groups included in the Medicaid eligibility expansion are non-disabled adults ages 18-64 without minor children with incomes 0-138% of the FPL (up to $16,395 for an individual and $22,108 for a couple), and parents and caretaker relatives with incomes between 109-138% of the FPL (from $21,974 to $27,821 for a family of 3 in 2016/parents with incomes below 109% were previously effectively Medi-Cal eligible). The state also covers legal immigrants subject to the five year bar from federal Medicaid funding (who are currently proposed to shift from Medi-Cal to Covered California coverage in 2018). The ACA provided enhanced Medicaid funding for the benefit costs of this population of 100% for the first three years (2014-2016), 95% in 2017, 94% in 2018, 93% in 2018 and 90% in 2020 and thereafter. The AHCA also codifies the 2012 Supreme Court decision in *National Federation of Independent Business v. Sebelius*, which made the ACA Medicaid expansion optional for states.
AHCA	After January 1, 2020, ACHA makes the enhanced 90% matching rate only available for expansion-eligible individuals already enrolled in Medicaid as of December 31, 2019 who do not have a break in eligibility for more than one month after that date. After January 1, 2020, the State could only enroll newly eligible individuals at the State's traditional matching rate for that individual (California's traditional matching rate is 50%). The ACA expansion optional for states, in effect codifying the 2012 Supreme Court decision.
CA Impact	In 2016-17, projected Medi-Cal ACA optional expansion enrollment was 3.9 million individuals each month, at a cost of $20 billion total funds ($19.2 billion federal funds, $888 million state General Fund [GF]). The Governor's 2017-18 Budget assumes average monthly enrollment in the ACA Medi-Cal optional expansion of 4.1 million individuals, at a cost of $18.9 billion total funds ($17.3 billion federal funds, $1.6 billion state GF). DHCS preliminary fiscal analysis indicates this matching rate change represents the most significant cost shift to states which expanded their Medicaid programs. DHCS estimates this will cost $4.8 billion in 2020, and grow to over $18.5 billion in 2027. The GF share would be about $3.3 billion in 2020, increasing to $13 billion in 2027.

Planned Parenthood Defunding For One Year

ACA	Does not prohibit funding for Planned Parenthood.
AHCA	For a one-year period following enactment, the AHCA would prevent federal funds from being made available to an entity (including its affiliates, subsidiaries, successors, and clinics) if it is: • A nonprofit organization described in section 501(c)(3) of the Internal Revenue Code and exempt from tax under section 501(a) of the code; • An essential community provider that is primarily engaged in providing family planning and reproductive health services and related medical care; • An entity that provides abortions—except in instances in which the pregnancy is the result of an act of rape or incest or the woman's life is in danger; and, • An entity that had expenditures under the Medicaid program that exceeded $350 million in fiscal year 2014.
CA Impact	Planned Parenthood indicates it has 115 health centers in California, which provided 1.5 million patient visits in 2015. Approximately 87% of Planned Parenthood's patients have incomes below 200% of the FPL. The four major areas of service are sexually transmitted infection and HIV testing (39%), pregnancy testing (26%), contraception (16%) and emergency contraception (8%). Abortion represented 2% of Planned Parenthood's services in 2015. Planned Parenthood indicates it receives $253 million in federal funding, comprising approximately 80% of its total operating budget. DHCS preliminary fiscal states California has a long history of providing coverage and services for family planning. Established in 1997, the Family Planning, Access, Care and Treatment Program (FPACT) has been a model in delivering family planning services to low-income individuals and reducing California's teen pregnancy rates to near-historic lows as well as reducing unintended pregnancy and the associated costs. DHCS indicates the federal proposal does not permit any Medicaid, Children's Health Insurance Program or block grant program funds to be provided to any provider who offers abortion services in addition to primary services of family planning. In California, DHCS indicates the federal prohibition appears to only apply to the Planned Parenthood Affiliates of California, which currently provides services to more than 600,000 Medi-Cal and Family PACT beneficiaries. DHCS estimates the one-year federal prohibition on these providers represents over $400 million. The Congressional Budget Office indicates that the AHCA prohibition would reduce direct spending nationally by $178 million in 2017 and by $234 million over the 2017-2026 period. Those savings would be partially offset by increased spending for other Medicaid services. CBO states, to the extent that there would be reductions in access to care under the AHCA, they would affect services that help women avert pregnancies, particularly for individuals who reside in areas without other health care clinics or medical practitioners who serve low-income populations. CBO projects that about 15% of those people would lose access to care. The government would incur some costs for Medicaid beneficiaries currently served by affected entities because the costs of about 45% of all births are paid for by the Medicaid program. CBO estimates that the additional births stemming from the reduced access under the AHCA would

	add to federal spending for Medicaid. In addition, some of those children would themselves qualify for Medicaid and possibly for other federal programs. By CBO's estimates, in the one-year period in which federal funds for Planned Parenthood would be prohibited under the AHCA, the number of births in the Medicaid program would increase by several thousand, increasing direct spending for Medicaid by $21 million in 2017 and by $77 million over the 2017-2026 period. Overall, with those costs netted against the savings estimated above, CBO estimates implementing the provision would reduce direct spending by $156 million over the 2017-2026 period.

Medicaid Essential Health Benefits (EHB)

ACA	Requires the ACA Medi-Cal expansion population to receive Medicaid benchmark or benchmark equivalent coverage to receive at least coverage of the EHBs. The EHBs are: ▪ Ambulatory patient services; ▪ Emergency services; ▪ Hospitalization; ▪ Maternity and newborn care; ▪ Mental health and substance use disorder services, including behavioral health treatment; ▪ Prescription drugs; ▪ Rehabilitative and habilitative services and devices; ▪ Laboratory services; ▪ Preventive and wellness services and chronic disease management; and, ▪ Pediatric services, including oral and vision care.
AHCA	Repeals the requirement that the Medicaid expansion population receive EHBs.
CA Impact	California went beyond the ACA requirement that the EHB be provided to the Medi-Cal optional expansion population. Instead, California requires the mental health services and substance use disorders included in the EHB package adopted by the state (a particular Kaiser small group product) to be provided to the entire Medi-Cal population. This change, and other changes required by the ACA, resulted in an expansion of the scope of Medi-Cal coverage of mental health disorder and substance use disorder treatment, and the number of individuals eligible for those services. The additional mental health benefits provided include psychology and group therapy for non-specialty mental health program qualifying individuals. The additional substance use disorder services include intensive outpatient treatment and residential substance use disorder services (these two services were previously limited to pregnant women and children), and elective inpatient detoxification for individuals without an underlying medical condition other than the condition requiring detoxification.

Redetermination of Medicaid eligibility for the ACA expansion population

ACA	Required, through federal regulations implementing the ACA, annual redeterminations of eligibility for the Medicaid expansion population once every 12 months and not more frequently than once every 12 months.
AHCA	Requires states with Medicaid expansion populations to redetermine expansion enrollees' eligibility every six months, instead of annually. Provides a temporary 5%

	matching increase to states for activities directly related to complying with this requirement.
CA Impact	Requiring more frequent eligibility redeterminations are likely to affect Medi-Cal optional expansion enrollment based on California data on continued Medi-Cal eligibility following redetermination. During a nine-month period in 2016, between 69% to 88.5% of individuals subject to redetermination retained Medi-Cal coverage each month. For the Medi-Cal expansion population, CBO projects, on the basis of historical data (and taking into account the increased frequency of eligibility redeterminations required by the AHCA), that fewer than one-third of those enrolled as of December 31, 2019, would have maintained continuous eligibility two years later. Under the AHCA, CBO estimates the higher federal matching rate would apply for fewer than 5% of newly eligible enrollees by the end of 2024.

Hospital Presumptive Eligibility (PE) for Medicaid Coverage

ACA	Required states to establish a hospital PE program whereby hospitals can determine temporary eligibility for Medicaid on-line at the hospital for individuals under age 65. The hospital PE program provides qualified individuals immediate access to temporary, no-cost Medi-Cal while applying for permanent Medi-Cal coverage or other health coverage.
AHCA	Repeals hospital PE.
CA Impact	In the first six months of 2016, nearly 109,000 individuals applied for coverage through hospital PE. DHCS preliminary fiscal analysis indicates approximately 25,000 individuals each month are offered coverage through hospital PE. DHCS indicates that, due to the nature of hospital PE and the removal of this provision, costs will shift to hospitals and individuals that will no longer be found eligible for Medi-Cal. In 2017-18, state expenditures on hospital PE were nearly $400 million ($192 million state General Fund). Hospitals located in San Diego County that participate in the hospital PE program include the five Scripps hospitals, three Sharp hospitals, UCSD Medical Center, Alvarado Hospital, Rady Children's Hospital, and Kaiser San Diego.

Retroactive Medi-Cal Coverage

ACA	The ACA did not change retroactive Medi-Cal coverage.
AHCA	Decreases the period when Medicaid benefits may be covered retroactively from up to three months before a recipient's application to the first of the month in which a recipient makes an application.
CA Impact	Medicaid currently provides coverage up to three months before the month an individual applies for coverage. This "retroactive coverage" provides financial protection for low-income individuals from medical expenses they incurred before they apply for Medi-Cal coverage. For example, if an individual is unable to apply for

	Medicaid immediately due to hospitalization, a disability, or other circumstances, retroactive Medi-Cal ensures health care providers can be reimbursed for their costs, and low-income individuals do not end up facing severe medical debt or bankruptcy due to medical expenses.

Disproportionate Share Hospital Funding

ACA	Medicaid allotments to states for payments to hospitals that treat a disproportionate share of uninsured and Medicaid patients are to be cut significantly in each year. Subsequent legislation postponed these cuts to the period from 2018 to 2025. The cuts are currently scheduled to be $2 billion in 2018 and to increase each year until they reach $8 billion in 2024 and 2025.
AHCA	Would eliminate the DSH cuts for states that have not expanded Medicaid under the ACA starting in 2018, and for the remaining states starting in 2020, boosting outlays by $31 billion over the next 10 years.
CA Impact	DHCS indicates the estimated additional federal funding for California if the disproportionate share hospital reductions are eliminated in 2020 would be approximately $1.4 billion.

Allowable Home Equity for Receipt of Medi-Cal Nursing Facility and Long-Term Services

ACA	Made no change to the Medicaid home equity provisions.
AHCA	Eliminates states' option to increase the amount of allowable home equity above $500,000 for individuals applying for Medicaid coverage of nursing facility services or other long-term services and supports.
CA Impact	The 2005 federal Deficit Reduction Act (DRA) caps an individual's equity interest in their home at $500,000 for purposes of determining eligibility for nursing facility services or other long-term care services. The DRA allowed states to increase this amount to $750,000. Federal law requires the cap to be adjusted by the CPI-U. In 2008, California passed legislation adopting the federal option to increase the home equity limit to $750,000. As a high cost state with a median home value of $487,000, the lowering of the home equity limit to $500,000 could result in some Medi-Cal beneficiaries losing access to nursing facility services and long-term care services, particularly in high cost urban areas such as San Francisco. The median home value in San Diego is $555,700.

Repeal of Community First Choice Option Medicaid Matching Rate Increase

ACA	Allows states to elect the Community First Choice option, which allows states to receive a 6% point increase in their matching rate for some services provided by home and community-based providers to certain Medicaid recipients.
AHCA	Repeals the 6% matching rate increase for the Community First Choice Option.
CA Impact	California was the first state approved to enact the Community First Choice Option, which allowed the state to take advantage of the 6% enhanced matching rate to provide In-Home Supportive Services (IHSS) to certain Medi-Cal beneficiaries who otherwise would need institutional care. More than 500,000 Californians have received services through the Community First Choice Option since 2011.

	DHCS preliminary fiscal analysis indicates this would result in the elimination of the enhanced 6% matching rate for specific IHSS program costs beginning in 2020. DHCS indicates California's IHSS program is the largest in the country, and is the core of the state's home-and-community-based system that allows the elderly and disabled to remain in their homes rather than be placed in a more costly institutional care setting. Serving over 480,000 beneficiaries today, DHCS indicates this reduction in funding is estimated to increase state costs by about $400 million in 2020, growing annually.

Premium Tax Credits

ACA	Provides advance premium tax credits (also referred to as subsidies) to reduce the cost of insurance coverage for individuals with incomes between 138% FPL and 400% FPL (between $16,395 and $47,080 for an individual in 2016) who purchase individual insurance coverage through exchanges.
AHCA	Repeals current the ACA premium subsidies beginning in 2020. Revises calculation of individual or family income contribution to premiums so it considers both household income as well as age. Allows current subsidies to be applied to catastrophic plans and certain plans not sold through Exchanges. Prohibits subsidies' application to plans that cover abortion services. States that this provision does not restrict any health insurance issuer offering a health plan from offering separate coverage for abortions, as specified, or a plan that includes such abortions, so long as premiums for such separate coverage or plan are not paid for with any amount attributable to the credit. For tax years 2018 and 2019, requires repayment of the full amount of premium subsidies, instead of the capped amount in the ACA, regardless of income. Creates an advanceable, refundable tax credit for the purchase of state-approved, major medical health insurance and unsubsidized COBRA coverage. Credits are newly means tested and are available in full to those making $75,000 per year ($150,000 for joint filers). They phase down by $100 for every $1,000 in income higher than those thresholds. Eligibility is based on not having access to government or employer coverage and being a citizen, national, or qualified alien. Credits are age-adjusted as follows: • Under age 30: $2,000; • Between 30 and 39: $2,500; • Between 40 and 49: $3,000; • Between 50 and 59: $3,500; and, • Over age 60: $4,000. Credits are "additive for a family" and capped at $14,000. They are indexed at CPI

	plus 1%.
CA Impact	In 2016, Covered California Advance Premium Tax Credits were $4.2 billion, approximately $3,500 per individual and $5,300 per household. Over one-third of Covered California enrollees receive more than $4,000 per year in tax credits. Sixteen percent receive more than $6,000 per year. One-third of households receive more than $6,000 per year and 11% of households receive more than $10,000 per year. According to a study by the Kaiser Family Foundation, when comparing the premium subsidies available in 2020 under the ACA compared to the AHCA a 40 year old making $20,000 living in San Diego could qualify for $3,380 tax credit under the ACA compared to $3,000 under the AHCA. A 60 year old making $20,000 could qualify for a $8,200 tax credit under the ACA compared to $4,000 under the AHCA. A 27 year old making $20,000 could qualify for $2,600 under the ACA compared to $2,000 under the AHCA. Changing the tax credit structure to a significantly less generous flat tax will disadvantage many, especially those individuals living in regions of the state with higher insurance costs. Some individuals with income over 400% FPL will newly have access to tax credits. Many people who will have higher premium costs will switch to lower premium plans which will provide less generous coverage and higher cost sharing in the form of copayments and deductibles. Restrictions on the use of tax credits to purchase plans that cover abortion services could limit the ability of Californians to utilize the AHCA tax credits because California plans are required to cover abortion services. According to the Department of Managed Health Care, all health plans must treat maternity services and legal abortion neutrally. Exclusions and limitations are also incompatible with both the California Reproductive Privacy Act and multiple California judicial decisions that have unambiguously established under the California Constitution that every pregnant woman has the fundamental right to choose to either bear a child or to have a legal abortion.

Cost-Sharing Subsidies

ACA	Provides cost-sharing reductions for individuals with incomes below 250% FPL (at or below $29,425 in 2016) who purchase individual insurance coverage through exchanges.
AHCA	Repeals cost-sharing subsidies for individuals purchasing individual coverage in exchanges, beginning in 2020.
CA Impact	In 2016, Covered California cost-sharing subsidies were over $700 million, approximately $1,090 per individual and $1,500 per household. San Diego County enrollees received $60 million in cost-sharing reductions. Without access to these reductions in cost-sharing many individuals will have to pay more in copayments, deductibles and coinsurance. This would result in a significant loss of federal support for Californians who need the funding to offset health insurance cost-sharing.

Small Business

ACA	Creating temporary tax credits for small employers with no more than 25 full-time equivalent employees whose average annual wages are less than $50,000 who purchase coverage through an exchange.
AHCA	Repeals the temporary tax credits beginning in 2020. Makes the tax credit unavailable 2018-2020 for plans providing coverage of elective abortion.
CA Impact	The elimination of these tax credits would make health insurance even more unaffordable for small business owners trying to provide coverage for their employees who would take advantage of the tax credits. Restrictions on the use of tax credits to purchase plans that cover abortion services could limit the ability of Californians to utilize the AHCA tax credits since California plans are required to cover abortion services. According to the Department of Managed Health Care the all health plans must treat maternity services and legal abortion neutrally. Exclusions and limitations are also incompatible with both the California Reproductive Privacy Act and multiple California judicial decisions that have unambiguously established under the California Constitution that every pregnant woman has the fundamental right to choose to either bear a child or to have a legal abortion.

Individual Mandate

ACA	Requires all individuals with access to affordable coverage (cost less than 9% of household income) to purchase minimum essential coverage or pay a penalty of $695 or 2.5% of income (up to a cap) for 2016. Exceptions are made for individuals not lawfully present in the U.S., religious objectors, incarcerated individuals, individuals with income below tax filing thresholds, members of Indian tribes, and people who are granted a hardship waiver or who have been without coverage for less than three months of the year.
AHCA	Reduces the individual mandate penalty to zero for 2016 and beyond. Continuous Coverage – For Benefit Year 2019, implements a 12-month look back period to assess whether an applicant went without coverage for greater than 63 days. If such a break in coverage occurred, there will be a flat 30% late-enrollment surcharge applied to their base premiums for 12 months. The surcharge is the same for all those having such a break (it does not vary by health status). The surcharge applies for special enrollment applicants in Benefit Year 2018.
CA Impact	The impact of the repeal of the individual mandate penalties and the imposition of the continuous coverage provision depend upon the extent to which these policies act as incentives or disincentives for both healthy and unhealthy individuals to obtain coverage. If more healthy people drop coverage, premiums will increase for those who remain covered. According to the CBO in 2017 the elimination of the individual mandate penalties would result in about four million additional people becoming uninsured. Also, the CBO indicates related to the continuous coverage provisions, in 2018 one million people would be induced to buy coverage and in 2019 and later years two million fewer people would purchase insurance because of the surcharge.

Employer Mandates

ACA	Requires employers with over 200 employees to enroll full-time employees into employer-based health coverage with sufficient notice and options for employees to opt out. Requires employers with at least 50 full-time employees to pay a penalty if the employer does not offer qualifying coverage and at least one full-time employee qualifies for premium tax credits to purchase insurance in an exchange. The penalty is $2,000 for each of all the full-time employees minus the first 30 employees. For employers with more 50 employees the penalty is higher.
AHCA	Reduces the penalty to zero for 2016 and beyond.
CA Impact	According to the CBO, fewer employers would offer health insurance because of the repeal of the mandate (and because tax credits will be available for higher income people). However, CBO also indicates that because tax credits are smaller and nongroup coverage will be less attractive under the AHCA, some employers would be less likely to drop coverage for their employees.

Health Insurance Rating Factors

ACA	Limits variations in premium rates that can be charged by health insurers for individuals and small groups by family structure (individual vs. family), geographic area, age (older people cannot be charged more than three times a younger person) and tobacco use (a tobacco user can only be charged 1.5 times a nontobacco user). California chose not to allow the tobacco rating.
AHCA	Changes age-rating bands to 5:1 (they are 3:1 under the ACA) and permits states to set their own age bands.
CA Impact	Older adults will be charged five times more than younger adults, making premiums even more unaffordable. Younger adults will be charged lower premiums.

Actuarial Value

ACA	Actuarial Values (AV) is an amount for a standard population that the health plan will pay of the health care expenses, as opposed to the amount the enrollee will pay through some combination of deductibles, copays, and coinsurance. The ACA requires AV to be calculated based on the provision of EHBs to a standard population. The statute groups health plans into four tiers: bronze, with an AV of 60%; silver, with an AV of 70%; gold, with an AV of 80%; and platinum, with an AV of 90%. The ACA regulations establish that a de minimis variation of +/- 2 percentage points of AV is allowed for each tier.
AHCA	Repeals the AV levels that correspond to metallic levels of coverage established under the ACA.
CA Impact	Would allow health insurance plans to have AV of below 60%. CBO predicts more plans would offer, low AV plans which would result in higher cost-sharing payments (higher co-payments and deductibles) under the AHCA than under the ACA. Relieving health plans of AV requirements means it will be more difficult for consumers to shop and compare coverage options.

High Risk Pool

ACA	Requires a temporary high-risk health insurance pool program
AHCA	Establishes the Patient and State Stability Fund – Provides for a fund to reduce costs for patients and to stabilize state markets. The fund would provide $15 billion in 2018 and 2019 and $10 billion annually for 2020 through 2026. Funding is allocated for first two years based mainly on healthcare spending in the individual market and to a lesser extent on other factors like the state uninsured rate below 100% FPL (favoring non-expansion states) and the amount of plans participating in state exchanges. After the first two years, funding is set by HHS based on "cost, risk, low income uninsured population, and issuer competition." In 2020, the bill would phase in a state matching formula, presumably to help assist states that use money to build this own program. The fund can be used by states for the following purposes: • Provide financial assistance, high-risk individuals who do not have access to health insurance coverage in the individual market; • To help incentivize stable premiums; • To lower insurance costs in the individual and small group markets; • To promote participation in state insurance markets; • To provide access to preventive, dental, vision, and mental health services; • To pay providers; and, • To reduce cost-sharing and premiums.
CA Impact	With the methodology outlined in the AHCA, the Oliver Wyman Health Group published an analysis estimating state allocations under the Patient and State Stability Fund for 2018. Using 2015 billable member months, as published by CMS, and Current Population Survey data, they estimate that 33 states would qualify for payments in 2018, and they estimate that California would receive over $1.6 billion.

Other Tax Provisions

ACA	Starting in 2018 imposes an excise tax on high cost employer-sponsored health coverage of 40% of aggregate coverage costs in excess of $10,200 (self only) and $27,500 (family coverage). *Referred to as "Cadillac tax"* Modifies the definition of qualified medical expenses for Health Savings Accounts (HSAs), Flexible Spending Accounts (FSAs), and others to include insulin and any prescribed drug, even if the medicine is available over-the-counter Increases the additional tax for HSA and Archer MSA withdrawals, if not used for qualified expenses, to 20% from 10% and 15%, respectively for distributions after 12/31/2010 Limits employee contributions via salary reduction to health FSAs to $2,500 annually beginning in 2013, indexed at CPI-U in subsequent years Increases the Medicare Hospital Insurance Tax rate by .9 percentage points on wages in excess of $200,000 ($250,000 for married couples filing jointly and $125,000 for married taxpayers filing separately).

	Imposes an additional "Unearned Income Medicare Contribution" tax of 3.8% on the lesser of net investment income or the modified adjusted gross income that is over a threshold amount. Imposes an excise tax of 2.3% on sales price of medical devices Imposes an annual non-deductible fee on certain manufacturers and importers of branded prescription drugs and biologics – excluding orphan drugs totaling $4 billion in 2017 Imposes an aggregate, non-deductible annual fee on health insurers of $13.9 billion in 2017 and $14.3 billion in 2018, subsequently indexed to the rate of premium growth. Limits the amount of executive compensation health insurers can deduct under section 162(m) of the Internal Revenue code – including rules applicable to deferred deduction remuneration – to $500,000 for those health insurance issuers receiving at least 25% of their gross premium income from plans meeting ACA minimum essential coverage.
AHCA	Delays the effective date of the Cadillac tax to 2025. Health Savings Accounts (HSA), Other Taxes – "Effectively repeals" the over-the-counter medicine tax as of 2018 tax year and lowers HSA distribution tax to pre-ACA levels as of December 31, 2017. Repeals limits on contributing to FSAs as of December 31, 2017. Restores the pre-ACA medical deductibility percentage beginning in 2018. Repeals the additional the additional 0.9% Medicare tax beginning in 2018. Repeals the net investment tax beginning in 2018. Device Tax – Repeals for taxable years beginning after December 31, 2017. Pharma Tax – Specifies that the tax would not apply for years beginning after December 31, 2017. Insurer Tax – Repeals the health insurance tax beginning after December 31, 2017. Insurer Remuneration – Repeals the limit on the deduction of a covered health insurance provider for compensation attributable to services performed by an applicable individual starting in 2018. HSAs – Sets basic limit at least $6,550 in the case of self-only coverage and $13,100 in the case of family coverage beginning in 2018. Both spouses would be able to make catch-up contributions, among other policies.
CA	The elimination and reduction of these substantial revenues to fund the Medicaid

Impact	expansion, advanced premium tax credits and cost-sharing subsidies were critical components of California's efforts to implement the ACA. California would be very unlikely to make up such a significant loss of federal financing.