ALSTON & BIRD

American Health Care Act

On March 6, 2017, both the House Energy and Commerce Committee and the House Ways and Committee released draft legislation, the "American Health Care Act," to repeal and replace the Affordable Care Act (ACA). Each Committee will mark-up its respective policies on March 8, 2017. After mark-up, the House Budget Committee will combine the bills into one House bill. Modifications to the bill are anticipated prior to the legislation receiving consideration on the House floor.

The chart below provides a broad overview of key issues and policies in the legislation. Among other things, the legislation (when taken together) would repeal the penalties associated with the individual and employer mandates retroactively to 2016. The legislation would allow insurance companies to impose a 30 percent late-enrollment surcharge on individual or small group market applicants who had a lapse in coverage for more than 63 days, phases out the ACA's Medicaid expansion and transitions the program to a per capita cap model, and eliminate a number of ACA taxes. The legislation would delay the "Cadillac Tax" on high cost health plans until 2025. The legislation also would preserve certain provisions of the ACA, including provisions that allow children to stay on their parents' insurance until age 26 and that require insurers to cover people with pre-existing conditions.

This chart will be updated as Congressional activity warrants. At this juncture, the Congressional Budget Office has not completed its analysis of the American Health Care Act and is not expected to do so until after the markups on March 8.

Policy	House Bill (E&C)	House Bill (W&M)
Individual Market: Premium Tax Credit		Premium Tax Credit. Repeals the ACA premium tax credit effective in 2020. Makes certain changes to the premium tax credit for 2018 and 2019 as described below. *(Subtitle_ - Sec_03, p. 10)* Starting in 2020 a new health coverage tax credit is available (see below). Recapture Excess Advance Payments of Premium Tax Credits. Requires, for tax years 2018 and 2019, individuals receiving excess premium tax credits to repay the entire excess amount, regardless of income. *(Subtitle_ - Sec_01, p. 1)* Additional Modifications to Premium Tax Credit. For 2018 and 2019, the premium tax credit is extended to individual market insurance sold off Exchanges (as well as on-Exchange), but does not apply to grandfathered health plans, "grandmothered" health plans, or plans that cover abortions for reasons other than to save the life of the mother or in the case of rape or incest. Advance payments of the premium tax credit are not available for any health plan sold off an Exchange. For 2019, the percentage of the premium tax that must be paid is modified to take into account both income tier and age of the individual or oldest family member. For 2019, the percentage will be adjusted to reflect (a) the

Policy	House Bill (E&C)	House Bill (W&M)
Individual Market: Premium Tax Credit (cont'd)		excess of premium growth from 2013 through 2018 over the rate of income growth and (b) the excess of premium growth in 2018 over the rate of the consumer price index growth. The adjustment in (b) applies only if the aggregate amount of premium tax credits and cost-sharing reduction for 2018 exceeds 0.504 percent of the gross domestic product for 2018. *(Subtitle_ - Sec_01, p. 2)* Refundable Tax Credit for Health Insurance Coverage. Establishes, beginning on Jan. 1, 2020, an advanceable, refundable tax credit for individual market coverage and unsubsidized COBRA coverage (*i.e.*, COBRA continuation coverage with no portion of the premiums subsidized by an employer). The credit is not available for grandfathered health plans, "grandmothered" plans, excepted benefit coverage, or plans that provide certain abortion coverage. The State (or plan administrator in the case of COBRA coverage) must certify that the plan is eligible for the credit. The annual amount of the credit is are age-adjusted as follows: under age 30, $2,000; age 30-39, $2,500; age 40-49, $3,000; age 50-59, $3,500; and over age 60, $4,000. The tax credit is are additive with respect to the five oldest individuals and is capped at $14,000. The credit is fully available to individuals with income of $75,000 per year ($150,000 for joint filers). Married couples are required to file joint returns to determine eligibility. The credit amount is reduced by 10 percent of the amount above the income threshold until it is phased out to zero (*e.g.*, $100 reduction for every $1,000 above the income threshold). To be eligible, an individual must be covered by eligible health insurance, not be eligible for other coverage (including government or employer-based insurance), be a citizen or qualified alien, and not be incarcerated. The credit amounts will grow by the consumer price index plus one percent. Establishes an advance payment program by Jan. 1, 2020 to make payments to providers of eligible health insurance on behalf of eligible taxpayers. The program is intended to build off of existing methods and procedures under the ACA and will be administered by HHS. If an employed individual applies for the advance payment program, the individual must submit a written statement from each employer of the individual (or qualifying family member) stating whether that individual is eligible for any other specified coverage in connection with his/her employment. Employers must provide this statement at the request of any employee.

Policy	House Bill (E&C)	House Bill (W&M)
Individual Market: Premium Tax Credit (cont'd)		Eligible taxpayers may request that any excesses of the dollar amount of the credit over the amount paid for insurance be deposited into a designated HSA. Any amount contributed to the designated HSA is treated as a rollover contribution. Per the Secretary's discretion, payments can be made to more than one designated HSA so long as the payments do not exceed the total excess credit. Individuals with seriously delinquent tax debt (unpaid tax greater than $50,000 with a notice of lien or levy made) will not receive the credit or any excess payments to HSAs. To the extent feasible, payments will be made in advance on a monthly basis. The tax imposed will be increased by the excess of the aggregate amount paid on behalf of the taxpayer over the amount that is allowed as a credit. Insurers providing health insurance for any individual receiving the advance tax credit must submit a return on a monthly basis that includes: the name, address, and TIN of each individual under the policy; the premiums paid; the amount of advance payments made on behalf of the individual; the months during which the health insurance was provided; and whether policy is a high deductible health plan. Insurers must provide these individuals with a written statement (with information on contact information for the individual who submitted the return and the information shown on the return) on or before Jan. 31 of the year following the year to which the statement relates. There also are special rules for qualified small employer health reimbursement arrangements (QSEHRAs). Specifically, if an individual is eligible for the tax credit, the credit amount will be reduced by the benefit under the QSEHRA. With regards to abortion, individuals may purchase and insurers may offer coverage for these services so long as the credit is not used to pay for the premiums of such coverage or plan. Care required due to or exacerbated by the performance of an abortion is not treated as an abortion. *(Subtitle_ - Sec_15, p. 19)*
Individual Market: Cost-Sharing Subsidy	Repeal of Cost-Sharing Subsidy. Repeals the cost-sharing subsidy program (Sec. 1402 of the ACA) in 2020. *(Sec. 131)*	
Individual Market: High-Risk Pools	Patient and State Stability Fund. Establishes a temporary Patient and State Stability Fund, from Jan. 1, 2018 through Dec. 31, 2026, designed to	

Policy	House Bill (E&C)	House Bill (W&M)
Individual Market: High-Risk Pools (cont'd)	"lower patient costs and stabilize State markets." The purposes for which the Fund may be used include: • Providing assistance to high-risk individuals who do not have access to health insurance coverage offered through an employer, in order to facilitate enrollment in health insurance coverage in the individual market in the State. • Providing incentives to appropriate entities to enter into arrangements with the State to help stabilize premiums in the individual market. • Reducing the cost of providing health insurance coverage in the individual and small group market for otherwise high-cost individuals. • Promoting participation in the individual and small group markets in the State and increasing available health insurance options through same. • Promoting access to preventive services, dental care services, and mental health and substance use disorder services. • Providing payments, directly or indirectly, to health care providers for the provision of certain health care services. • Providing assistance to reduce consumer out-of-pocket costs for individuals enrolled in health insurance coverage in the State. States generally would be required to submit a one-time application to be eligible for an allocation of funds through this program. For these purposes, the bill would authorize $15 billion for each of years 2018 and 2019, and $10 billion for each of years 2020 through 2026. If a State failed to apply for an allocation, or its application was not approved, the CMS Administrator would be authorized to use such allocation for applicable purposes (*i.e.*, premium stabilization through a reinsurance mechanism) for that State (referred to here as the Federal standard). States would be required to make certain non-Federal contributions in order to obtain their share of the Federal allocation. If a State obtained its allocation through the application process, the State's required contribution would increase annually from seven percent of the Federal allocation in 2020 to 50 percent in 2026. If a State obtained its allocation by defaulting to the Federal standard, the State's required contribution would increase from 10 percent of the Federal allocation in 2020 to 50 percent in years 2024 and beyond. This section creates two separate methodologies for determining funding allocation amounts: one for years 2018 and 2019; and one for years 2020 and beyond. For 2018 and 2019, most of the total Federal allotment (85	

Policy	House Bill (E&C)	House Bill (W&M)
Individual Market: High-Risk Pools (cont'd)	percent) would be allocated based on each State's relative share of total incurred claims for benefit years 2015 and 2016, respectively, based on medical loss ratio reported for the on-Exchange individual market. The remaining funds from the Federal allotment (15 percent), would be available to those States that either: (1) experienced an increase in their uninsured population for individuals below 100 percent of Federal poverty level (FPL) between 2013 and 2015; or (2) had fewer than three plans offering coverage on the individual Exchange in 2017. For 2020 and beyond, the allocation determination would be based on a methodology to be established by the CMS Administrator in a manner that takes into consideration costs, low-income uninsured population size, and issuer competition. This section further specifies how any appropriated, but unused, funds should be allocated by the Administrator. This section also prohibits the allocation of funds to pay for any abortion or to assist in the purchase, in whole or in part, of health benefit coverage that includes coverage of abortion. *(Sec. 132)*	
Medicaid Reform	Presumptive Eligibility Determinations. Removes the ability of a hospital to elect to be a qualified entity to make presumptive eligibility determinations after Jan. 1, 2020, and any such election made prior to that date shall cease to be effective on that date. Repeals States' authority to make presumptive eligibility determinations as of Jan. 1, 2020 for non-pregnant childless adults with incomes below 133 percent of FPL, adjusted for family size. *(Sec. 111)* Mandatory Medicaid Income Eligibility Level. Decreases the mandatory Medicaid income eligibility level from 133 percent of FPL to 100 percent, effective Dec. 31, 2019. *(Sec. 111)* Community-Based Attendant Services. Repeals the increased Federal Medical Assistance Percentage (FMAP) for community-based attendant services, effective Jan. 1, 2020. *(Sec. 111)* Medicaid Expansion Optional. Codifies that a State has the option through Dec. 31, 2019 to expand Medicaid eligibility to non-pregnant childless adults whose income does not exceed 133 percent of FPL, adjusted for family size, and terminates such authority thereafter. *(Sec. 112)*	

Policy	House Bill (E&C)	House Bill (W&M)
Medicaid Reform (cont'd)	Termination of Increased FMAP for Newly-Eligible Individuals. Terminates increased FMAP for non-pregnant childless adults whose income does not exceed 133 percent of FPL, adjusted for family size, who were enrolled in a State's Medicaid program on or after Jan. 1, 2020; maintains increased FMAP for newly-enrolled individuals who were enrolled on or before Dec. 31, 2019 and who do not have a break in eligibility for medical assistance for more than one month after Jan. 1, 2020. *(Sec. 112)* Formula for Expansion State Matching Rate. Amends the formula for the expansion State matching rate, available for non-pregnant childless adults whose income does not exceed 133 percent of FPL, adjusted for family size, in expansion States that implemented Medicaid expansion prior to enactment of the ACA, such that the phase-up matching rate is set at 80 percent for CY 2017 and after. Applies the expansion State matching rate only to expenditures made on or after Jan. 1, 2020 for newly-enrolled non-pregnant childless adults whose income does not exceed 133 percent of FPL, adjusted for family size, who were enrolled on or before Dec. 31, 2019 and who do not have a break in eligibility for medical assistance for more than one month after Jan. 1, 2020. *(Sec. 112)* Sunset of Essential Health Benefits Requirement. Repeals the requirement that State Medicaid plans must provide the same Essential Health Benefits package that Qualified Health Plans offered through an Exchange must provide, effective Dec. 31, 2019. *(Sec. 112)* Letting States Disenroll High-Dollar Lottery Winners. Adds a new subparagraph in the section on modified adjusted gross income (MAGI) on "Treatment of Certain Lottery Winnings and Income Received as a Lump Sum." Requires a State that uses MAGI to determine eligibility for medical assistance to include lump sum lottery winnings of less than $80,000 as income in the month in which the winnings were received; to include lump sum lottery winnings of between $80,000 and $90,000 as income over two months; to include lump sum lottery winnings of between $90,000 and $100,000 over three months; and to include lump sum lottery winnings over $100,000 over a period of three months plus one additional month for each increment of $10,000 of such winnings received, not to exceed a period of 120 months (for winnings of $1,260,000 or more). Allows for an exemption if the denial of eligibility would cause an undue medical or	

Policy	House Bill (E&C)	House Bill (W&M)
Medicaid Reform (cont'd)	financial hardship. Requires a State to notify an individual who loses eligibility under this section before such eligibility loss. Defines the terms "qualified lottery winnings" and "lump sum income." Allows a State to intercept State lottery winnings to recover amounts paid under the State Medicaid plan for medical assistance furnished to the individual. Would not limit the Medicaid eligibility of a lottery winner's household members. *(Sec. 114)* Repeal of Retroactive Eligibility. Repeals the provision that requires a State Medicaid plan to make assistance available up to three months before the month in which an individual applies for medical assistance and is determined to be eligible for such assistance, and instead requires a State Medicaid plan to make such assistance available only in or after the month in which the individual applies. Effective for individuals who apply for medical assistance on or after Oct. 1, 2017. *(Sec. 114)* Individuals who are not Citizens or Nationals of the U.S. Repeals the provision that requires a State to provide a reasonable opportunity for an individual to provide satisfactory evidence of citizenship or nationality and that prohibits a State from delaying, denying, reducing, or terminating the individual's eligibility for benefits under the program on the basis of the individual's immigration status until such a reasonable opportunity has been provided, effective six months after enactment. In the case of a State that elects to provide a reasonable period to present satisfactory evidence of citizenship or nationality, specifies that no Federal Medicaid funds shall be paid for items or services furnished to such individual during such period before satisfactory evidence is produced. *(Sec. 114)* Allowable Home Equity Limits. Removes a State's authority to establish a higher home equity threshold for ineligibility for medical assistance than otherwise would apply ($500,000), effective for eligibility determinations made after the date that is 180 days after enactment. Allows a grace period for a State that requires legislation to amend the State's home equity threshold for ineligibility, such that the State's plan would not be found to fail to comply with requirements of title XIX of the Social Security Act. *(Sec. 114)*	

Policy	House Bill (E&C)	House Bill (W&M)
Medicaid Reform (cont'd)	Safety Net Funding for Non-Expansion States. Adds a new section 1923A to the Social Security Act that provides $10 billion total over five years (2018 through 2022) for FMAP payments to non-expansion States that adjust the payment amounts otherwise provided to health care providers for services furnished to Medicaid enrollees. Sets the FMAP percentage for expenditures for payments to such health care providers at 100 percent in each of 2018 through 2021 and 95 percent in 2022. Limits payment to a non-expansion State in a given year to a share of the $2 billion available, based on the size of the State's population with income below 138 percent of the FPL in 2015 relative to the total population of individuals with income below 138 percent FPL for all non-expansion States in 2015. Limits the payment adjustment for services furnished by a health care provider to a Medicaid enrollee under this new section to the provider's costs incurred. Specifies that a non-expansion State that expands Medicaid eligibility shall not be treated as a non-expansion State for any subsequent year. *(Sec. 115)* Increased Frequency of Eligibility Determinations. Requires a State to re-determine Medicaid eligibility for non-pregnant childless adults with incomes that do not exceed 133 percent of FPL, adjusted for family size, no less frequently than once every six months. Increases by five percent the applicable Federal matching percentage for the period Oct. 1, 2017 through Dec. 31, 2019 with respect to State expenditures attributable to increased frequency of eligibility re-determinations. *(Sec. 116)* Civil Monetary Penalties. Allows the Secretary to impose civil monetary penalties up to $20,000 per individual who was knowingly enrolled for medical assistance on or after Oct. 1, 2017 whose income does not meet the applicable income threshold. Allows the Secretary to impose civil monetary penalties up to $20,000 per claim presented on or after Oct. 1, 2017 for an item or service furnished to an individual whose income does not meet the applicable threshold. *(Sec. 116)* Per Capita Allotment for Medical Assistance. Reforms the Medicaid program to establish a per capita cap model, starting in FY 2020. Sets	

Policy	House Bill (E&C)	House Bill (W&M)
Medicaid Reform (cont'd)	forth, in detail, a formula for determining each State's per capita allotment. In brief, the base year would be set to FY 2016 for purposes of establishing each State's targeted spending for each of the following categories of enrollees: elderly, blind and disabled, children, expansion adults, and other nonelderly, nondisabled, non-expansion adults. The targeted spending amount would increase annually by the percentage increase in the medical care component of consumer price index for all urban consumers (CPI-U) from Sept. 2019 to Sept. of the applicable year. If any State were to exceed its targeted aggregate amount for a given fiscal year, that State would be subject to reductions in Federal Medicaid funding for the following fiscal year. Certain expenditures and categories of enrollees would be exempt from the calculation and application of each State's cap. Disproportionate Share Hospital (DSH) payments, certain non-DSH supplemental expenditures, Medicare cost-sharing (for dually-eligible individuals), and safety net provider payment adjustments in non-expansion States would be exempt, as would the following populations: CHIP Medicaid expansion enrollees, individuals receiving services at an Indian Health Service facility, individuals eligible for services under the Breast and Cervical Cancer Early Detection Program, and partial-benefit enrollees (*e.g.*, aliens eligible for emergency medical care, individuals eligible for family planning services, individuals eligible for tuberculosis related services, individuals eligible for premium assistance, and partial duals). The per capita allotment would apply to waiver programs and supersede any payment limitations otherwise applicable under a given waiver. States would be permitted to expand Medicaid coverage after FY 2016, but the target per capita amount would be based on the per capita target amount for the State's FY 2016 non-expansion population, as adjusted. Reporting requirements would be updated to establish a penalty for failure to satisfactorily report data on expenditures and enrollees for any given year, to allow States to appeal applicable calculations made by the Secretary (subject to certain limitations), to provide for a temporary increase in funding (for Oct. 1, 2017 through Oct. 1, 2019) that supports additional reporting requirements (*i.e.*, medical assistance expenditures within the applicable enrollee and service categories	

Policy	House Bill (E&C)	House Bill (W&M)
Medicaid Reform (cont'd)	necessary for calculating each State's allotment), and to establish auditing requirements. *(Sec. 121)*	
Continuous Coverage	Continuous Health Insurance Coverage Incentive. Establishes a monthly penalty for individual and small group coverage, equal to 30 percent of a policyholder's otherwise applicable premium, for individuals who do not maintain continuous coverage. This penalty would apply to all applicable enrollments in plan year 2019 and beyond, as well as to applicable enrollments made during a special enrollment period (SEP) for plan year 2018. The penalty is intended to reduce the risk of adverse selection in the individual and small group markets. Individuals would be subject to a 12-month lookback period (calculated from the date of enrollment) and would have to demonstrate that there was not a period of a least 63 continuous days within the lookback period during which the individual did not have creditable coverage. If an individual is unable to demonstrate that he or she maintained continuous coverage during the lookback period, the 30 percent penalty would apply to monthly premiums for the first plan year of coverage (or remainder of the plan year thereof, if enrolling during a SEP). This penalty would also apply to young adults who age out of their parents' coverage (after age 26) and who fail to enroll in new coverage during the first subsequent open enrollment period. *(Sec. 133)*	
Health Savings Accounts		Maximum Contribution Limit to Health Savings Account Increased to Amount of Deductible and Out-of-Pocket Limitation. Increases the basic limit on aggregate HSA contributions to equal the maximum limit on the amount of the annual deductible and out-of-pocket expenses of a high deductible health plan beginning in 2018. Thus, the contribution limit will be at least $6,550 for self-only coverage and $13,100 in 2018. *(Subtitle_ - Sec_16, p. 50)* Allow Both Spouses to Make Catch-Up Contributions to the Same Health Savings Account. Allows spouses, if both are eligible individuals and either has family coverage under a high deductible health plan, to make catch-up contributions to one HSA beginning in 2018. *(Subtitle_ - Sec_17, p. 51)* Special Rule for Certain Medical Expenses Incurred Before Establishment of Health Savings Account. Provides circumstances

Policy	House Bill (E&C)	House Bill (W&M)
Health Savings Accounts (cont'd)		under which HSAs may be used to pay for medical expenses incurred before the HSA was established. If an HSA is established within 60 days of the start date of coverage under a high deductible plan, the HSA is treated as if it had been established on the start date of coverage for purposes of determining whether the HSA can reimburse the expense tax-free. *(Subtitle_ - Sec_18, p. 53)* Repeal of Increase of Tax on Health Savings Accounts. Reduces the additional tax on non-medical distributions to the pre-ACA level of 10%. (*Subtitle _ - Sec._09, p. 16)*
Benefit Design	Increasing Coverage Options. Repeals current actuarial value (AV) standards (*i.e.*, metal levels of coverage), effective for plan years 2020 and beyond. *(Sec. 134)* Change in Permissible Age Variation in Health Insurance Premium Rates. Allows for a 5:1 age rating variation (which the Secretary of HHS may implement through interim final regulation), or such other ratio as a State may set forth, starting with plan years beginning on or after Jan. 1, 2018. Issuers still would be subject to the existing requirement that they also offer child-only coverage. *(Sec. 135)*	
Disproportionate Share Hospital (DSH) Payments	Elimination of DSH Cuts. Repeals DSH cuts for non-Medicaid expansion States in 2018; repeals DSH cuts for Medicaid expansion States in 2020. *(Sec. 113)*	
Key Repealed Taxes		Remuneration From Certain Insurers. Repeals the limit on the deduction of a health insurer executive pay beginning in 2018. *(Subtitle _ - Sec_01, p. i)* Repeal of Tanning Tax. Repeals the tax on indoor tanning services beginning in 2018. *(Subtitle_ - Sec_01, p. ii)* Repeal of Tax on Prescription Medications. Repeals tax on brand name pharmaceutical manufacturers beginning in 2018. *(Subtitle_ - Sec_01, p. iii)* Repeal of Health Insurance Tax. Repeals the health insurance tax beginning in 2018. *(Subtitle_ - Sec_02, p. iii)* Repeal of Net Investment Income Tax. Repeals tax on investment income, on individuals, estates, and trusts with income above certain amounts beginning in 2018. *(Subtitle_ - Sec_01, p. iv)*

Policy	House Bill (E&C)	House Bill (W&M)
Key Repealed Taxes (cont'd)		Small Business Tax Credit. Repeals the small business tax credit beginning in 2020. For 2018 and 2019, the credit is not available for plans that cover certain abortions. *(Subtitle_ - Sec_04, p. 11)* Individual Mandate. Zeroes out the penalty for failure to maintain minimum essential coverage beginning in 2016. *(Subtitle_ - Sec_05, p. 14) (Note: A continuous coverage penalty is included in the House E&C bill to reduce the risk of adverse selection.)* Employer Mandate. Zeroes out the penalty for employers for failure to provide minimum essential coverage beginning in 2016. *(Subtitle_ - Sec_06, p. 14)* Repeal of Tax on Employee Health Insurance Premiums and Health Plan Benefits ("Cadillac Plan Tax"). Delays the effective date of the Cadillac plan tax (currently scheduled to start in 2020) to 2025. *(Subtitle_ - Sec_07, p. 15)* Repeal of Tax on Over-the-Counter Medications. Repeals the prohibition on reimbursement from health savings accounts (HSAs), Archer MSAs, and flexible spending arrangements, and health reimbursement arrangements for over-the-counter medications beginning in 2018. *(Subtitle_ - Sec_08, p. 15)* Repeal of Increase of Tax on Health Savings Accounts. Repeals the increased tax amount on HSA or Archer MSA distributions for non-qualified medical expenses beginning in 2018. *(Subtitle_ - Sec_09, p. 16)* Repeal of Limitations on Contributions to Flexible Spending Accounts. Repeals the limit on salary reduction contributions to health FSAs beginning in 2018. *(Subtitle_ - Sec_10, p. 16)* Repeal of Medical Device Excise Tax. Repeals the excise tax on the sale of certain medical devices beginning in 2018. *(Subtitle_ - Sec_11, p. 17)* Repeal of Elimination of Deduction for Expenses Allocable to Medicare Part D Subsidy. Repeals the elimination of tax deductions for employers on the value of the Part D subsidy and reinstates the business-expense deduction for retiree prescription drug costs without a reduction of any Federal subsidy beginning in 2018. *(Subtitle_ - Sec_12, p. 17)*

Policy	House Bill (E&C)	House Bill (W&M)
Key Repealed Taxes (cont'd)		Repeal of Increase in Income Threshold for Determining Medical Care Deduction. Repeals the increase in the adjusted gross income threshold from 7.5 percent to 10 percent for individuals who itemize deductions for qualifying medical expenses beginning in 2018. *(Subtitle_ - Sec_13, p. 18)* Repeal of Medicare Tax Increase. Repeals the additional Medicare Hospital Insurance taxes beginning in 2018. *(Subtitle_ - Sec_14, p. 18)*
Family Planning Providers	Prohibited Entities. Imposes a one-year freeze, beginning on the date of enactment, on direct spending to a State for payments to a "prohibited entity," directly or through a managed care organization under contract with the State. Defines "prohibited entity" as a non-profit 501(c)(3) organization and its affiliates, subsidiaries, successors, and clinics; that is engaged primarily in family planning services and related medical care; that furnishes abortions for reasons other than pregnancy resulting from rape or incest, or harm to the woman; and for which the total amount of Federal and State expenditures during FY 2014 exceeded $350 million. Specifies that "direct spending" means budget authority provided by law other than an appropriations act, entitlement funding, and the Supplemental Nutrition Assistance Program. (*Sec. 103)*	
Miscellaneous Provisions	Prevention and Public Health Fund. Repeals Prevention and Public Health Fund funding for FY 2019 and beyond. Rescinds unobligated funds at the end of FY 2018. *(Sec. 101)* Community Health Center Program. Provides $422 million in funding for FY 2017 for the Community Health Center Fund, which makes grants to Federally-Qualified Health Centers (FQHCs). *(Sec. 102)*	