ITUP
Insure the Uninsured Project

Fact Sheet

September 2017

(As amended 9/25/17)

The Graham-Cassidy-Heller-Johnson Proposal (H.R. 1628, Revised)

ACA Repeal and Replace Worst Case for California

On Sunday, September 24, 2017 only a few days before the Senate is to vote on the bill, Senators Graham, Cassidy, Heller and Johnson released a new version of H.R. 1628 (Graham-Cassidy proposal). Under the Graham-Cassidy proposal, California would experience unprecedented cuts in federal funding for health care and dramatic increases in the number of uninsured Californians.

The revised version does little to mitigate the harm to California and may, in fact, be still worse because the revisions seek to allocate more federal funds to specific states, such as Alaska.

Impact of Graham-Cassidy for California

Federal Funding. By 2026, according to the fiscal estimates released on September 25, 2017 by the California Department of Health Care Services (DHCS), California could see a total reduction of nearly ***$86 billion*** in federal funds. The DHCS analysis reflects proposed cuts to federal Medicaid funding (-$211 billion) and the marketplace (-$62 billion), only partially offset by California's allocation under the new ACA block grant established by the bill (+$187 billion).[1] DHCS estimates that in 2027 when the ACA block grant expires, California could experience a one-year loss of ***$53 billion***, associated with the end of the new block grant and continuation of the Medicaid per capita cap.[2]

Number of Uninsured in California. Graham-Cassidy would not only rollback California coverage successes of the ACA, but undo decades of progress on coverage in California. Under H.R. 1628, the number of uninsured in California could grow from approximately ***three million to nearly ten million***. Pre-ACA, California had 5.6 million uninsured individuals.[3] In 1998, approximately 6.8 million Californians were uninsured.[4] Once H.R. 1628 is fully implemented in 2027, more than 6.7 million Californians could lose coverage.[5]

Medicaid Per Capita Cap. As with many previous proposals considered by Congress, Graham-Cassidy goes beyond rollbacks to the ACA and restructures traditional Medicaid to a fixed, per capita cap program (or alternatively a block grant program if states choose that option). Traditional Medicaid populations – children, parents, seniors and persons with disabilities – will be affected by the shift in federal responsibility for Medicaid.

- ✓ Under the per capita cap program and based on the DHCS analysis of the original Graham-Cassidy proposal, California would lose approximately ***$26 billion*** in federal funds from 2020-2026, and an additional ***$8.7 billion*** in 2027.[6]
- ✓ Under one scenario analyzed by the U.C. Berkeley Labor Center, an estimated ***1.3 million children, plus 80,000 seniors and 80,000 individuals with disabilities*** could lose coverage because of the funding gaps caused by the transition to a per capita cap program.[7]

Summary of the Revised Graham-Cassidy Proposal

Near the end of July 2017, as the U.S. Senate began voting on various Republican-sponsored initiatives to roll back the Affordable Care Act (ACA), Senators Graham (R-South Carolina) and Cassidy (R-Louisiana) offered an amendment to the Better Care Reconciliation Act (BCRA), which Senator Heller (R-Nevada) later co-sponsored. On September 13, 2017, Senator Johnson (R-Wisconsin) joined Senators Graham, Cassidy and Heller as a co-sponsor of H.R. 1628, a revision to the July 2017 amendment. *On September 24, the sponsors released a revised amendment.*

The Graham-Cassidy proposal eliminates penalties for individuals and employers that do not comply with the ACA coverage mandates and allows states to waive many of the consumer protections of the ACA. In addition, Graham-Cassidy includes dramatic restructuring and cuts in the federal commitment to the Medicaid program through inclusion of the per capita cap program from prior Congressional proposals. However, Graham-Cassidy goes further than prior Senate proposals by establishing a new state block grant program consolidating ACA funding for coverage expansion (premium tax credits, cost-sharing reductions and Medicaid expansion), reducing the funding and implementing complex funding formulas for determining individual state grants.

Changes introduced in the September 24 revised amendment are indicated by orange italics.

Market-Based State Grants

Starting in 2020, replaces enhanced federal funding under the ACA for the Medicaid adult expansion, subsidies in the form of tax credits and cost-sharing subsidies (CSRs) with "market-based" state grants. Appropriates $1.176 trillion ($136 - $200 billion annually for 2020-2026). The annual appropriation is a funding ceiling for state grants. Annual appropriations do not adjust based on economic downturns or other factors that impact coverage nationally.

Requires states to submit a one-time funding request for the new grants to achieve any one of seven purposes including strategies to address health care needs of high-risk individuals, help stabilize premiums, assist with out-of-pocket costs, provide private insurance for individuals eligible for Medicaid, direct payments to providers, and other initiatives to support participation in individual coverage.

Eliminates the ACA Medicaid expansion for adults after 2019 and limits states to using no more than 15 percent (20 percent with an additional waiver) of a state's allotment to fund health insurance coverage for the remaining Medicaid beneficiaries. *Requires states to use at least 50 percent of the state grant for individuals with modified adjusted gross incomes between 45 percent and 295 percent of the federal poverty line (FPL).* Under the formulas, federal Medicaid funding would grow more slowly than estimates under current law.

The state grant allocations are based on the following formulas:

- ***2020 Baseline***. Each state selects four consecutive quarters from federal fiscal year (FFY) 2014 through the end of FFY 2017. The bill combines total federal expenditures in each state during

the selected quarters for the Medicaid adult expansion population, ACA tax credits, CSR subsidies and Basic Health Program to establish a base amount for 2017. To finalize the 2020 baseline, the 2017 base amount will be adjusted for years 2018-2020 as follows: the Medicaid expansion portion adjusted using inflators prepared by the Medicaid and CHIP Payment and Access Commission and the exchange, marketplace portion adjusted using the medical portion of the consumer price index (CPI-M). In years after 2020 and through 2026, each state baseline is adjusted based on additional formulas, as outlined below. *Adds an adjustment to increase state allocations for high-spending, low-density states, such as Alaska.*

- ***Years 2021-2026***. State grant allocations for 2021-2023 build on the prior year allocation adjusted by a formula that considers the number of low-income individuals in each state relative to the total number in the country. The formula divides the number of individuals (U.S. citizens and legal residents only) between 50 and 138 percent of the federal poverty level (FPL) in each state by the total number of individuals between 50 and 138 percent FPL nationally. State grants are determined by multiplying the total amount of funds available nationally by the "State's Percent of Beneficiaries (SPB)" resulting from the formula above. *Each year, adjusts the formula so that an additional one-tenth of state allocations depends on the SPB rather than the amount allocated in the previous year. By 2026, bases six-tenths of state allocations on the SPB.* Other adjustments are also applied.

- ***Risk Adjustment***. Starting in *2023*, phases in a risk adjustment program to revise state per-beneficiary amounts, in a budget neutral manner, based on an index of factors (disease burden, age, regional costs, gender, etc.) with details to be developed by CMS.

- ***Additional Funds***. *Creates an $11 billion contingency fund for 2020-2021 with 25 percent allocated to low-density states and 75 percent allocated to states that did not adopt the ACA Medicaid expansion. Additional funds are allocated to states with recent 1332 approved waivers, such as Alaska, Hawaii and Minnesota. California would be ineligible for any of these funds.*

- ***Disproportionate Share Hospital (DSH) Payments***. States will have access to DSH funds that were phasing out under the ACA if the state grant in any year 2021-2025 is less than the 2020 baseline (adjusted by CPI-M). States could receive less than the adjusted 2020 baseline, and become eligible to access DSH funds, because of the re-distribution of funds among states for risk adjustment, other adjustments outlined in the bill, and/or the SPB formula as discussed above.

According to the bill authors, the new grants are intended to allow for flexibility in how states address the needs of those losing Medicaid, ACA subsidies and other consumer protections in the ACA. However, the SPB adjustment formula does not account for Medicaid expansion populations below 50 percent FPL or individuals between 138 and 400 percent FPL eligible for CSR subsidies and ACA tax credits. This omission contributes to the proposed allocation formulas penalizing Medicaid expansion states, and states successful in enrolling low- and moderate-income individuals into marketplaces, including California.

Gives states that receive market-based grants additional flexibility on consumer protections including essential health benefit requirements, actuarial value standards, cost sharing and out-of-pocket limits, area and age rating, with some limitations. In addition, in submitting grant requests, states can also request waivers of ACA provisions, including essential health benefits, premium rating rules, the prohibition on charging more for individuals with pre-existing conditions, and other ACA consumer protections. *Requires states to describe in the application how the state will maintain access to adequate and affordable coverage for individuals with pre-existing conditions. Prior language required states to describe how they would maintain this access if a waiver was approved. This language does not provide the legal guarantees for individuals with pre-existing conditions that currently exist in the ACA, such as consumer protections, often referred to as "guardrails," that prohibit states from waiving key protections.*

The revised proposal specifies that a state must also certify compliance with several existing ACA requirements, including allowing dependents up to age 26 to remain on their parent's health plan and mental health parity.

Medicaid

- ***ACA Medicaid Adult Expansion***. In 2020, repeals the Medicaid adult expansion and enhanced federal funding for this expansion. *Allows some Native Americans to retain Medicaid coverage, providing they are covered under the ACA adult expansion of Medicaid as of December 31, 2019.* Transitions federal funding for the Medicaid expansion to the Market-Based State Grant Program. California currently has over 3.8 million individuals enrolled through the ACA Medicaid adult expansion.

- ***Medicaid Per Capita Cap***. In 2020, ends Medicaid as an entitlement that guarantees coverage to all eligible individuals and, in its place, implements formula-based, fixed funding for states using a "per capita cap model." Establishes state Medicaid funding levels under the per capita cap program by requiring states to identify eight consecutive fiscal quarters as the state's "per capita base period." Requires CMS to calculate the percentage of a state's total Medicaid expenditures for the base period for specified beneficiary categories to determine the state's per capita cap allocation.

  Includes in the per capita cap calculation Medicaid expenditures associated with specific beneficiary categories – the elderly, blind and disabled, children, and other adults. Excludes Children's Health Insurance Program, Indian Health Service, Breast and Cervical Cancer Services and partial benefit beneficiaries (e.g., beneficiaries dually eligible for Medicare and Medicaid and pregnant and emergency-only immigrant populations). Excludes from the per capita cap calculation blind and disabled children for whom states will continue to receive their traditional federal match. Generally, adjusts a state's total Medicaid expenditures for the selected base period to exclude certain payments, such as DSH payments, Medicare cost-sharing payments and Medicaid expenditures to address a public health emergency.

  Until 2025, annually adjusts state per capita cap allocations based on the medical component of the consumer price index (CPI) for urban areas and establishes the adjustment for elderly, blind and disabled beneficiary categories as the medical CPI plus one percentage point. For 2025 and

thereafter, sets the adjustment factor for all beneficiary categories, except the elderly, blind and disabled beneficiary category, at CPI for urban areas. For the elderly, blind and disabled beneficiary category the adjustment factor will be the medical CPI for 2025 and thereafter.

- ***Medicaid Block Grant***. States have the option to receive a five-year block grant in lieu of implementing the per capita cap for Medicaid nonelderly, nondisabled, adult beneficiaries. States choosing the block grant gain some flexibility in adjusting Medicaid program design and eligibility. The initial block grant amount is based on a formula that considers the state's per enrollee Medicaid expenditures for the fiscal year multiplied by the number of adult enrollees and the federal average Medicaid matching rate for the state for the fiscal year. In subsequent years, the block grant amount would be adjusted annually using the CPI for urban areas (not medical CPI).

  Under a block grant, states must continue to serve mandatory, nonelderly, nondisabled, adult populations. States must provide the following services: hospital inpatient and outpatient, laboratory and X-rays, nursing facility, physician, home health care, rural health clinic, federally-qualified health center, family planning, nurse midwife, certified pediatric and family nurse practitioner, freestanding birth center, emergency medical transportation, non-cosmetic dental and pregnancy-related. Benefits must include mental health and substance use services that meet mental health parity requirements. State block grant programs can adopt enrollee cost sharing, including premiums and deductibles, provided the charges do not exceed five percent of family income.

- ***State Options: Increased Eligibility Redeterminations and Work Requirement***. Allows states to: (1) conduct six-month redeterminations of eligibility for expansion adults and provides a five percent enhanced federal match to assist states in covering the administrative costs of conducting the additional redeterminations, (2) impose a work requirement for nondisabled, nonelderly, non-pregnant adults. Under the work requirement, eligible low-income adults would have to participate in work activities, as defined, for a state-specified period to maintain Medicaid eligibility. States that adopt a work requirement will receive a five percent enhanced federal match to support the additional administrative costs.

- ***Provider Tax***. Introduces a new restriction on states' ability to finance Medicaid through provider taxes, a financing mechanism used by most states, including California.

- ***Home and Community-Based Services (HCBS)***. In 2020, ends enhanced Medicaid match for Home and Community-Based Attendant Services and Supports ($19 billion cut over ten years), which California currently uses to support the In-Home Supportive Services Program. Establishes an $8 billion, four-year demonstration project providing state incentive payments for home and community-based services for the aged, blind, and disabled. States compete to secure funding and the 15 lowest population density states receive priority consideration.

- ***Institutions for Mental Diseases (IMDs)***. In 2019, loosens some existing limitations on Medicaid coverage for certain inpatient psychiatric hospital services, as specified. The Medicaid IMD exclusion generally prohibits the use of federal Medicaid financing for care provided to most patients in mental health and substance use disorder residential treatment facilities larger than 16 beds, known

as IMDs. Amendment language allows for up to 50 percent match for IMDs if states meet specified conditions.

- ***State Performance Bonuses***. For 2023–2026, implements a Medicaid and CHIP quality performance bonus payment program for states that achieve lower than expected aggregate medical expenditures and meet specific quality measures. Appropriates $8 billion dollars for this purpose.

- ***Enhanced Medicaid Funding for Native Americans***. Extends eligibility for enhanced federal Medicaid matching funds to any provider that serves specific Medicaid-eligible Native Americans.

- ***Increased Federal Match for Certain States***. *Provides a higher rate of Medicaid federal financial participation (matching rate) for certain "high-poverty" states, based on state federal poverty levels. The specified rates would apply specifically to Alaska and Hawaii.*

Insurance Market

- ***Coverage Mandates***. Eliminates the ACA penalties for individuals and employers who do not comply with the ACA mandates to obtain coverage, retroactive to December 31, 2015.

- ***Refundable Tax Credits and Cost Sharing Reduction (CSR) Subsidies.*** After 2020, ends refundable tax credits and CSR subsidies.

- ***Short Term Assistance***. Appropriates $25 billion total for 2019-2020 only to fund arrangements with insurers to assist with coverage and access disruptions, as well as to help stabilize premiums and promote individual market participation. *Allocates five percent to low-density states.*

- ***Health Savings Accounts (HSAs)***. Allows HSAs to be used for health insurance premiums, as specified. Prohibits HSAs to be used to pay premiums for high deductible health plans if they cover abortions, except where necessary to save the life of the mother or in the case of rape and incest. Allows HSAs to be used to pay qualified medical expenses incurred by an account holder's children who are under age 27. Increases the maximum contribution limit for HSAs. Allows both spouses to make "catch-up" contributions to the same HSA. For individuals age 55 and over, the HSA contribution is increased by $1,000 ("catch-up" contribution). Currently, only the account holder can make this contribution. Allows HSAs to pay for over-the-counter medications and medical expenses incurred 60 days before the HSA was established if the account holder was in a high deductible health plan during that time.

- ***Small employer tax credits.*** In 2020, eliminates the ACA small employer tax credit and eliminates the credit for insurance expenses for employee coverage in health plans that cover abortion services.

Other Provisions

- ***Women's Health Services.*** After 2018, redefines qualified health plans to exclude plans that provide abortion services beyond those to save the life of the mother or in cases of rape or incest. Imposes a one-year moratorium on states providing any federal funds to Planned Parenthood clinics. The Senate Parliamentarian has ruled that both these provisions violate Senate rules for reconciliation bills. (Known as the "Byrd rule," the rule limits what can be done through 51 vote budget

reconciliation bills. If the Senate Parliamentarian determines the provision violates the Byrd rule, the provision requires 60 votes to pass the Senate.)

- ***ACA Taxes.*** Repeals ACA taxes, including tax penalties associated with the individual and employer mandates, over-the-counter medications, health savings accounts and medical devices.

- ***Community Health Centers.*** For 2017, allocates $422 million for community health centers.

- ***The Prevention Fund***. Repeals the ACA Prevention and Public Health Fund, an $18.75 billion program to fund public health activities.

- ***Federal administration***. Establishes a $2 billion Better Care Reconciliation Implementation Fund for federal administrative expenses associated with the implementation of H.R. 1628.

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[1] California Department of Health Care Services (DHCS), "Summary and Preliminary Fiscal Analysis of the Combined Medicaid and Health Benefit Exchange Provisions in the Graham-Cassidy-Heller-Johnson Amendment," September 2017, http://www.dhcs.ca.gov/Documents/Graham_Cassidy_Impact_Memo_DHCS_092217.pdf.

[2] DHCS et al.

[3] Kaiser Family Foundation, "State Health Facts: Health Insurance Coverage of the Total Population," 2013, http://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[4] Robert J. Mills, "Health Insurance Coverage: 2000," Current Population Reports, September 2001, https://www.census.gov/prod/2001pubs/p60-215.pdf. (According to the report, the uninsured rate in California was 20.5 percent in 1998. In 1998, California had a population 32.99 million. The number of uninsured Californians in 1998 was derived by multiplying the total population by the uninsured rate.)

[5] Jacob Leibenluft, Edwin Park, Matt Broaddus, and Aviva Aron-Dine, "Like Other ACA Repeal Bills, Cassidy-Graham Plan Would Add Millions to Uninsured, Destabilize Individual Market," Center on Budget and Policy Priorities, https://www.cbpp.org/research/health/like-other-aca-repeal-bills-cassidy-graham-plan-would-add-millions-to-uninsured.

[6] DHCS et al.

[7] Laurel Lucia, Ian Perry, and Ken Jacobs, "The GOP's last ditch effort to repeal the Affordable Care Act is the worst one yet for California," U.C. Berkeley Labor Center, September 2017, http://laborcenter.berkeley.edu/the-gops-last-ditch-effort-to-repeal-the-affordable-care-act-is-the-worst-one-yet-for-california/.

Insure the Uninsured Project (ITUP) is a nonpartisan nonprofit, 501(c)(3) organization with the mission to to promote innovative and workable policy solutions that expand health care access and improve the health of Californians, through policy-focused research and broad-based stakeholder engagement.

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