ITUP
Insure the Uninsured Project

Fact Sheet

August 2017

Summary: Senate Better Care Reconciliation Act (BCRA)

Incorporating The Graham-Cassidy-Heller Amendment

Near the end of July 2017, as the U.S. Senate began voting on various Republican-sponsored initiatives to rollback 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.

The Graham-Cassidy-Heller amendment retains many of the harmful provisions in the BCRA including dramatic restructuring of the Medicaid program. The primary distinctive provision is the proposal to establish a "Market-Based State Grant Program" allocating to states federal funds intended to replace the ACA Medicaid adult expansion, ACA tax credits and cost sharing reduction (CSR) subsidies.

- ***Market-Based State Grants.*** Starting in 2020, replaces enhanced federal funding for the Medicaid adult expansion, ACA tax credits and CSR subsidies with "market-based" state grants. Appropriates $1.043 trillion ($140 - $158 billion annually for 2020-2026). Requires states to submit a one-time funding request to address health care needs of high-risk individuals, help stabilize premiums, assist with out-of-pocket costs, and/or fund other initiatives to support participation in the individual market. Ten percent of a state's allotment can fund wraparound, optional services for certain Medicaid beneficiaries. Requires a three-five percent state match.

  The 2020 grant allocation to states is based on the following complicated formula:

  - 10 percent of the total available funds are allocated based on the number of individuals between 100 and 138 percent of the federal poverty level (FPL) in a state, divided by the total number of individuals between 100 and 138 percent FPL nationally.
  - 20 percent based on the number of adults between 45 and 64 years of age in a state, divided by the total number of individuals between 45 and 64 years of age nationally.
  - 25 percent based on the number of individuals between 100 and 138 percent FPL in a state, divided by the number of individuals nationally with an average per capita income of less than $52,500 in 2016 and who are between 100 and 138 percent FPL. Only states with an average per capita income less than $52,500 in 2016 can receive funds in this element of the program.
  - 10 percent to states with low population density. California would be ineligible for these funds.
  - 35 percent to expansion states, such as California, based on the number of individuals between 100 and 138 percent FPL in a state, divided by the total number of individuals between 100 and 138 percent FPL in all expansion states.

The proposed allocation formula includes a funding floor and a ceiling, based on the total amount of 2016 federal funds received by a state for the ACA Medicaid adult expansion, the Basic Health Program, ACA premium tax credits and CSR subsidies. Generally, the ceiling is three times the amount of 2016 federal funds a state received for these programs and the floor is no less than 75 percent of this amount.

Additional provisions of the proposed state grants. Calculates state allocations for 2021 to 2024, and state-specific funding floors and ceilings, by adjusting the 2020 rate using the medical component of the consumer price index (CPI). The urban CPI is used to adjust the 2025 state allocation. The 2026 state allocation is based on a formula that generally parallels that used in 2020 with more funds allocated based on poverty level, age, per capita income and population density. The allocation dedicated to expansion states, such as California, is eliminated in 2026.

State allocations for 2021-2026 outside a certain percentage of the national mean are subject to an additional adjustment. Adjustments must maintain budget neutrality, unless the allocation involves a low density state (less than 15 individuals per square mile.)

Although the grants would allow for flexibility in how states address the needs of those losing ACA affordability protections and coverage, according to an analysis by the Center for Budget and Policy Priorities (CBPP), the proposed grant program will be $26 billion below current projected funding levels in 2020. The gap grows to $83 billion in 2026. In addition, CBPP found that the proposed formula benefits non-expansion states and harms states, such as California, that expanded coverage under the ACA. The Market-Based State Grant Program ends completely in 2026.

Medicaid

- ***ACA Medicaid Adult Expansion***. In 2020, repeals the Medicaid adult expansion and allows states the option to expand Medicaid to childless adults up to 133 percent of the federal poverty level (FPL). Eliminates the enhanced federal match for the Medicaid adult expansion population. States that choose to expand Medicaid to childless adults or to maintain their existing coverage to this population will receive their traditional federal match, which is 50 percent for California.

  California currently has over 3.8 million individuals enrolled through the ACA Medicaid adult expansion. The rate change proposed in the amendment increases the state's costs five-fold to continue Medi-Cal coverage for these individuals, according to the California Department of Health Care Services (DHCS). From 2021-2027, DHCS estimates the increased cumulative state costs to be $74.1 billion ($51.9 billion state general fund), if the enhanced federal match is eliminated.

- ***Medicaid Per Capita Cap***. 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 the federal Department of Health and Human Services (DHHS) 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, expansion adults 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 Disproportionate Share Hospital (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 1 percentage point. For 2025 and thereafter, sets the adjustment factor for all beneficiary categories at CPI for urban areas. If a state's per capita costs for a beneficiary category are 25 percent higher or lower than the mean for all states for those beneficiaries, DHHS will reduce or increase the outlier state's allocation for that category. These adjustments do not apply to predominantly rural states and the adjustments cannot result in a net increase in federal Medicaid payments.

DHCS estimates the transition to a Medicaid per-capita cap model would cost California $2.6 billion in 2020, growing to $11.3 billion by 2027.

- ***Medicaid Block Grant***. States have the option to receive a block grant in lieu of implementing the per capita cap for Medicaid nonelderly, nondisabled, adult beneficiaries. The BCRA grants states choosing the block grant significant flexibility in adjusting Medicaid program design and eligibility. The initial block grant amount would generally parallel the amount the state would have received under the per capita cap model for adults, with some adjustments. 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 but have the option to add the Medicaid adult expansion population to the block grant. 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.

- ***Retroactive eligibility***. Eliminates 90-day retroactive Medicaid eligibility as of October 1, 2017 except for seniors and persons with disabilities. For most Medicaid populations eligibility will be limited to the month in which the applicant applied.

- ***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)***. On and after October 1, 2018, 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.

Insurance Market

- ***Coverage Mandates***. Eliminates the ACA penalties for individuals and employers who do not comply with the mandate 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.

- ***Eligibility for Exchange Participation, Tax Credits and CSRs***. After 2020, repeals provisions determining eligibility for exchange participation, tax credits and CSRs, including provisions regarding advanced determinations for these benefits. Terminates the disclosure of tax return information used to facilitate eligibility determinations after 2020.

- ***Short Term Assistance***. Appropriates $55 billion total for 2018-2020 to fund arrangements with insurers to assist with coverage and access disruptions, as well as to help stabilize premiums and promote individual market participation.
- ***Health Savings Accounts (HSAs)***. Allows HSAs to be used for health insurance premiums. 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 for primary care service arrangements, coverage restricted to primary care services in exchange for a fixed periodic fee. Increases the maximum contribution limit for HSAs. Allows both spouses to make "catch-up" contributions to the same HSA if both spouses are at least 55 years old. 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 medical expenses incurred 60 days before the HSA was established if the account holder was in a high deductible health plan during that time.
- ***Catastrophic Plans***. In 2019, allows any individual participating in the individual market to enroll in a catastrophic plan. Currently, enrollment in catastrophic plans is limited to individuals under 30 years of age and those with a hardship exemption from the requirement to maintain minimum essential coverage. (Hardships exemptions apply when financial situations and other circumstances keep an individual from securing comprehensive insurance coverage.)
- ***Waiver for State Innovation***. Decreases the federal scrutiny on 1332 waivers and allows state waivers of significant ACA requirements, including essential health benefits, individual mandate, cost-sharing subsidies, premium tax credits, qualified health plan standards, among others. DHHS can deny a state waiver request if it determines the state action would increase the federal deficit.
- ***Age-Adjusted Rates***. Beginning in 2020, allows states to change the ratio for health care premiums between the youngest and oldest adults to 5:1 instead of the 3:1 ratio in the ACA. Authorizes states to adopt a different ratio.*
- ***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.
- ***Small Business Health Plans***. Allows for small business health plans (SBHPs), enabling multiple small businesses to jointly purchase large group coverage through associations that would generally be exempt from state insurance regulation. Sponsors for SBHPs are associations with a constitution and bylaws established for a purpose other than providing health benefits to its members, such as a trade association. SBHPs need to be certified by DHHS.*

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.*

- ***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 (2010-2022 and $2 billion annually thereafter).
- ***Federal administration***. Establishes a $2 billion Better Care Reconciliation Implementation Fund for federal administrative expenses associated with BCRA implementation.

* *Provisions the Senate Parliamentarian ruled violates Senate rules for reconciliation bills. Known as the "Byrd rule," the rule limits what can be done through 51 vote budget reconciliation bills. Depending on what specific health reform proposal the Senate ultimately considers, provisions identified by the Senate Parliamentarian would require 60 votes to pass the Senate. The Senate Parliamentarian identified several other provisions still under review including waivers for state innovation.*

Kaiser Permanente
L.A. Care Health Plan
The California Endowment
The California Wellness Foundation