NASUAD
National Association of States United for Aging and Disabilities
202.898.2578 • www.nasuad.org

Affordable Care Act Repeal Legislation Summary

Background

On March 6th, 2017, Republican leadership in the Energy and Commerce and Ways and Means committees released legislation that would repeal and replace the Affordable Care Act, called the American Health Care Act. This is an updated bill compared to the draft that was leaked on February 24, 2017 to Politico. The legislation continues to closely track with other policy documents released by House Republican leadership, such as the "Better Way" blueprint from Speaker Paul Ryan, as well as the briefing documents that were presented to the House Republican Caucus last month. Additionally, the Republican Governor's Association has been developing some proposals for ACA replacement and Medicaid reform. NASUAD will provide comparisons between the House Legislation and the RGA proposals in a future publication.

This legislation will likely be advanced through the House of Representatives. However, even if the bill passes the House in its current form, some of these policies may not become law. As we noted previously, several Republicans in the Senate have expressed reservations about some of the policies included in this bill. This includes some members who argue that the bill is too generous and creates a new entitlement through new tax credits, versus others who have expressed concern about removing Medicaid expansion funding and moving to a per capita funding cap on Medicaid. Additionally, the legislation has not yet received a score by the Congressional Budget Office, which is the formal process for assessing the financial impact of Federal legislation. The CBO is also expected to project the impact of the legislation on the number of insured individuals in the nation. Since the bill includes repeals of many of the ACA's significant taxes and revenue devices without many major offsets, there are concerns that the bill may not be cost-neutral (which is required for a bill passed via reconciliation), which could present a challenge with this bill.

We are updating our previous memo to reflect changes to the House legislation that have been made since the February 24th bill was leaked. NASUAD will continue to provide updates to members as we learn more about this, and other proposals to reform the nation's health care system.

More information and the full bill text is available at:

- The Energy and Commerce Committee, for Medicaid provisions and related policies;
- The Ways and Means Committee, for provisions relating to tax credits, tax repeals, and other market reforms;

Key Provisions in the American Health Care Act (the House ACA Repeal and Replace bill)

The legislation would effectively terminate the Affordable Care Act at the end of 2019, with a wide range of policies being terminated on December 31, 2020 with significant changes to the Medicaid and insurance marketplace taking effect simultaneously. This includes provisions such as:

- Repealing the ACA advanced premium tax credits (APTCs) which are used to subsidize the purchase of health insurance on the exchanges;
- Repealing ACA taxes, including the increased Medicare tax; the health insurer tax; and the medical device tax, among others:
    - The tax on high-cost health plans, known as the Cadillac tax, is delayed but not fully repealed;
- Establishing a new tax credit to purchase insurance that is based upon age rather than income:
    - The credit would vary from $2,000 for individuals younger than 30 to $4,000 for individuals over 60.
        - The tax credit is available for each individual in a family up to a maximum of $14,000 per household.
    - The updated legislation includes a gradual phase-out of the tax credits for individuals making more than $75,000 a year (or couples making more than $150,000). For every $1,000 in income above these thresholds, the credit decreases by $100.
- Eliminating the increased Federal match (FMAP) for 1915k/Community First Choice services;
- Removing increased FMAP for ACA expansion groups (note: this has a gradual attrition policy explained below);
- Setting a per-capita cap on Medicaid expenditures; and
- Providing $100 billion in grants to states in order to establish programs that support the insurance marketplace and individuals with significant health conditions.

Below, we provide updated detail on some of the policies included in this legislation. Provisions and policies that have changed since our analysis of the draft legislation on February 24th are noted in red:

Provision	Implications for LTSS	Policy in the Draft Legislation
The Medicaid Community First Choice (CFC) Option. Also known as the 1915(k) state plan benefit.	1915(k) allows states to provide HCBS through the Medicaid state plan to individuals who meet the state's institutional level of care requirements. Services include attendant care supports and related services, which includes purchase of items that could be substituted	Retains 1915(k) services and eligibility; terminates the 6 percent FMAP increase, effective January 1, 2020.

Provision	Implications for LTSS	Policy in the Draft Legislation
	for human assistance. Participating states receive a 6 percent FMAP increase for CFC services. Eight States currently participate (CA, CT, MD, MT, NY, OR, TX, WA). For more information: https://www.medicaid.gov/medicaid/hcbs/authorities/1915-k/index.html	
Medicaid expansion	Expanded Medicaid to individuals under 65 who are not eligible for Medicare and who have incomes below 138 percent FPL, which was made optional by a Supreme Court Ruling. The Federal government financed 100 percent of the costs for the first three years. The matching rate gradually lowers to 90 percent, where it stays indefinitely. While this expansion was largely targeted to adults without disabilities, some states have explicitly allowed individuals who access Medicaid through this group to receive LTSS if they meet clinical eligibility criteria (see California for example: http://www.disabilityrightsca.org/pubs/555101.pdf). The Medicaid expansion excludes people on Medicare, but individuals receiving SSDI who are in the 24 month waiting period for Medicare could be included in this group.	Codifies that the Medicaid expansion is optional for states, as the law was never updated to reflect the Supreme Court ruling. Does not repeal the expansion. Ends the ability of states to expand this group to an income level above 138 percent FPL, effective January 1, 2020. Places significant restrictions on the increased matching rate for states that expand. The matching rate continues through January 1, 2020. After 2020, the matching rate continues for individuals who meet the following criteria: • Qualified for the enhanced matching rate as ACA newly eligible; • Were enrolled in Medicaid prior to January 1, 2020; and • Did not have a break in enrollment for more than one month after 2020. Essentially, this will lead to a gradual attrition and eventual elimination of the enhanced FMAP for the newly-eligible ACA group. States can still elect to cover Medicaid for the ACA expansion population, but will not receive the higher Federal match for individuals who enroll after 2020. They would instead receive their state's regular FMAP. The provision also ratchets down

Provision	Implications for LTSS	Policy in the Draft Legislation
		increased FMAP that was provided to certain states (such as New York and Massachusetts) that expanded their Medicaid program to childless adults before the ACA passed.
Mandatory Eligibility Level for Children age 6-18	This is an income based eligibility group for children, and is not a LTSS or disability-related eligibility group. However, some children with disabilities may access Medicaid through this poverty-related group instead of via a disability group	The bill reverts back to the pre-ACA mandatory minimum eligibility level of 100% FPL. ACA had raised this to 133% FPL. Eligibility levels for children of other ages are not impacted.
Medicaid Benchmark Plans include Essential Health Benefits	The ACA amended Medicaid Benchmark Benefit Plans, also known as Alternative Benefit Plans, to require that they include the Essential Health Benefit package. EHBs are provided to all individuals who are eligible for Medicaid via the ACA expansion, and states can elect to establish EHBs for other populations. The EHB includes benefit requirements such as rehabilitative and habilitative services, in addition to other health care benefits. Such supports can be beneficial to individuals with disabilities and/or chronic conditions.	The bill removes this requirement, effective January 1, 2020.
Medicaid "Per-Capita Caps"	This is a new policy, which sets upper spending limits on Medicaid based upon total enrollees. The per-capita caps are divided up by category of eligibility, which includes: • Individuals age 65 or older; • Individuals who are blind or have a disability; • Children under the age of 19 who are not eligible via a CHIP program; • Individuals who qualify as newly eligible for the ACA expansion; and • Other adults who are not included in the prior groups.	Beginning in FY2021, the FMAP for a state will be reduced if it spends above the target limits in the prior year. FY2020 is the first year that the spending limits would apply. The policy would reduce the quarterly Federal payments to a state by ¼ of the previous year's overage (effectively spreading out the reduction over the entire calendar year). The policy creates a spending baseline of FY2019 for each of the five eligibility categories. The spending limit is calculated for each of these groups by increasing the FY2019 baseline by the Medical care component of the Consumer Price Index for

Provision	Implications for LTSS	Policy in the Draft Legislation
	This policy excludes several groups of individuals from the per-capita caps: • Individuals eligible for Medicaid via a combined CHIP program; • Individuals receiving Indian health services; • Persons on Medicaid via breast and cervical cancer eligibility; • Partial-benefit dual eligible individuals; • Individuals receiving Medicaid payments for employer-sponsored insurance premiums/cost-sharing; • Undocumented immigrants who receive Medicaid-funded emergency care services. The policy also excludes several types of expenditures from the spending cap, including: • Disproportionate Share Hospital Payments; • Medicare cost-sharing payments; • Increased safety-net payments for providers in non-expansion state (that are created by this legislation).	Urban Consumers (CPI-M) up to the current year, ~~and adding one percentage point. The calculation is done each year, so the 1% increase is not compounding and would have a diminished impact over time. For example, if the CPI-U from FY2019-2020 is 2.1%, the inflation index would be 3.1%. And it the CPI-U FY2019-2023 is 8.6%, the inflation index would be 9.6%.~~ The baseline of FY2019 is set using FY2016 per-capita spending information. The FY2016 calculation is adjusted using the medical component of CPI-M between 2016-2019 ~~plus one percentage point.~~ Allowable supplemental payments that are not attributable to a specific person or service are calculated separately as a percentage of total expenditures and distributed across all population groups for purposes of calculating the per-capita caps. Delivery Systems Reform Improvement Payments (DSRIP) authorized under 1115 waivers are also excluded from the per-capita cap calculation. States must provide CMS with reporting information on the medical assistance expenditures and enrollment information for each of the five eligibility categories used to calculate per-capita caps. States are provided with 100% FMAP for MMIS/eligibility system design, implementation, and installation as well as operations/maintenance in FY2018-FY2019 to support the development of systems to meet the reporting requirements. States are also provided with a 10% increase to Medicaid

Provision	Implications for LTSS	Policy in the Draft Legislation
		administration matching (for a total of 60% match) for expenses directly related to implementing the new data requirements.
Public Health and Prevention Fund	The Affordable Care Act established the Prevention and Public Health Fund to provide expanded and sustained national investments in prevention and public health, to improve health outcomes, and to enhance health care quality. The fund was initially provided with $15 billion over a 10-year period; however, legislation following the ACA reduced the funding allocations. ACL has received resources from this Fund to support several of its activities, including chronic disease self-management, falls prevention, and Alzheimer's education and outreach. Other CDC programs have focused on diabetes and stroke prevention, which are significant for older adults.	The legislation would end funding for the Fund after September 30th, 2018 (FY18). Any unused funding at the end of FY18 would be rescinded.
Federally Qualified Health Centers	FQHCs provide a wide range of community-based health supports. While they are generally not directly related to LTSS provisions, they provide many supports to low-income individuals on Medicaid. This includes older adults and people with disabilities.	The proposed bill extends some enhanced funding for FQHCs under section 330 of the Public Health Services Act. The ACA originally included enhanced funding, which was extended by subsequent legislation. In FY2017, FQHCs received an additional $3.6 billion under this section. The legislation allocates an additional ~~$285~~ $422 million for FQHCs.
Hospitals Providing Presumptive Eligibility	Under the ACA, eligible Hospitals were allowed to provide presumptive eligibility determinations to individuals that were likely to be Medicaid eligible. This enabled potentially-eligible persons to enroll in Medicaid at the Hospital in order to defray medical costs and uncompensated care. This provision largely applies to individuals in non-ABD groups, as the disability determination could prevent immediate eligibility determinations; however, some	Ends the requirement for states to allow eligible Hospitals to provide presumptive eligibility determinations, effective January 1, 2020.

Provision	Implications for LTSS	Policy in the Draft Legislation
	older adults or persons with disabilities may qualify for presumptive eligibility.	
Counting Lump Sum Payments for MAGI eligibility	This would impact individuals who are determined eligible under the Modified Adjusted Gross Income calculations. MAGI groups do not have asset tests. Medicaid eligibility is determined based on income at a certain point in time; thus, individuals who receive a large lump-sum payment in one month can become eligible for Medicaid (or re-establish eligibility) in the following month. While MAGI generally applies to eligibility categories for individuals under age 65 without disabilities, some people who become eligible via MAGI groups have disabilities and LTSS needs.	This provision would count lump-sum income from sources such as a lottery, gambling, or an inheritance, in excess of $80,000 over multiple months, thus preventing individuals from re-establishing Medicaid eligibility as quickly. Under the legislation, individuals could have income from a large payment (exceeding $1,260,000) counted for up to 10 years.
Removal of Retroactive Eligibility	Medicaid policy allows eligibility to be established for three months prior to the date of application, if the individual met all of the Medicaid eligibility requirements during that three-month period. Under this policy, medical expenses incurred prior to application for Medicaid can potentially be covered by the individual, including older adults and people with disabilities. A recent court ruling in Ohio stated that this policy should apply to LTSS as well. This would likely impact some older adults and people with disabilities, particularly those who have lived in an Assisted Living Facility or other covered Medicaid LTSS setting in the 3 months prior to their application and/or those who utilized Hospital services before being determined eligible.	Beginning October 1, 2017, retroactive eligibility would be repealed. Medicaid eligibility would be established in (or after) the month when a person applies for the program.
Removal of Interim Coverage pending	Current policy requires that states provide Medicaid to individuals who attest to being a citizen (or legal immigrant not barred	The proposal would change the law to require that documentation be provided prior to the individual receiving Medicaid

Provision	Implications for LTSS	Policy in the Draft Legislation
Immigration Documentation	from receiving Medicaid) and meet all other eligibility criteria. These individuals are given a reasonable opportunity to provide documentation proving citizenship.	services. States could still provide a reasonable timeframe for individuals to provide documentation, but would not receive any FFP for services delivered prior to the documentation being received. This provision would take effect six months after the law is enacted.
Removal of Ability to Increase Home Equity Exclusion	For the purposes of determining Medicaid eligibility in categories that have an asset test (which includes LTSS and eligibility categories for older adults and people with disabilities), Medicaid excludes a certain amount of home equity from the applicant's assets. In 2017, the first $560,000 is excluded from the asset test. States have the option to increase the exclusion to an amount that is no more than $840,000. These amounts are indexed each year based on CPI-U.	The legislation would remove the ability to increase the exclusion above the minimum rate; thus all states would set their home equity exclusions at the $560,000 rate (and, in future years, at the dollar amounts calculated using the CPI-U inflationary factor). The provision would take effect 180 days after the law is enacted, except that states who require a state plan amendment to enact the policy would be given additional grace time until after their next legislative session.
Excluded providers from Medicaid	This provision is a new policy which creates a new payment exclusion for certain providers of abortion services. The payment exclusion lasts for 1 year from the enactment of the law. It is unlikely to directly impact LTSS providers, but may limit the sources of care that some individuals are able to utilize.	Excluded providers are those that meet the following criteria (including all subsidiary organizations): • A 501(c)(3) organization; • Is an "essential community provider" under the ACA that is primarily engaged in family planning services, reproductive health, and related care; • Provides abortions that are not due to rape, incest, or a life-threatening condition to the mother; and • Received more than $350 million from Medicaid programs in FY2014 throughout all affiliates, subsidiaries, successors, etc.
Repeal of Medicaid DSH Cuts	Hospitals that provide a disproportionate amount of care to low-income, uninsured, and/or Medicaid eligible individuals can	The legislation rescinds the DSH cuts and returns national DSH levels to pre-ACA amounts in two waves. States that did not

Provision	Implications for LTSS	Policy in the Draft Legislation
	qualify for supplemental DSH payments. DSH payments are capped at an annual allotment for each state. The ACA reduced aggregate DSH cuts based on the expectation that Hospitals would serve fewer uninsured individuals. The cuts were delayed several times by subsequent legislation.	expand Medicaid under the ACA would have their DSH allotments restored in 2018. States that expanded Medicaid would have the DSH levels restored in 2020.
Additional Payments under DSH		Provides increased funds for safety net providers in states that did not expand Medicaid during calendar years 2018-2022. Allocates $2 billion a year for those five years ($10b total) for these payments. Eligible states receive 100% FMAP for these payments for the first four years and 95% for the fifth year. Funds for states are determined by the ratio of individuals with income below 138% FPL across the non-expansion states. Payments to individual providers are limited to the costs incurred providing services to uninsured and Medicaid-eligible individuals.
Requires More Frequent Eligibility Determinations for Expansion Populations		Beginning October 1, 2017, states would be required to do eligibility redeterminations at least every 6 months for individuals in the ACA Medicaid expansion. Increases civil monetary penalties for individuals who knowingly enroll in the program when they are not eligible. Provides states with a 5% increase to Federal matching funds attributable to implementing this requirement from October 1, 2017 – December 31, 2019.
State Innovation Fund	This is a new policy that creates a grant program and funds it with $100 billion over a nine year period. The funding is $15 billion in FY2018 & FY2019, and $10 billion in the following seven years.	Allocates $100 billion over the nine-year period beginning in FY2018 for grants to states in order to: • Provide financial assistance to high-risk individuals; • Creating incentives to stabilize insurance prices;

Provision	Implications for LTSS	Policy in the Draft Legislation
	There are a number of things that states can use the funding to achieve, many of which are targeted to individuals who are high-risk and/or projected to have high utilization. The innovation funds focus on stabilizing the private marketplace and do not include reference to long-term services and supports. While older adults and individuals with disabilities are not necessarily a targeted population, they are likely to fall into one or both of those groups.	• Reducing cost of providing insurance to individuals who are expected to have high utilization; • Increasing insurance company participation in the individual and small group markets; • Promoting access to preventive services, dental care, and/or vision services; • Providing direct payments to health care providers for the provision of certain services. The services would be defined by HHS; and • Providing assistance to reduce out-of-pocket costs for insured individuals. ~~In FY18-19, funds are provided to states based on a formula that accounts for the number of individuals eligible for ACA premium tax credits and the amount that the state's average premium costs exceed the national average. In later years, HHS is directed to establish a formula that accounts for low-income individuals in the state.~~ States can elect to develop their own program or have a default federal program established. Both options require state match, but at different levels. In 2018 and 2019, there are two components to the formula for allocating funds to states: • 85% of the allocation is based upon incurred claims for costs in the individual market; • 15% is allocated based upon states that saw an increase in uninsured individuals below 100% FPL or that have fewer than three plans offering

Provision	Implications for LTSS	Policy in the Draft Legislation
		coverage on the 2017 health care exchange. In subsequent years, the HHS secretary is directed to set allocations based upon a factor that takes into account the cost of care, the risk profile of the population, the number of low-income uninsured individuals, and health plan competition. Beginning in FY2020, states that establish their own programs have a 7% matching requirement for these funds. This increases by 7% each year, ending at a 50% matching requirement in FY2026. States that use the default program have a 10% match beginning in 2020, increasing by 10% each year until it reaches 50%, where it remains until 2026.
Age Rating Provisions	Under the ACA, insurers are prohibited from charging more than a 3-to-1 variation on premiums based upon an individual's age. This means that older adults cannot be charged more than 3 times the insurance cost of a younger individual. AARP commissioned a report by Milliman to assess the impact of this policy proposal. The report concluded that increasing the rating provision from the ACA level to 5-to-1 would lower premiums for people in their 20s by about 25% and increase premiums for people 65 and older by the same percentage. http://www.aarp.org/content/dam/aarp/ppi/2017-01/Milliman%20ACA%20Age%20Bands_2.7.17.pdf	The legislation would increase this limitation to a 5-to-1 ratio, or a state-defined limit, beginning in 2018.
~~Essential Health Benefits (Non-Medicaid)~~	~~The EHB includes benefit requirements such as rehabilitative and habilitative services, in addition to other health care benefits. Such supports can be beneficial to individuals with disabilities and/or~~	~~The bill would repeal EHB requirements and allow state-defined EHBs, beginning in 2018.~~

Provision	Implications for LTSS	Policy in the Draft Legislation
	~~chronic conditions. EHB is included as a requirement for many health plans.~~	