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Affordable Care Act Repeal Legislation Summary

On September 9th, Senators Graham (SC), Cassidy (LA), Heller (NV), and Johnson (WI) released their proposal to repeal and replace the Affordable Care Act (ACA). This bill (called the Graham-Cassidy bill) is the last-minute effort to revive the ACA repeal and replace efforts that stalled over the summer. The legislation was written as an attempt to find a middle ground between those who would like to see the ACA and its underlying regulations and taxes repealed and those who wish to preserve the coverage gains achieved over the past three years.

The bill would continue to leverage a technical parliamentary process called reconciliation which allows them to pass the bill with 50 votes, including the Vice President as a tiebreaker, instead of the usual 60-vote threshold required for Senate passage. As shared previously, this procedure places strict controls on what can and cannot be included in the legislation.[1] Democrats successfully challenged some provisions in prior versions of the ACA repeal legislation, and are likely to also challenge some provisions within this bill as well. Additionally, the process is tied to the Federal fiscal year which ends on September 30th. This leaves a very short timeline to receive a CBO score, complete any committee work on the legislation, and pass the bill before the window to use reconciliation expires.

Today it remains uncertain whether the bill has sufficient support to secure 50 votes in the Senate, and it seems unlikely that the legislation will be passed before reconciliation expires. Several key members of Republican leadership have expressed skepticism that the bill will even come up for a vote on the floor. However, there has been increasing interest and news coverage of the bill, and there is a slight chance that it could be enacted. Therefore, we believe that it is important to understand the bill contents and its implications.

Although most of the discussion about the bill focuses on its creation of a block-grant for states that replaces the ACA premium credits, cost-sharing subsidies, and Medicaid expansion, the bill has a number of significant and important changes to the underlying Medicaid program as well. The Medicaid components of the legislation are very similar to prior versions of ACA repeal advanced in the House and debated in the Senate.

This memorandum includes a chart that provides an analysis of the newest Senate bill and its underlying provisions. NASUAD will continue to provide updates to members if the legislation is debated and/or brought up to the Senate floor.

More information and the full Senate bill text is available at: https://www.cassidy.senate.gov/read-about-graham-cassidy-heller-johnson

[1] See http://bit.ly/2rGdbso for more information

Key Provisions in the Legislation

The legislation would enact sweeping changes to the Affordable Care Act, but does not repeal and replace it in its entirety. It leaves a number of taxes and regulations in place, transforms the federal funding for ACA into a state block grant, and imposes a per capita limit on total state Medicaid expenditures. Highlights of the bill include:

- Repealing the ACA's advance premium tax credits, cost sharing reduction payments, Medicaid expansion, and Basic Health Plan;
- Replacing those coverage expansion provisions with a block grant to states, funded at approximately $1.2 trillion over seven years, that can be used for things such as expanding coverage, stabilizing the marketplace, subsidizing health care and paying for some insurance costs;
- Repealing the ACA individual and employer mandates;
- Allowing states to apply for waivers of key ACA benefit mandates and insurance regulations;
- Repealing several ACA taxes, including the medical device tax and taxes on certain HSA provisions, while leaving other taxes in place such as the tax on high-cost health plans, known as the Cadillac tax, the health insurance fee, and the Medicare surcharge on high earners;
- Eliminating the increased Federal match (FMAP) for 1915k/Community First Choice services;
- Creating a new HCBS payment adjustment policy that provides $8 billion in grant funding to states in order to ensure access and quality for community-based LTSS;
- Creating an option for states to establish work requirements on certain adults without disabilities;
- Setting a per-capita cap on Medicaid expenditures, and providing states with the option to receive a block grant for certain populations; and
- Expanding the ability of states to apply for waivers of core ACA policies under section ACA 1332 waivers.

Many of the Medicaid provisions are quite similar to the House-passed legislation as well as the bill that failed in the Senate over the summer. The major differences between this bill and the prior legislation are the treatment of ACA coverage expansions and the repeal of fewer ACA imposed taxes. Below, we provide detail on some of the policies included in this legislation, with a specific emphasis on changes to Medicaid and LTSS policy.

Provision	Policy in the Legislation
Medicaid Per Capita Cap Option	
Basic Policy	Sets upper spending limits on per-capita Medicaid service expenditures, beginning in 2020. A state that exceeds its limit would have their excess expenditures reduced from federal funding in the following year.
Upper Limit Policy	The limits are based upon state spending during a "base period" of 2 years (8 consecutive quarters) selected by the state. The quarters must fall between the first fiscal quarter of 2014 and the third fiscal quarter of 2017.
Included Populations	The four groups included in the per-capita cap policy are: • 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; and • Other adults who are not included in the prior groups. This policy excludes several groups of individuals from 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; • Individuals eligible based on Tuberculosis; • Individuals eligible only for family-planning services; • Undocumented immigrants who receive Medicaid-funded emergency care services; and • Children under the age of 19 who are eligible on the basis of disability or blindness.
Inflationary Updates	The base period expenditures are trended forward using CPI-Medical to establish the initial FY2019 baseline. Between FY2020-2025, the inflationary factor used for the per-capita caps is: • CPI-Medical plus 1 percentage point for older adults and people with disabilities • CPI-Medical for all other populations After FY2025, the inflationary updates are: • CPI-Medical for older adults and people with disabilities; • CPI-U for all other populations.
Included Expenses	Supplemental payments to providers (non-DSH) are included in the per-capita caps, as are delivery systems reform payments, uncompensated care pools, and other similar sources of funding for providers. That is, they are allowed to continue, but will be subject to the overall spending limits. As in prior proposals, these payments are excluded from the calculation of each group's medical expenses, and then calculated as a ratio of overall

	medical costs. The per-capita caps are adjusted upward by this ratio to account for the supplemental payments. Importantly, these payments would continue to be subject to the Medicaid UPL policy could be impacted by the reduction in provider-tax safe harbor policies, if they are financed via that mechanism. The policy also excludes several types of expenditures from the spending cap, including: • Disproportionate Share Hospital Payments; • Medicare cost-sharing payments; • Vaccinations for Children; and • Payments for public health emergencies between 2020-2024 (up to an aggregate national limit of $5 billion).
Adjustment of Caps to States that are Outliers	Beginning in 2020, HHS is directed to adjust the cap amounts for states that have payments significantly above or below the national average. States that exceed the average spending in one of the per-capita cap categories (ie: children, older adults, people with disabilities, etc) by more than 25% would have the cap for that category adjusted downward by an amount determined by the Secretary which is no less than 0.5% and no more than 2% in the following year. Similarly, states with spending for a category that is at least 25% below the average spending would have a secretary-defined increase of 0.5% - 3% to the per-capita cap in the following year. Overall, the adjustments must be budget neutral to the federal government. The adjustment is applied on a category-by-category basis, except for FY2020 and FY2021, where all categories would be treated as one for purposes of the calculation and adjustment. The adjustment would not apply to states with less than 15 people per square mile (currently that would include Alaska, Wyoming, Montana, North Dakota, and South Dakota).
Increased Administrative Matching	Between FY2018-2019 (October 1, 2017- September 30, 2019), the matching rate for IT systems development is increased from 90% to 100%; the maintenance and operations rate is increased from 75% to 100%. These increased rates apply only to a state that selects the most recent 8 calendar quarters with available data as the base rate for per capita caps.
Delay of Per Capita Caps for Certain States	For low-density states with less than 15 people per square mile, a per-capita limitation may not be applied to their Medicaid expenditures if their Market Based Health Care Block Grant amount (see below) is less than the amount it received in 2020 increased by CPI-U or if the Secretary determines that the grant is insufficient to provide adequate coverage and support in the state. This would be determined on an annual basis; subsequent year per capita caps would be applied as if the delay never occurred, unless an additional delay is awarded to the state.

Reduction in Per Capita Caps for Certain High DSH States	This is a provision that would apply to New York which would reduce the caps based upon the required contributions that counties and political subdivisions are required to pay towards the State's non-Federal share of Medicaid funds.
Flexible Block Grant Option	
Basic Policy	Medicaid agencies may submit an application to HHS in order to implement a flexible block grant program that would significantly modify the Medicaid program in their state. The block grant program would last for 5 years, and could be extended for subsequent 5 year periods. A state that elects to end its block grant program must complete the current 5 year period that it is in. After termination of the programs, the per capita caps would apply as though the block grant had never occurred.
Block Grant Application	States would submit an application that outlines key components of the block grant: • A description of the goals, and how the state would meet program requirements, including benefits packages, eligibility, state administration, and other requirements; • Participant eligibility requirements; • A description of the benefits package, including amount, duration, and scope of services; • A plan for notifying program enrollees of the changes; • Agreement to collect and report certain enrollment, expenditure, utilization, and outcomes data; and • An information technology plan. The legislation would require a 30 day notice and comment period at the state level before submission, as well as a 30 day notice and comment period at the Federal level prior to approval.
Block Grant Eligibility	The flexible block grant option would only apply to individuals who fall into the "Non-Disabled, Non-Pregnant Adults" category. The state must cover adults within this group who qualify for a Mandatory Medicaid eligibility category under Section 1902(a)(10)(A)(i) of the act. Any income determinations must use Modified Adjusted Gross Income as the basis for eligibility.
Services	Services that must be included to individuals who qualify for mandatory eligibility groups are: • Hospital services; • Laboratory and x-ray services; • Nursing facility services for individuals age 21 and over; • Physician services; • Home health services; • Rural health clinic services; • FQHC services; • Family planning services; • Nurse midwife services;

	• Certified pediatric and family nurse practitioner services; • Mental health and substance use coverage; • Freestanding birth center services; • Emergency medical transportation; • Non-cosmetic dental services; and • Pregnancy services. States may also provide optional services in addition to these benefits. While the legislation does not explicitly draw the distinction, it appears that states may provide a different package of benefits to individuals who would not qualify under a mandatory Medicaid eligibility group. The targeted health assistance must have actuarial value standards of 95% of the pre-ACA benchmark benefit packages in Medicaid (which are based upon private insurance in the state). States may set their own limits on amount, duration, and scope of benefits subject to this actuarial value requirement. States may include cost-sharing requirements, provided that it does not exceed 5% of family income for the beneficiary. The benefit package must include mental health and substance use coverage for all individuals, and must adhere to mental health parity requirements. If the benefit includes prescription drugs, the state must also adhere to all of the requirements of the Medicaid drug rebate program.
Calculation of Block Grant Amount	Block grant amounts would be calculated based upon the per capita caps established for the first year of the demonstration. These are multiplied by the number of enrollees in the second fiscal year prior to the first year of the demonstration trended forward based upon increase in state population. Then, the total amount is multiplied by the average state FMAP for the year (which is calculated as part of the per-capita cap process). This formula can be visualized as: (Average State FMAP x (Per-capita cap for population x ((Population enrollment in second fiscal year prior) x (percentage increase in state population)))) The legislation caps the total population that can be used in this first-year formula at the number of enrollees in the "base period" calculation for the Per Capita Caps increased by the total growth in state population plus 3 percentage points. Subsequent years are calculated by trending the prior block grant amount forward by using the CPI-U increase from the second previous April to the previous April. States must make maintenance of effort payments, which amounts to the block grant amount multiplied by the state's share of CHIP Enhanced FMAP. States that do not meet

	the MOE requirements will have their block grant reduced by the dollar amount they underspent their MOE. A reduction could also be made for noncompliance.
Nonapplicability of Provisions	Some Medicaid requirements would not apply to block grant services, including statewideness, comparability of services, freedom of choice, and reasonable/ comparable eligibility standards and procedures. The Secretary would also have latitude to waive other provisions of Medicaid, if appropriate.
Other Medicaid Provisions	
The Medicaid Community First Choice (CFC) Option (also known as the 1915(k) state plan benefit).	Retains 1915(k) services and eligibility; terminates the 6 percent FMAP increase, effective January 1, 2020.
Medicaid expansion	Ends the ACA Medicaid expansion beginning January 1, 2020, or on September 1, 2017 for states that did not expand before July 1, 2016. Creates an optional eligibility category that would cover members of an Indian tribe who were enrolled in a Medicaid expansion on December 31, 2019 and who do not have a break in eligibility of more than 6 months (or a longer period if the state so decides).
Funding for Territories	Lowers the FMAP for territories from the current 55% to the pre-ACA level of 50%
Medicaid Benchmark Plans include Essential Health Benefits	The bill removes the requirement that Medicaid Benchmark Benefits, also known as Alternative Benefit Plans, include the ACA Essential Health Benefits package. The provision is effective January 1, 2020.
Medicaid and CHIP Quality Bonus Payments	During FY2023-2026, states can receive bonus payments if they meet HHS-defined benchmarks for lower-than-expected expenditures and meet quality measures. The quality measures will be established via HHS rulemaking in consultation with states and other experts such as NCQA or AHRQ. The payments are made to states by adjusting FMAP upwards, subject to the aggregate limit on spending calculated under the per-capita cap policy. Overall payments cannot exceed $8 billion under the program.
Permitting States to Apply a Work Requirement	Creates a new policy allowing work requirements, as defined by TANF, for certain individuals who are not an: • Older adult; • Individual with a disability; • Pregnant woman or woman in a 60-day postpartum period; or • Child under the age of 19; • The only parent/caretaker relative of a child under age 6 or a child with disabilities; and • Individuals under 20 years old who are married or head of household and who are in an educational/job training program; • Individuals participating in impatient/intensive outpatient drug and/or alcohol treatment; and • Full-time students in higher education institutions.

	Provides 5% administrative matching increase to implement the work requirements.
Optional Inpatient Psychiatric Services	Adds a new optional benefit, effective October 1, 2018, for inpatient psychiatric hospital services for adults age 21-64. Services can be provided for no longer than 30 consecutive days and no more than 90 days in a calendar year. In order to adopt this provision, states may not reduce the number of licensed psychiatric beds and must maintain the same level of state funding (outside of Medicaid) for inpatient services and psychiatric treatment. States receive 50% FFP for these services regardless of their normal FMAP, except for a state that had FMAP greater than 50% and provided these services to individuals via Medicaid prior to September 30, 2018.
Presumptive Eligibility	Ends option for states to extend presumptive eligibility to ACA expansion groups or former foster care children, effective January 1, 2020. Ends the requirement for states to allow eligible hospitals to provide presumptive eligibility determinations, effective January 1, 2020.
Enrollment Simplification	Ends the Medicaid eligibility and enrollment simplification requirements, including coordination with the ACA exchanges, effective January 1, 2020.
Special Provisions for Indian Tribe members	Extends the 100% FMAP for services provided through Indian Health Services facilities to services delivered by any provider to a Medicaid eligible individual who is a member of a recognized Indian tribe.
Retroactive Eligibility	Modifies retroactive eligibility so that individuals could be retroactively eligible 2 months prior to Medicaid application date (as opposed to the current policy which allows for 3 months of retroactive eligibility). Individuals applying for a group based upon being over 65, having a disability, or blindness, would still have three months of retroactive eligibility. This is effective October 1, 2017.
Excluded providers from Medicaid	Creates a payment exclusion for certain providers of abortion services, namely Planned Parenthood. The payment exclusion lasts for 1 year from the enactment of the law.
Treatment of Medicaid DSH Cuts	Medicaid DSH cuts would not be altered. One modification is made that would reduce the DSH cut in states that experience a shortfall in their Market Based Health Grant (see below). Between 2021-2025, if the state's Market Based Health Grant is less than the 2020 amount increased by CPI-U in a given year, the state's DSH cut is offset by the amount of the grant shortfall. Additionally, in 2026, a state with a Market Based Health Grant shortfall can receive an increase of their total DSH allotment. The increase is the sum of all prior reductions to the state's DSH allotment from 2018-2025, subtracting any offsets to those DSH cuts from 2021-2025 made by the first part of this provision. The calculated increase cannot exceed the total shortfall for 2026.
Provider Taxes	Reduces the allowable safe-harbor threshold for provider taxes from 6% under current law to 4% in 2025 and every year thereafter. This reduction occurs as follows: the 2021 threshold is 5.6%, 2022 is 5.2%, 2023 is 4.8%, 2024 is 4.4%, 2025 and thereafter is 4%.

Requires More Frequent Eligibility Determinations for Expansion Populations	Beginning October 1, 2017, states would have the option to do eligibility redeterminations at least every 6 months, or more frequently if they choose, for individuals in the ACA Medicaid expansion. Provides 5% increase in administrative matching for states that elect this option.
Ensuring Access to HCBS/ Provider Payment Adjustment Incentive Demonstration	Establishes a HCBS incentive payment demonstration program at 1915(l) of the act. Under this demonstration, the state would make HCBS payment adjustments to providers for HCBS quality improvement and maintaining access to services. The amount of the payment adjustment would be fully federally funded. The bill would allocate $8 billion, which would be awarded on a competitive basis to states. Preference would be given to the 15 states with the lowest population density. The demonstration project would last 4 years from January 1, 2020 until December 31, 2023.
Other Health Care Provisions	
Calculation of Tax Credits	Repeals ACA advance premium tax credits, effective January 1, 2020. Replaces the tax credits (and ACA Medicaid expansion) with block grants to states described below.
Mandate	Sets the Individual and Business mandate penalties at $0, retroactively effective January 1, 2016
ACA Taxes and Fees	Repeals certain ACA taxes, notably the medical device tax and taxes on HSAs, effective at the end of 2017. Does not repeal many other ACA taxes, such as the health insurer fee or the "Cadillac tax" on high cost health plans.
Short Term State Assistance	Allocates $25 billion over two years - $10 billion in calendar year 2019 and $15 billion in calendar year 2020 - for arrangements with insurance issuers to assist with purchasing health insurance coverage. Funds are limited to arrangements with insurance issuers in order to assist with purchase of health coverage via premium stabilization and promoting market participation.
Market-Based Health Care Grant Program (i.e. State Health Care Block Grant)	Creates a grant program to states for the purposes of: • Providing assistance to high-risk individuals; • Stabilizing insurance prices and promoting plan participation; • Providing provider payments for health care services defined by HHS; • Reducing out-of-pocket costs such as copays and deductibles; • Providing health insurance coverage for certain Medicaid-eligible individuals (limited to 15% of the grant award, with option to apply for an exception that permits up to 20% of the amount to be spent on this); and • Covering other individuals not eligible for Medicaid or CHIP through managed care organizations.
Market-Based Health Care Grant Program Funding	Provides $1.17 trillion over seven years to fund this program using the following calendar year allocations: • $146 billion in 2020; • $146 billion in 2021; • $157 billion in 2022; • $168 billion in 2023;

	• $179 billion in 2024; • $190 billion in 2025; and • $190 billion in 2026. In 2020, States would initially be allocated funding based upon a formula that takes into account prior Federal spending on ACA tax credits and cost-sharing subsidies; the Medicaid expansion (including the optional expansion above 133% FPL as well as individuals who would have been eligible for the expansion but were instead covered under a waiver); and the Basic Health Program within each state during a designated base period. The base period would be selected by the state and encompass any consecutive 4 quarters between the first quarter of 2014 and the first quarter of 2018. The Medicaid expansion funding would be adjusted for inflation based upon projections by MACPAC that estimate the change in expenditures between the base period and November of 2019. The remaining funds would be inflated based upon the change in CPI Medical for the same period. Between 2021-2026, there would be a gradual transition from the 2020 allocation policy towards one that distributes funding based upon a state's proportion of low-income individuals between 45% FPL and 133% FPL. This new policy would include adjustments based upon the risk characteristics of the state as well as reductions if the state's cost of health coverage exceeds the lowest value of CHIP benchmark coverage. If the total amount of state grants calculated for a year exceeds the aggregate appropriated amount of funding for that year, state awards will be decreased proportionately. Similarly, if the awards are less than the appropriated amounts, awards would be increased proportionately. States would be allowed to roll-over unused funds for one year. After that period, the funding would be rescinded and the treasury is directed to use unspent money for deficit reduction.
Contingency Fund	Creates a fund that can be used to increase the allocations to states with less than 15 individuals per square mile or those that did not expand Medicaid. The funding would be available in 2020 and 2021. In 2020, $6 billion would be available for this purpose and in 2021 there would be $5 billion. 25% of the funds would be allocated to low-density states and 75% would be for non-expansion states.
Insurance Provision Waivers	States that receive funding under the Market-Based Health Care Grant Program may apply to waive certain health coverage requirements, but only for coverage that is provided by an insurer receiving funding through the Grant Program to an individual who is receiving a direct benefit from the Grant program. Provisions that may be waived include:

	• Rating bands (ie: restrictions on difference in premium rates based upon age or health status), except that no variation may be made based upon gender or membership in a "protected class" of individuals; • Essential Health Benefits and other benefit mandates; and • Medical Loss Ratio rebate requirements.
1332 Waivers	Modifies the ACA 1332 waivers to provide that states may request all, or a portion, of the funds that would be used in tax credits or cost sharing reductions be given to the state in order to implement the waiver. Directs the HHS Secretary to approve all waivers that meet the specified criteria, and sets a time limit of 45 days between application and approval. Extends the timeframe for waivers from five years to eight years, with unlimited renewals. Prohibits HHS from cancelling a waiver prior to the 8 year period ending. Allocates $2 billion to assist states with the preparation and submission of 1332 waivers.
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. The legislation does not explicitly change this limitation; however, the waiver provisions discussed earlier would provide for an option to modify this at the state level.
Public Health and Prevention Fund	The legislation would end funding for the Public Health and Prevention Fund after September 30th, 2018 (FY18). Any unused funding at the end of FY18 would be rescinded.
Federally Qualified Health Centers	The legislation allocates an additional $422 million for FQHCs in FY2017.
Implementation Fund	Allocates $2 billion for Federal administrative expenses to implement the changes required by the legislation.
Cost Sharing Subsidies	Repeals the subsidies beginning in 2020.
Coverage of Abortion Services	Excludes any plan covering abortion services, except those necessary to save the life of the mother or those resulting from rape or incest, from the definition of "Qualified Health Plan" for receiving ACA tax credits or small business tax credits. This is effective January 1, 2018.