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Introduction

This brief provides an overview of the most recent changes to the Graham-Cassidy repeal and replace proposal and a just-released preliminary analysis of the proposal by the Congressional Budget Office (CBO). On September 13th, Senators Lindsey Graham (R-SC) and Bill Cassidy (R-LA)—along with Senators Dean Heller (R-NV) and Ron Johnson (R-WI) and former Senator Rick Santorum (R-PA)—released a new proposal (hereafter “Graham-Cassidy” or “proposed legislation”) to repeal and replace the Affordable Care Act (ACA). On September 25th, the sponsors released several updates to the proposed legislation.¹ Also on September 25th, the CBO provided its preliminary analysis of one of the earlier versions of the bill.²

Overview of the Revised Proposal

The Graham-Cassidy ACA repeal and replace legislation would retain many features of the Better Care Reconciliation Act (BCRA) voted down by the Senate on July 25th, including per capita caps on Medicaid spending³ and elimination of the individual and employer mandates. However, it goes beyond that proposal by converting Marketplace and Medicaid expansion federal funding into a “Market-Based Health Care Grant Program” block grant and giving states significant flexibility to end various ACA consumer protections. Following are the key takeaways from the most recent version of the proposed legislation and a short summary of the CBO preliminary analysis.

- › **Converts Medicaid and Marketplace Funding to New Block Grants.** The new Market-Based Health Care Grant Program replaces federal funding for Marketplace subsidies and Medicaid expansion coverage after 2019. States would have significant flexibility to use block grant funds for coverage, payments to providers, or other health care-related purposes, with federal appropriations provided for calendar years 2020 through 2026. No state match is required to receive the funding.
- › **Provides Less Block Grant Funding Relative to Current Law, and No Funding After 2026.** Over the 2020 to 2026 period, the block grant would provide substantially less federal funding than under current law Medicaid expansion funding and Marketplace subsidies. The block grant ends in 2026, leaving states with no funding to continue block grant initiatives, unless the program is reauthorized.⁴
- › **Includes Broad Authority that Could Diminish Consumer Coverage and Raise Premiums for Those with Pre-existing Conditions.** The proposal gives states broad latitude to establish coverage that does not meet the ACA’s consumer protection and insurance regulation provisions for individual or small group coverage funded through the Market-Based Health Care Grant Program. In states that permit it, individuals with pre-existing conditions could face substantially higher premiums in the individual and small group markets, or find their policies do not cover essential services.
- › **Repeals the Individual Mandate without Replacement, Potentially Destabilizing State Markets.** By retroactively repealing the individual mandate without any replacement and leaving the guaranteed issue requirement in place, the proposed legislation would likely decrease coverage in 2018 and create broader challenges to market stability in 2019. Insurers would reconsider their participation in markets that will change dramatically in 2020, depending on federal implementation rules, state choices, and other actions that will make the individual market highly volatile and unpredictable in most states.
- › **Eliminates the Medicaid Expansion, Restructures Federal Medicaid Financing, and Alters Other Key Elements of the Medicaid Program.** The Medicaid expansion would be permanently terminated after December 31st, 2019, with a limited exception for certain American Indians; states would no longer have the option to cover expansion populations, even at regular match. Federal Medicaid financing for remaining populations would be converted to a per capita cap and selected other beneficiary protections would be eliminated or modified. The current proposal does not delay Medicaid Disproportionate Share Hospital (DSH) cuts, other than for states whose Market-Based Health Care Grants grow, relative to a base year, by less than the medical component of the Consumer Price Index (CPI). The legislation also restricts states’ abilities to rely on provider taxes, phasing down the threshold under which a provider tax is presumed to be permissible from the current level of 6 percent to 4 percent in federal fiscal year (FFY) 2025 and beyond.

Key Changes in the Revised Proposal

- › **Additional short-term assistance for low-density states.** Five (5) percent of Short Term Assistance funds must be allotted to low-density states, defined as those with fewer than 30 people per square mile (previously defined as those with fewer than 15 people per square mile). These states include: Alaska, Idaho, Montana, Nebraska, Nevada, New Mexico, North Dakota, South Dakota and Wyoming.
- › **Coverage under the grant must now meet additional coverage requirements.** States must certify that they will require compliance with several federal standards, including: coverage under parents' plan until age 26, minimum hospital stay following birth, mental health parity, required coverage for reconstructive surgery following mastectomies, and genetic non-discrimination. Additionally, to obtain funds, states must now provide description of how the state "shall" maintain access to adequate and affordable coverage to individuals with pre-existing conditions (prior versions of the bill required states to describe how the state "intends" to ensure access for those with pre-existing conditions). Notably, there is no statutory standard for what constitutes adequate and affordable coverage.
- › **Instead of obtaining "waivers" from federal law, states can offer coverage that does not meet all federal requirements.** While this language is effectively a waiver, it may have been re-crafted to make it easier for states to receive approval from the Centers for Medicare and Medicaid Services (CMS) to make these types of changes. Typically, waivers under other statutory authority require close scrutiny from CMS. The "waivers" or alternative rules now proposed under Graham-Cassidy would appear to be easier for states to obtain, and appear subject to little federal review or supervision. The new language may also help avoid provisions of the bill being excluded under the "Byrd Rule" for not meeting reconciliation requirements.
- › **States have discretion to allow rating rules that increase premiums for people with pre-existing conditions.** The new version's "waiver" flexibility puts more restrictions on state's ability to change rating laws, and on the surface appears to prohibit premium rating based on health. But the new version expressly allows "multiple risk pools" which could open the door to discrimination based on health status if states allow insurers to put people with pre-existing conditions in separate risk pools where all premiums will be higher than standard rates.
- › **Continues Medicaid coverage for American Indians.** Continues Medicaid coverage for American Indians enrolled in a Medicaid expansion as of December 31st, 2019 who remain enrolled without a break of more than six months (or longer, as specified by a state). The earlier version of the proposal gave states the option as to whether to continue this coverage.
- › **Modifies per capita cap base period for certain states.** Permits states that expanded Medicaid after July 1st, 2015 to choose a shorter base period of as few as four quarters for their per capita cap calculations. This provision applies to Alaska, Montana, and Louisiana.
- › **Eliminates per capita cap exemption for low-density states.** Drops a provision that would have delayed implementation of the per capita cap for low-density states that had Market-Based Health Care allotments that did not keep pace over time with medical CPI growth.
- › **Increases FMAP for two states.** Increases the federal Medicaid matching rate for Alaska and Hawaii for their Medicaid programs, beginning January 1st, 2018.

Summary of CBO Preliminary Analysis:

CBO's preliminary analysis of the Graham-Cassidy legislation does not include the level of detail about either costs or coverage that is typical of a complete CBO score. The analysis summarizes the key provisions in the proposed legislation and confirms that it will produce sufficient savings to satisfy the reconciliation rules governing consideration of the legislation in the Senate; CBO will continue to develop a full score (likely using the most recent version of the legislation).

CBO's preliminary analysis notes that "millions" will likely lose coverage under the proposed legislation and attributes this to three main causes: (1) lower Medicaid enrollment because of approximately \$1 trillion less federal Medicaid funding over the next ten years; (2) lower enrollment in non-group coverage because of reduced subsidies; and (3) lower enrollment in all types of health insurance because penalties for not having insurance would be repealed. CBO notes that these as-yet unquantified coverage losses would be partially offset by new programs and higher enrollment in employer-based insurance, but that overall coverage of people with "comprehensive health insurance that covers high cost medical events" would be reduced by millions compared to current expectations in each of the next ten years.

CBO also anticipates increased market disruption and implementation challenges because of the short timeframe in which states would implement the new block grants. CBO's analysis describes some of the challenges that state would face in providing income-based assistance under the block grants (e.g., enacting legislation; creating a new administrative infrastructure; establishing new systems for verifying eligibility, making payments, enrolling individuals, certifying insurance as eligible for subsidies; and ensuring that payments are correct). CBO notes that financial constraints could limit states' options in establishing new income-based subsidies for non-group coverage.

Endnotes

1. The latest version of the proposed legislation released on September 25th is Version LYN17752 and is available here: <https://www.cassidy.senate.gov/imo/media/doc/LYN17752.pdf>
2. Congressional Budget Office, Preliminary Analysis of Legislation that Would Replace Subsidies for Health Care with Block Grants, September 2017, available at: <https://www.cbo.gov/publication/53126>. CBO based its analysis on Version LYN17744 of the proposed legislation, available here: <https://www.cassidy.senate.gov/imo/media/doc/LYN17744.pdf>
3. As discussed below, the new legislation changes the growth rate for elderly and disabled in 2025 and beyond as compared to BCRA.
4. Manatt Health analysis of September 13 Graham-Cassidy proposal, prepared for Robert Wood Johnson Foundation State Health & Value Strategies, *Update: State Policy and Budget Impacts of New Graham-Cassidy Repeal and Replace Proposal*, available at: http://www.statenetwork.org/wp-content/uploads/2017/09/SHVS_Graham-Cassidy-Sept-2017_Final.pdf

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