September 2017

Summary of Revised Graham-Cassidy Health Care Legislation

by Chris Jacobs

TEXAS PUBLIC POLICY FOUNDATION

September 2017

Table of Contents

Summary of Revised Graham-Cassidy Health Care Legislation

by Chris Jacobs

Summary of CBO Score

On Monday evening, the Congressional Budget Office (CBO) released a preliminary estimate of the Graham-Cassidy bill. CBO concluded that the bill would comply with reconciliation parameters—namely, that it would reduce the deficit by at least as much as the underlying reconciliation vehicle (the House-passed American Health Care Act), reduce the deficit by at least $1 billion in each of its two titles in its first 10 years, and not increase the deficit overall in any of the four following decades.

Although it did not include any specific coverage or premium numbers, CBO did conclude that the bill would likely decrease coverage by millions compared to the current policy baseline. The report estimated that the bill's block grant would spend about $230 billion less than current law—a 10 percent reduction overall (an average 30 percent reduction for Medicaid expansion states, but an average 30 percent increase for non-expansion states). Moreover, CBO believes at least $150 billion in block grant funding would not be spent by the end of the 10-year budget window.

CBO believes that "most states would eventually make changes in the regulations for their non-group market in order to stabilize it and would use some funds from the block grants to facilitate those changes." Essentially, current insurance regulations mean that markets would become unstable without current law subsidies, such that states would use a combination of subsidies and changes in regulations to preserve market stability.

CBO believes that most Medicaid expansion states would attempt to use block grant funding to create Medicaid-like programs for their low-income residents. However, the analysis concludes that by 2026, those states' block grants would roughly equal the projected cost of their current Medicaid expansion—forcing them to choose between "provid[ing] similar benefits to people in a [Medicaid] alternative program and extend[ing] support to others" further up the income scale. In those cases, CBO believes "most of those states would then choose to provide little support to people in the non-group market because doing so effectively would be the more difficult task."

Overall, CBO believes that the bill would reduce insurance coverage, because of its repeal of the subsidies, Medicaid expansion, and the individual mandate. The budget office believes that states with high levels of coverage under Obamacare would not receive enough funds under the revised block grant to match their current coverage levels, while states with lower levels of coverage would spend the money slowly, in part because they lack the infrastructure (i.e., technology, etc.) to distribute subsidies easily. CBO also believes that employment-based coverage would increase under the bill, because some employers would respond to changes in the individual market by offering coverage to their workers.

With respect to the Medicaid reforms in the bill, CBO concludes that most "states would not have substantial additional flexibility" under the per capita caps. Some states with declining populations might choose the block grant option, but the grant "would not be attractive in most states experiencing population growth, as the fixed block grant would not be adjusted for such growth." States could reduce their spending by reducing provider payment rates, optional benefit categories, limiting eligibility, improving care delivery, or some combination of the approaches.

For the individual market, CBO expresses skepticism about the timelines in the bill. Specifically, its analysis found that states' initial options would "be limited," because implementing new health programs by 2020 would be "difficult":

> To establish its own system of subsidies for coverage in the nongroup market related to people's income, a state would have to enact legislation and create a new administrative infrastructure. A state would not be able to rely on any existing system for verifying eligibility or making payments. It would need to establish a new system for enrolling people in nongroup insurance, verify eligibility for tax credits or other subsidies, certify insurance as eligible for subsidies,

and ultimately ensure that the payments were correct. Those steps would be challenging, particularly if the state chose to simultaneously change insurance market regulations.

While CBO believes that states that expanded Medicaid would be likely to create programs for populations currently eligible for subsidies (i.e., those households with incomes between one and four times poverty), it notes that such states "would be facing large reductions in funding compared with the amounts under current law and thus would have trouble paying for a new program or subsidies for those people."

CBO believes that without subsidies and with current insurance regulations in place, a "death spiral" would occur, whereby premiums would gradually increase and insurers would drop out of markets. (However, "if a state required individuals to have insurance, some healthier people would enroll, and premiums would be lower.") To avoid this scenario, CBO believes that "most states would eventually modify various rules to help stabilize the nongroup market," thereby increasing coverage take-up when compared to not doing so. However, "coverage for people with pre-existing conditions would be much more expensive in some of those states than under current law."

While widening age bands would "somewhat increase insurance coverage, on net," CBO notes that "insurance covering certain services not included in the scope of benefits to become more expensive—in some cases, extremely expensive." Moreover, some medically underwritten individuals (i.e., subject to premium changes based on health status) would become uninsured, while others would instead obtain employer coverage.

Finally, CBO estimated that the non-coverage provisions of the bill would increase the deficit by $22 billion over 10 years. Specific estimates for those provisions are integrated into the summary below.

Summary of Changes Made

On Sunday evening, the bill's sponsors released revised text of their bill. Compared to the original draft, the revised bill:

- Strikes language repealing sections of Obamacare related to eligibility determinations (likely to comply with the Senate's "Byrd rule" regarding budget reconciliation);
- Changes the short-term "stability fund" to set aside 5 percent of funds for "low-density states," which some conservatives may view as a carve-out for certain states, similar to that included in July's Better Care Reconciliation Act;
- Re-writes waiver authority, but maintains (and arguably strengthens) language requiring states to "maintain access to adequate and affordable health insurance coverage for individuals with pre-existing conditions," which some conservatives may view as imposing limiting conditions on states that wish to reform their insurance markets;
- Requires states to certify that they will "ensure compliance" with sections of the Public Health Service Act relating to 1) the under-26 mandate; 2) hospital stays following births; 3) mental health parity; 4) re-constructive surgery following mastectomies; and 5) genetic non-discrimination;
- Strikes authority given to the Health and Human Services Secretary in several sections, and replaces it with authority given to the Centers for Medicare and Medicaid Services (CMS) Administrator;
- Includes a new requirement that at least half of funds provided under the Obamacare replacement block grant must be used "to provide assistance" to households with family income between 50 and 300 percent of the poverty level;
- Requires CMS Administrator to adjust block grant spending upward for a "low-density state" with per capita health care spending 20 percent higher than the national average, increasing allocation levels to match the higher health costs—a provision some conservatives may consider an earmark for specific states;
- Imposes new requirement on CMS Administrator to notify states of their 2020 block grant allocations by November 1, 2019—a timeline that some may argue will give states far too little time to prepare and plan for major changes to their health systems;
- Slows the transition to the new Obamacare replacement block grant formula outlined in the law, which now would not fully take effect until after 2026—even though the bill does not appropriate block grant funds for years after 2026;
- Gives the Administrator the power not to make an annual adjustment for risk in the block grant;
- Strikes the block grant's annual adjustment factor for coverage value;

- Delays the block grant's state population adjustment factor from 2020 until 2022—but retains language giving the CMS Administrator to re-write the entire funding allocation based on this factor, which some conservatives may view as an unprecedented power grab by federal bureaucrats;
- Re-writes rules re-allocating unspent block grant allocation funds;
- Prohibits states from receiving more than a 25 percent year-on-year increase in their block grant allocations;
- Makes other technical changes to the block grant formula;
- Changes the formula for the $11 billion contingency fund provided to low-density and non-expansion states—25 percent ($2.75 billion) for low-density states, 50 percent ($5.5 billion) for non-Medicaid expansion states, and 25 percent ($2.75 billion) for Medicaid expansion states;
- Includes a $750 million fund for "late-expanding" Medicaid states (those that did not expand Medicaid under Obamacare prior to December 31, 2016), which some conservatives may consider an earmark, and one that encourages states to embrace Obamacare's Medicaid expansion to the able-bodied;
- Includes $500 million to allow pass-through funding under Section 1332 Obamacare waivers to continue for years 2019 through 2023 under the Obamacare replacement block grant;
- Strikes language allowing for direct primary care to be purchased through Health Savings Accounts (HSA), and as a medical expense under the Internal Revenue Code;
- Strikes language reducing American territories' Medicaid match from 55 percent to 50 percent;
- Restores language originally in BCRA allowing for "late-expanding Medicaid states" to select a shorter period for their per capita caps—a provision that some conservatives may view as an undue incentive for certain states that expanded Medicaid under Obamacare;
- Restores language originally in BCRA regarding reporting of data related to Medicaid per capita caps;
- Strikes language delaying Medicaid per capita caps for certain "low-density states";
- Includes new language perpetually increasing Medicaid match rates on the two highest states with separate poverty guidelines issued for them in 2017—a provision that by definition includes only Alaska and Hawaii, which some conservatives may view as an inappropriate earmark;
- Strikes language allowing all individuals to purchase Obamacare catastrophic coverage beginning in 2019;
- Strikes language clarifying enforcement provisions, particularly regarding abortion;
- Allows states to waive certain provisions related to insurance regulations, including 1) essential health benefits, 2) cost-sharing requirements, 3) actuarial value, 4) community rating, 5) preventive health services, and 6) single risk pool;
- Requires states to describe its new insurance rules to the federal government, "except that in no case may an issuer vary premium rates on the basis of sex or on the basis of genetic information," a provision that some conservatives may view as less likely to subject the rules to legal challenges than the prior language; and
- Retains language requiring each waiver participant to receive "a direct benefit" from federal funds, language that some conservatives may view as logistically problematic.

Full Summary of Bill (as Revised)

Last week, Senators Lindsey Graham (R-SC) and Bill Cassidy (R-LA) introduced a new health care bill. The legislation contains some components of the earlier Better Care Reconciliation Act (BCRA), considered by the Senate in July, with some key differences on funding streams. A full summary of the bill follows below, along with possible conservative concerns where applicable. Cost estimates are included below come from prior CBO scores of similar or identical provisions in BCRA.

Of particular note: It is unclear whether this legislative language has been fully vetted with the Senate Parliamentarian. When the Senate considers budget reconciliation legislation—as it would do should the Graham-Cassidy measure receive floor consideration—the Parliamentarian advises whether provisions are budgetary in nature and can be included in the bill (which can pass with a 51-vote

simple majority), and which provisions are not budgetary in nature and must be considered separately (i.e., require 60 votes to pass).

As the bill was released prior to issuance of a CBO score, it is entirely possible the Parliamentarian has not fully vetted this draft—which means provisions could change substantially, or even get stricken from the bill, due to procedural concerns as the process moves forward.

TITLE I

Revisions to Obamacare Subsidies:

Beginning in 2018, changes the definition of a qualified health plan to prohibit plans from covering abortion other than in cases of rape, incest, or to save the life of the mother. Some conservatives may be concerned that this provision may eventually be eliminated under the provisions of the Senate's "Byrd rule." (For more information, see these two articles.)

Eliminates provisions that limit repayment of subsidies for years after 2017. Subsidy eligibility is based upon estimated income, with recipients required to reconcile their subsidies received with actual income during the year-end tax filing process. Current law limits the amount of excess subsidies households with incomes under 400 percent of the federal poverty level (FPL), $98,400 for a family of four in 2017) must pay. This provision would eliminate that limitation on repayments, which may result in fewer individuals taking up subsidies in the first place. ***Saves $11.7 billion over 10 years—$8.5 billion in spending, and $3.2 billion in revenue.***

Repeals the subsidy regime entirely after December 31, 2019.

Small Business Tax Credit:

Repeals Obamacare's small business tax credit, effective in 2020. Disallows the small business tax credit beginning in 2018 for any plan that offers coverage of abortion, except in the case of rape, incest, or to protect the life of the mother—which, as noted above, some conservatives may believe will be stricken during the Senate's "Byrd rule" review. ***Saves $6 billion over 10 years.***

Individual and Employer Mandates:

Sets the individual and employer mandate penalties to zero, for all years after December 31, 2015. ***The individual mandate provision cuts taxes by $38 billion, and the employer mandate provision cuts taxes by $171 billion, both over 10 years.***

Stability Fund:

Creates two state-based funds intended to stabilize insurance markets—the first giving funds directly to insurers, and the second giving funds to states. The first would appropriate $10 billion each for 2018 and 2019, and $15 billion for 2020, ($35 billion total) to the Centers for Medicare and Medicaid Services (CMS) to "fund arrangements with health insurance issuers to address coverage and access disruption and respond to urgent health care needs within States." Instructs the CMS Administrator to "determine an appropriate procedure for providing and distributing funds." Does not require a state match for receipt of stability funds. Some conservatives may be concerned this provision provides excessive authority to unelected bureaucrats to distribute $35 billion in federal funds as they see fit.

Includes new language setting aside 5 percent of stability fund dollars for "low-density states"—a provision which some conservatives may oppose as an earmark for Alaska and other similar states.

Market-Based Health Care Grant Program:

Creates a longer-term stability fund for states with a total of $1.176 trillion in federal funding from 2020 through 2026—$146 billion in 2020 and 2021, $157 billion in 2022, $168 billion in 2023, $179 billion in 2024, and $190 billion in 2025 and 2026. Eliminates BCRA provisions requiring a state match. States could keep their allotments for two years, but unspent funds after that point could be re-allocated to other states. However, all funds would have to be spent by December 31, 2026.

Expands BCRA criteria for appropriate use of funds by states, to include assistance for purchasing individual insurance, and "provid[ing] health insurance coverage for individuals who are eligible for" Medicaid, as well as the prior eligible uses under BCRA: to provide financial assistance to high-risk individuals, including by reducing premium costs, "help stabilize premiums and promote state health insurance market participation and choice," provide payments to health care providers, or reduce cost-sharing.

However, states may spend no more than 15 percent of their resources on the Medicaid population (or up to 20 percent if the state applies for a waiver, and the Department of Health and Human Services (HHS) concludes that the state is using its funds "to supplement, and not supplant," the state Medicaid match). In addition, states must spend at least half of their funds on "provid[ing] assistance" to families with incomes between 50 and 300

percent of the federal poverty level (FPL). Some conservatives may believe these restrictions belie the bill's purported goal of giving states freedom and flexibility to spend the funds as they see fit.

Some conservatives may be concerned that, by doling out nearly $1.2 trillion in spending, the bill does not repeal Obamacare, so much as it redistributes Obamacare funds from "blue states" to "red states," per the formulae described below. Some conservatives may also be concerned that the bill creates a funding cliff—with spending dropping from $190 billion in 2026 to $0 in 2027—that will leave an impetus for future Congresses to spend massive new amounts of money in the future.

Grant Formula:

Sets a complex formula for determining state grant allocations, tied to the overall funding a state received for Medicaid expansion, the basic health program under Obamacare, and premium and cost-sharing subsidies provided to individuals in insurance Exchanges. Permits states to select any four consecutive fiscal quarters between September 30, 2013, and January 1, 2018, to establish the base period. (The bill sponsors have additional information regarding the formula calculations here.)

Intends to equalize grant amounts, with a phase-in of the new methodology for years 2021 through 2026. Ideally, the bill would set funding to a state's number of low-income individuals when compared to the number of low-income individuals nationwide. Defines the term "low-income individuals" to include those with incomes between 50 and 138 percent of the FPL (45-133% FPL, plus a 5 percent income disregard created by Obamacare). In 2017, those numbers total $12,300-$33,948 for a family of four.

Adjusts state allocations (as determined above) according to additional factors:

1. ***Risk Adjustment:*** The bill would phase in risk adjustment over four years (between 2023 and 2026), and limit the risk adjustment modification to no more than 10 percent of the overall allotment. Risk adjustment would be based on clinical risk factors for low-income individuals (as defined above). The CMS Administrator could cancel the risk adjustment factor in the absence of sufficient data.

2. ***Population Adjustment:*** Permits (but does not require) the Administrator to adjust allocations for years after 2022 according to a population adjustment factor. Requires CMS to "develop a state-specific population adjustment factor that accounts for legitimate factors that impact the health care expenditures in a state"—such as demographics, wage rates, income levels, etc.—but as noted above, does not require CMS to adjust allocations based upon those factors.

Notwithstanding the above, states could not receive a year-on-year increase in funding of more than 25 percent.

Requires the Administrator to adjust block grant spending upward for a "low-density state" with per capita health care spending 20 percent higher than the national average, increasing allocation levels to match the higher health costs—a provision some conservatives may consider an inappropriate earmark for Alaska. Imposes new requirement on the Administrator to notify states of their 2020 block grant allocations by November 1, 2019—a timeline that some may argue will give states far too little time to prepare and plan for major changes to their health systems.

Some conservatives may be concerned that, despite the admirable intent to equalize funding between high-spending and low-spending states, the bill gives excessive discretion to unelected bureaucrats in Washington to determine the funding formulae. Some conservatives may instead support repealing all of Obamacare, and allowing states to decide for themselves what they wish to put in its place, rather than doling out federal funds from Washington. Finally, some may question why the bill's formula criteria focus so heavily on individuals with incomes between 50-138 percent FPL, to the potential exclusion of individuals and households with slightly higher or lower incomes.

Provides $750 million for "late-expanding" Medicaid states—those that did not expand Medicaid under Obamacare prior to December 31, 2015—which some conservatives may consider an earmark, one that encourages states that have embraced Obamacare's Medicaid expansion to the able-bodied. Also includes $500 million to allow pass-through funding under Section 1332 Obamacare waivers to continue for years 2019 through 2023.

Grant Application:

Requires states applying for grant funds to outline the intended uses of same. Specifically, the state must describe how it "shall maintain access to adequate and affordable health insurance coverage for individuals with pre-existing conditions," along with "such other information as necessary for the Administrator to carry out this subsection"—language that could be used by a

future Democratic Administration, or federal courts, to undermine the waiver program's intent.

Explicitly requires states to "ensure compliance" with several federal insurance mandates:

1. Coverage of "dependents" under age 26;
2. Hospital stays following deliveries;
3. Mental health parity;
4. Reconstructive surgery following mastectomies; and
5. Genetic non-discrimination.

Some conservatives may note that these retained federal mandates belie the notion of state flexibility promised by the legislation.

Contingency Fund:

Appropriates a total of $11 billion—$6 billion for calendar year 2020 and $5 billion for calendar 2021—for a contingency fund for certain states. Half of the funding ($5.5 billion total) would go toward states that had not expanded Medicaid as of September 1, 2017, with the remaining one-quarter ($2.75 billion) going toward "low-density states"—those with a population density of fewer than 15 individuals per square mile—and another one-quarter ($2.75 billion) going toward states that did expand Medicaid.

Implementation Fund:

Provides $2 billion to implement programs under the bill. ***Costs $2 billion over 10 years.***

Repeal of Some Obamacare Taxes:

Repeals some Obamacare taxes:

- Restrictions on use of HSAs and Flexible Spending Arrangements to pay for over-the-counter medications, effective January 1, 2017, lowering revenues by $5.6 billion;
- Increased penalties on non-health care uses of Health Savings Account dollars, effective January 1, 2017, lowering revenues by $100 million;
- Medical device tax, effective January 1, 2018, lowering revenues by $19.6 billion; and
- Elimination of deduction for employers who receive a subsidy from Medicare for offering retiree prescription drug coverage, effective January 1, 2017, lowering revenues by $1.8 billion.

Some conservatives may be concerned that the bill barely attempts to reduce revenues, repealing only the smallest taxes in Obamacare—and the ones that corporate lobbyists care most about (e.g., medical device tax and retiree prescription drug coverage provision).

Health Savings Accounts:

Increases contribution limits to HSAs, raising them from the current $3,400 for individuals and $6,750 for families in 2017 to the out-of-pocket maximum amounts (currently $6,550 for an individual and $13,100 for a family), effective January 2018. Allows both spouses to make catch-up contributions to the same HSA. Permits individuals who take up to 60 days to establish an HSA upon enrolling in HSA-eligible coverage to be reimbursed from their account for medical expenses. ***Lowers revenues by a total of $19.2 billion over 10 years.***

Allows for HSA funds to be used for the purchase of high-deductible health plans, but only to the extent that such insurance was not purchased on a tax-preferred basis (i.e., through the exclusion for employer-provided health insurance or through Obamacare insurance subsidies).

Allows HSA dollars to be used to reimburse expenses for "dependents" under age 27, effectively extending the "under-26" provisions of Obamacare to HSAs. Prohibits HSA-qualified, high-deductible health plans from covering abortions, other than in cases of rape, incest, or to save the life of the mother—an effective prohibition on the use of HSA funds to purchase plans that cover abortion, but one that the Senate Parliamentarian may advise does not comport with procedural restrictions on budget reconciliation bills. ***No separate cost estimate provided for the revenue reduction associated with allowing HSA dollars to be used to pay for insurance premiums.***

Federal Payments to States:

Imposes a one-year ban on federal funds flowing to certain entities. This provision would have the effect of preventing Medicaid funding of certain medical providers, including Planned Parenthood, so long as Planned Parenthood provides for abortions (except in cases of rape, incest, or to save the life of the mother). CBO believes this provision would save a total of $225 million in Medicaid spending, while increasing spending by $79 million over a decade, because 15 percent of Planned Parenthood clients would lose access to services, increasing the number of births in the Medicaid program by several thousand. ***Saves $146 million over 10 years.***

Medicaid Expansion:

Phases out Obamacare's Medicaid expansion to the able-bodied, effective January 1, 2020. After such date, only members of Indian tribes who reside in states that had expanded Medicaid—and who were eligible on December 31, 2019—would qualify for Obamacare's Medicaid expansion. Indians could remain on the Medicaid expansion, but only if they do not have a break in eligibility (i.e., the program would be frozen to new enrollees on January 1, 2020).

Repeals the enhanced federal match (currently 95 percent, declining slightly to 90 percent) associated with Medicaid expansion, effective in 2020. Also repeals provisions regarding the Community First Choice Option, eliminating a six-percent increase in the Medicaid match rate for some home and community-based services. ***Saves $19.3 billion over 10 years.***

Retroactive Eligibility:

Effective October 2017, restricts retroactive eligibility in Medicaid from three months to two months. These changes would NOT apply to aged, blind, or disabled populations, who would still qualify for three months of retroactive eligibility. ***Saves $800 million over 10 years.***

Eligibility Re-Determinations:

Permits—but unlike the House bill, does not require—states, beginning October 1, 2017, to re-determine eligibility for individuals qualifying for Medicaid on the basis of income every six months, or at shorter intervals. Provides a five percentage point increase in the federal match rate for states that elect this option. ***No separate budgetary impact noted; included in larger estimate of coverage provisions.***

Work Requirements:

Permits (but does not require) states to, beginning October 1, 2017, impose work requirements on "non-disabled, non-elderly, non-pregnant" beneficiaries. States can determine the length of time for such work requirements. Provides a five percentage point increase in the federal match for state expenses attributable to activities implementing the work requirements.

States may not impose requirements on pregnant women (through 60 days after birth); children under age 19; the sole parent of a child under age 6, or sole parent or caretaker of a child with disabilities; or a married individual or head of household under age 20 who "maintains satisfactory attendance at secondary school or equivalent," or participates in vocational education. Adds to existing exemptions (drafted in BCRA) provisions exempting those in inpatient or intensive outpatient substance abuse treatment and full-time students from Medicaid work requirements. ***No separate budgetary impact noted; included in larger estimate of coverage provisions.***

Provider Taxes:

Reduces permissible Medicaid provider taxes from 6 percent under current law to 5.6 percent in fiscal year 2021, 5.2 percent in fiscal year 2022, 4.8 percent in fiscal year 2023, 4.4 percent in fiscal year 2024, and 4 percent in fiscal year 2025 and future fiscal years—a change from BCRA, which reduced provider taxes to 5 percent in 2025 (0.2 percent reduction per year, as opposed to 0.4 percent under the Graham-Cassidy bill). Some conservatives may view provider taxes as essentially "money laundering"—a game in which states engage in shell transactions solely designed to increase the federal share of Medicaid funding and reduce states' share. More information can be found here. CBO believes states would probably reduce their spending in response to the loss of provider tax revenue, resulting in lower spending by the federal government. ***Saves $13 billion over 10 years.***

Medicaid *Per Capita* Caps:

Creates a system of per capita spending caps for federal spending on Medicaid, beginning in fiscal year 2020. States that exceed their caps would have their federal match reduced in the following fiscal year.

The cap would include all spending on medical care provided through the Medicaid program, with the exception of DSH payments and Medicare cost-sharing paid for dual eligibles (individuals eligible for both Medicaid and Medicare).

While the cap would take effect in fiscal year 2020, states could choose their "base period" based on any eight consecutive quarters of expenditures between October 1, 2013, and June 30, 2017. The CMS Administrator would have authority to make adjustments to relevant data if she believes a state attempted to "game" the look-back period. Late-expanding Medicaid states could choose a shorter period (but not fewer than four) quarters as their "base period" for determining per capita caps—a provision that some conservatives may view as improperly incentivizing states that decided to expand Medicaid to the able-bodied.

Creates four classes of beneficiaries for whom the caps would apply: 1) elderly individuals over age 65; 2) blind and disabled beneficiaries; 3) children under age 19; and 4) all other non-disabled, non-elderly, non-expansion

adults (e.g., pregnant women, parents, etc.). Excludes State Children's Health Insurance Plan enrollees, Indian Health Service participants, breast and cervical cancer services-eligible individuals, and certain other partial benefit enrollees from the per capita caps. Exempts declared public health emergencies from the Medicaid per capita caps—based on an increase in beneficiaries' average expenses due to such emergency—but such exemption may not exceed $5 billion.

For years before fiscal year 2025, indexes the caps to medical inflation for children and all other non-expansion enrollees, with the caps rising by medical inflation plus one percentage point for aged, blind, and disabled beneficiaries. Beginning in fiscal year 2025, indexes the caps to overall inflation for children and non-expansion enrollees, with the caps rising by medical inflation for aged, blind, and disabled beneficiaries—a change from BCRA, which set the caps at overall inflation for all enrollees beginning in 2025.

Eliminates provisions in the House bill regarding "required expenditures by certain political subdivisions," which some had derided as a parochial New York-related provision.

Provides a provision—not included in the House bill—for effectively re-basing the per capita caps. Allows the Secretary of Health and Human Services to increase the caps by between 0.5% and 3% (a change from BCRA, which set a 2% maximum increase) for low-spending states (defined as having per capita expenditures 25% below the national median), and lower the caps by between 0.5% and 2% (unchanged from BCRA) for high-spending states (with per capita expenditures 25% above the national median). The Secretary may only implement this provision in a budget-neutral manner, i.e., one that does not increase the deficit. However, this re-basing provision shall NOT apply to any state with a population density of under 15 individuals per square mile.

Requires the HHS to reduce states' annual growth rate by one percent for any year in which that state "fails to satisfactorily submit data" regarding its Medicaid program. Permits HHS to adjust cap amounts to reflect data errors, based on an appeal by the state, increasing cap levels by no more than two percent. Requires new state reporting on inpatient psychiatric hospital services and children with complex medical conditions. Requires the HHS Inspector General to audit each state's spending at least every three years.

For the period including calendar quarters beginning on October 1, 2017, through October 1, 2019, increases the federal Medicaid match for certain state expenditures to improve data recording, including a 100 percent match in some instances.

Home and Community-Based Services:

Creates a four-year, $8 billion demonstration project from 2020 through 2023 to expand home- and community-based service payment adjustments in Medicaid, with such payment adjustments eligible for a 100 percent federal match. The 15 states with the lowest population density would be given priority for funds.

Medicaid Block Grants:

Creates a Medicaid block grant, called the "Medicaid Flexibility Program," beginning in Fiscal Year 2020. Requires interested states to submit an application providing a proposed packet of services, a commitment to submit relevant data (including health quality measures and clinical data), and a statement of program goals. Requires public notice-and-comment periods at both the state and federal levels.

The amount of the block grant would total the regular federal match rate, multiplied by the target per capita spending amounts (as calculated above), multiplied by the number of expected enrollees (adjusted forward based on the estimated increase in population for the state, per Census Bureau estimates). In future years, the block grant would be increased by general inflation.

Prohibits states from increasing their base year block grant population beyond 2016 levels, adjusted for population growth, plus an additional three percentage points. This provision is likely designed to prevent states from "packing" their Medicaid programs full of beneficiaries immediately prior to a block grant's implementation, solely to achieve higher federal payments.

In a change from BCRA, the bill removes language permitting states to roll over block grant payments from year to year—a move that some conservatives may view as antithetical to the flexibility intended by a block grant, and biasing states away from this model. Reduces federal payments for the following year in the case of states that fail to meet their maintenance of effort spending requirements, and permits the HHS Secretary to make reductions in the case of a state's non-compliance. Requires the Secretary to publish block grant amounts for every state every year, regardless of whether the state elects the block grant option.

Permits block grants for a program period of five fiscal years, subject to renewal; plans with "no significant changes" would not have to re-submit an application for their block grants. Permits a state to terminate the block grant, but only if the state "has in place an appropriate transition plan approved by the Secretary."

Imposes a series of conditions on Medicaid block grants, requiring coverage for all mandatory populations identified in the Medicaid statute, and use of the Modified Adjusted Gross Income (MAGI) standard for determining eligibility. Includes 14 separate categories of services that states must cover for mandatory populations under the block grant. Requires benefits to have an actuarial value (coverage of average health expenses) of at least 95 percent of the benchmark coverage options in place prior to Obamacare. Permits states to determine the amount, duration, and scope of benefits within the parameters listed above.

Applies mental health parity provisions to the Medicaid block grant, and extends the Medicaid rebate program to any outpatient drugs covered under same. Permits states to impose premiums, deductibles, or other cost-sharing, provided such efforts do not exceed 5 percent of a family's income in any given year.

Requires participating states to have simplified enrollment processes, to coordinate with insurance Exchanges, and to "establish a fair process" for individuals to appeal adverse eligibility determinations. Allows for modification of the Medicaid block grant during declared public health emergencies—based on an increase in beneficiaries' average expenses due to such emergency.

Exempts states from per capita caps, waivers, state plan amendments, and other provisions of Title XIX of the Social Security Act while participating in Medicaid block grants.

Performance Bonus Payments:

Provides an $8 billion pool for bonus payments to state Medicaid and SCHIP programs for Fiscal Years 2023 through 2026. Allows the Secretary to increase federal matching rates for states that 1) have lower than expected expenses under the per capita caps, 2) report applicable quality measures, and 3) have a plan to use the additional funds on quality improvement. While noting the goal of reducing health costs through quality improvement, and incentives for same, some conservatives may be concerned that this provision—as with others in the bill—gives near-blanket authority to the HHS Secretary to control the program's parameters, power that conservatives believe properly resides outside Washington—and power that a future Democratic Administration could use to contravene conservative objectives. CBO believes that only some states will meet the performance criteria, leading some of the money not to be spent between now and 2026. ***Costs $3 billion over 10 years.***

Inpatient Psychiatric Services:

Provides for optional state Medicaid coverage of inpatient psychiatric services for individuals over 21 and under 65 years of age. (Current law permits coverage of such services for individuals under age 21.) Such coverage would not exceed 30 days in any month or 90 days in any calendar year. In order to receive such assistance, the state must maintain its number of licensed psychiatric beds as of the date of enactment, and maintain current levels of funding for inpatient services and outpatient psychiatric services. Provides a lower (i.e., 50 percent) match for such services, furnished on or after October 1, 2018; however, in a change from BCRA, allows for higher federal match rates for certain services and individuals to continue if they were in effect prior to September 30, 2018. ***No separate budgetary impact noted; included in larger estimate of coverage provisions.***

Medicaid and Indian Health Service:

Makes a state's expenses on behalf of Indians eligible for a 100 percent match, irrespective of the source of those services. Current law provides for a 100 percent match only for services provided at an Indian Health Service center. ***Costs $3.5 billion over 10 years.***

Disproportionate Share Hospital (DSH) Payments:

Adjusts reductions in DSH payments to reflect shortfalls in funding for the state grant program described above. For fiscal years 2021 through 2025, states receiving grant allocations that do not keep up with medical inflation will have their DSH reductions reduced or eliminated; in fiscal year 2026, states with grant shortfalls will have their DSH payments increased. ***Costs $17.9 billion over 10 years.***

High-Poverty States:

Provides for a permanent increase in the federal Medicaid match for two states, based on poverty guidelines established for 2017. Specifically, provides for a 25 percent increase to the state with the "highest separate poverty guideline for 2017," and a 15 percent increase to the state with the "second highest separate poverty guideline for 2017"—provisions that by definition would apply only to Alaska and Hawaii, respectively. Some conservatives may be concerned first that these provisions represent

inappropriate earmarks, and further that they would change federal spending in perpetuity based on poverty determinations made for a single year. ***Costs $7.2 billion over 10 years.***

TITLE II

Prevention and Public Health Fund:

Eliminates funding for the Obamacare prevention "slush fund," and rescinds all unobligated balances, beginning in Fiscal Year 2019. ***Saves $7.9 billion over 10 years.***

Community Health Centers:

Increases funding for community health centers by $422 million for Fiscal Year 2018—money intended to offset reductions in spending on Planned Parenthood affiliates (see "Federal Payments to States" above). ***Spends $422 million over 10 years.***

Cost-Sharing Subsidies:

Repeals Obamacare's cost-sharing subsidies, effective December 31, 2019, and does not appropriate funds for cost-sharing subsidy claims for plan years through 2019. The House of Representatives filed suit against the Obama Administration (*House v. Burwell*) alleging the Administration acted unconstitutionally in spending funds on the cost-sharing subsidies without an explicit appropriation from Congress. The case is currently on hold pending settlement discussions between the Trump Administration and the House.

Grant Conditions:

Sets additional conditions for the grant program established in Title I of the bill. States may submit applications waiving certain provisions currently in federal statute:

1. Essential health benefits;
2. Cost-sharing requirements;
3. Actuarial value requirements, including plan metal tiers (e.g., bronze, silver, gold, and platinum);
4. Community rating—although states may not be able to vary premiums based on health status, due to contradictory language in this section;
5. Preventive health services; and
6. Single risk pool.

Requires states to submit their revised rules to the federal government, "except that in no case may an issuer vary premium rates on the basis of sex or on the basis of genetic information." Some conservatives may view this language as less likely to spark new legal challenges than the prior wording, which prohibited insurance changes based on "membership in a protected class." However, some conservatives may also find that the mutually contradictory provisions over whether and how states can vary insurance rates may spark other legal challenges.

The waivers only apply to an insurer receiving funding under the state program and "to an individual who is receiving a direct benefit" from the grant—which does not include reinsurance. In other words, each individual must receive some direct subsidy, rather than just general benefits derived from the broader insurance pool. Some conservatives may be concerned that, by tying waiver of regulations so closely to receipt of federal grant funds, this provision would essentially provide limited regulatory relief. Furthermore, such limited relief would require states to accept federal funding largely adjudicated and doled out by unelected bureaucrats.

Some conservatives may be concerned that, while well-intentioned, these provisions do not represent a true attempt at federalism—one which would repeal all of Obamacare's regulations and devolve health insurance oversight back to the states. It remains unclear whether any states would actually waive Obamacare regulations under the bill; if a state chooses not to do so, all of the law's costly mandates will remain in place there, leaving Obamacare as the default option.

Some conservatives may view provisions requiring anyone to whom a waiver applies to receive federal grant funding as the epitome of moral hazard—ensuring that individuals who go through health underwriting will receive federal subsidies, no matter their level of wealth or personal circumstances. By requiring states to subsidize bad actors—for instance, an individual making $250,000 who knowingly went without health coverage for years—with federal taxpayer dollars, the bill could actually raise health insurance premiums, not lower them. Moreover, some conservatives may be concerned that—because the grant program funding ends in 2027, and because all individuals subject to waivers must receive grant funding—the waiver program will effectively end in 2027, absent a new infusion of taxpayer dollars. ✭

About the Author

Chris Jacobs is a senior healthcare policy analyst at the Texas Public Policy Foundation. He has over a decade of experience in a variety of policy roles on and off Capitol Hill. He worked as the policy director for America Next, a new start-up think tank, and as a senior policy analyst for the Heritage Foundation and the Joint Economic Committee's Senate Republican staff. Before that, Chris worked as a policy advisor for the House Republican Conference under Chairman Mike Pence during the debate surrounding the Patient Protection and Affordable Care Act. He was also a health policy analyst for the Senate Republican Policy Committee during the first two years of the law's implementation. He got his start on Capitol Hill as an intern for then-Congressman Pat Toomey of Pennsylvania.

While serving as policy director for America Next, Chris contributed to the *Wall Street Journal's* Think Tank policy blog. He currently teaches part-time on health policy at The American University, where he received his bachelor's degree in political science and history *Phi Beta Kappa*.

About the Texas Public Policy Foundation

The Texas Public Policy Foundation is a 501(c)3 non-profit, non-partisan research institute. The Foundation's mission is to promote and defend liberty, personal responsibility, and free enterprise in Texas and the nation by educating and affecting policymakers and the Texas public policy debate with academically sound research and outreach.

Funded by thousands of individuals, foundations, and corporations, the Foundation does not accept government funds or contributions to influence the outcomes of its research.

The public is demanding a different direction for their government, and the Texas Public Policy Foundation is providing the ideas that enable policymakers to chart that new course.

901 Congress Avenue | Austin, Texas 78701 | (512) 472-2700 | www.TexasPolicy.com

CA 10.6.17