American Hospital Association

Legislative Advisory

September 14, 2017

Republican Senators Unveil New ACA Repeal and Replace Legislation

Sens. Lindsey Graham (R-SC), Bill Cassidy (R-LA), Dean Heller (R-NV) and Ron Johnson (R-WI) Sept. 13 unveiled a health care reform bill that would repeal components of the Affordable Care Act (ACA), make significant changes to how the Medicaid program is financed, and create a new grant program allowing states flexibility to design their own system to provide health care coverage and access to care.

The Senate has until Sept. 30, 2017 to pass the bill with 51 votes under the reconciliation rules. After that point, the legislation would require at least 60 votes in the Senate to move forward. The bill has not yet been scored by the Congressional Budget Office.

A summary of the draft legislation follows.

INDIVIDUAL AND EMPLOYER MANDATES

The bill would eliminate the financial penalties on individuals without coverage and employers that do not offer coverage, retroactive to calendar year (CY) 2016, thus effectively repealing the individual and employer coverage mandates.

MEDICAID PROVISIONS

The bill would restructure the current Medicaid financing system by implementing a per capita cap payment structure for most program spending, unless the state elects a block grant option for certain populations. In addition, the bill would repeal the enhanced federal funding for Medicaid expansion as of Dec. 31, 2019. Other changes to the Medicaid program are described below.

Per Capita-based Cap. Starting in fiscal year (FY) 2020, the federal government would establish a single overall per capita funding allotment for each state.

- The allotment would initially be based on spending targets for five different enrollee categories: 1) elderly, 2) blind or disabled, 3) expansion adults, 4) children under age 19, and 5) non-elderly, non-disabled adults. Some

populations, such as disabled children, would be excluded from the per capita cap structure.

- States would select a base period for expenditures, consisting of eight consecutive fiscal quarters between Quarter 1 of 2014 and Quarter 3 of 2017.
- The allotment would trend forward base period spending by the medical Consumer Price Index (CPI-M) with a separate trend factor of CPI-M plus 1 percent for elderly, blind and disabled enrollees. After FY 2024, the growth rate would be lowered to the urban Consumer Price Index (CPI-U) for most populations and to CPI-M for elderly, blind and disabled enrollees. These trend factors are lower than historic growth in the Medicaid program.
- Some populations, such as disabled children, would be excluded from the cap, and some flexibility is built in for public health emergencies.
- Beginning in FY 2020, the bill includes an adjustment for states that spend a certain amount above or below their target-spending amount. This adjustment is budget neutral and, therefore, would move money from higher-spending states to lower-spending states. States with low population density would be excluded from this adjustment.
- The per capita cap restructuring could be delayed for certain low population density states; however, the duration of the delay is not specified in the bill.

Block Grant Option. The bill would provide states with an option to receive a block grant in place of a per capita cap for certain healthy populations beginning in FY 2020. This option would allow states flexibility in the design of their Medicaid program, subject to certain federal requirements. Such federal requirements would include a list of services states must cover, such as inpatient and outpatient hospital, primary care and mental health and substance use disorder services, as well as limits on cost sharing.

- The grants would run for a period of five years, after which states could continue the block grant option or convert to a per capita cap allotment.
- The funding formula would be based on the target per capita amount from the per capita cap provision. This amount would increase annually by CPI-U but would not be adjusted for changes in enrollment. States would be permitted to roll over block grant funds from year to year and there would be some accommodation for spending on public health emergencies.

Other Changes to Medicaid. The bill would make other changes to the Medicaid program:

- *ACA Medicaid Disproportionate Share Hospital (DSH) Cuts*. As in current law, the ACA Medicaid DSH cuts would go into effect beginning in FY 2018. However, the bill provides certain exceptions for states participating in the Market-Based Grant Program (described below) that receive a low grant allotment amount.

- *Provider Taxes*. The bill would reduce the allowable provider tax limit from 6 percent to 4 percent over a five-year period beginning with 5.6 percent in FY 2021 and dropping 0.4 percentage points each FY until arriving at 4 percent in FY 2025. The cap would be 4 percent in FY 2025 and beyond.
- *Modified Retroactive Eligibility Coverage*. Beginning Oct. 1, 2017, the bill would only enable Medicaid recipients who are age 65 years or older, blind or disabled to receive retroactive eligibility for coverage.
- *Redeterminations for Medicaid Eligibility Based on Modified Adjusted Gross Income*. The bill would require states to conduct eligibility redeterminations every six months for populations whose eligibility was determined through modified gross income. This requirement would begin Oct. 1, 2017. States would receive a temporary five percentage point FMAP increase to help defray costs for complying with this new requirement from Oct. 1, 2017 to Dec. 31, 2019.
- *Inpatient Psychiatric Services*. The bill provides more flexibility to states by amending the Institutions for Mental Diseases exclusion to allow for coverage of qualified inpatient psychiatric hospital services for patients over 21 and under 65 years of age, as long as states meet certain criteria. Services would be limited to 30 consecutive days per month, not to exceed 90 days in a calendar year. States would receive a 50 percent federal matching rate for services provided. The provision would be effective on or after Oct. 1, 2018.
- *State Option for Work Requirements*. The bill would permit states to require non-disabled non-elderly, non-pregnant adults to satisfy a work requirement as a condition to receive Medicaid benefits. This option would begin Oct. 1, 2017. The bill also would increase a state's administrative federal matching rate for implementing the optional work requirement.
- *Establish New Demonstration Project for Home and Community-based Services*. The bill would require the Secretary of Health and Human Services (HHS) to establish a four-year demonstration project for the purpose of continuing and/or improving home and community-based services for the aged, blind and disabled populations. The demonstration project would run from Jan. 1, 2020 through Dec. 31, 2023 for 15 states selected through a competitive process.
- *Medicaid and CHIP Quality Performance Bonus Payments*. The bill would establish Medicaid and Children's Health Insurance Program quality performance bonus payment program for FYs 2023 – 2026 with $8 billion in total funding. The formula for these payments would largely be established by the Secretary.
- *New York State Limit on Per capita Cap Expenditures.* New York State would be subject to certain limitations in the financing of its Medicaid program. The bill would not permit a state with FY 2016 DSH allotments six-times the national average of FY 2016 state DSH allotments to require county governments to contribute to the state's share of the Medicaid financing. The state could, however, require counties with populations of 5 million or more (i.e., New York City counties) to contribute to the state share of Medicaid. To enforce this provision, beginning in FY 2020, the state would have its per capita amounts

decreased by the amount the state requires the county governments to contribute to the state share.

HEALTH INSURANCE MARKETPLACE & INSURANCE MARKET REFORMS

Marketplace Subsidies. The bill would repeal the advance premium tax credits and cost-sharing reductions (CSRs) beginning in CY 2020. The bill would not fund the CSRs for the two years prior (CYs 2018 and 2019)

Short-term Assistance to Insurers. The bill would provide $25 billion to insurers over two years (2019-2020) to stabilize premiums and promote market participation, although unspent funds may be carried over to future years.

Marketplace & Insurance Rule Waivers. The bill would modify Section 1332 waiver authority by expediting the federal approval process and extending the duration of the waivers. The current waiver "guardrails" that require comparable coverage and affordability, among others, would remain in place.

Catastrophic Coverage. The bill would allow individuals to enroll in a catastrophic health plan beginning Jan. 1, 2019.

MARKET-BASED HEALTH CARE GRANT PROGRAM

The bill would create a new Market-based Health Care Grant Program for states to help individuals obtain health care coverage and access health care services. This new program would be housed within Title XXI of the Social Security Act, which authorizes the CHIP program, and includes a seven-year appropriation worth $1.2 trillion in total. The program essentially "block grants" a portion of what would have been otherwise spent on coverage through Medicaid expansion, the Basic Health Program and the marketplace subsidies. States would need to apply to participate using a process established by the HHS Secretary.

States could use these funds for a variety of purposes, including: contracting with insurers to provide coverage, contracting with providers to deliver care, implementing high risk pools or a reinsurance program, and reducing consumer premiums and cost-sharing, among other uses. States could use up to 20 percent of the grant funds to provide coverage through Medicaid managed care plans, subject to certain conditions. States also could seek waivers of insurance market rules, including rules related to community rating (with some exceptions), essential health benefits, and medical loss ratio.

More specifically:

- The program would be funded annually for seven years, starting at $146 billion in CY 2020 and increasing incrementally to $190 billion in CY 2026 ($1.2 billion

in total over seven years). It does not appear that states will need to provide any matching funds.

- A state's initial allotment for CY 2020 would be a portion of the total amount allocated for the year based on historic spending in the state on Medicaid expansion, the marketplace subsidies and the Basic Health Program, trended forward.
- The 2020 amount would increase from 2021 – 2025 by taking into account the difference between what a state is expected to receive in 2026 and the 2020 allotment.
- The 2026 allotment would be determined based on the ratio of individuals in the state whose income is between 45 percent and 133 percent of poverty to the total number of such individuals in the nation.
- The allotments would be adjusted by a number of factors, including a risk-adjustment factor, a "coverage value adjustment" (related to the actuarial value of plans in the state) and, at the Secretary's option, a "population adjustment factor," which would take into account demographic characteristics, such as a state's wage rates, income levels and other factors. In addition, adjustments could be made for low population density states and states that did not expand Medicaid.
- State allotments that remain unused by a certain date would be transmitted to the general fund of the Treasury for deficit reduction.

TAX PROVISIONS

The bill would retain nearly all of the tax provisions of the ACA, including the fee on insurers, prescription drugs and indoor tanning services, as well as the 0.9 percent Medicare surtax and the tax on certain net investment income on high-income earners. The bill would repeal the medical device excise tax effective CY 2018, along with several other revenue provisions.