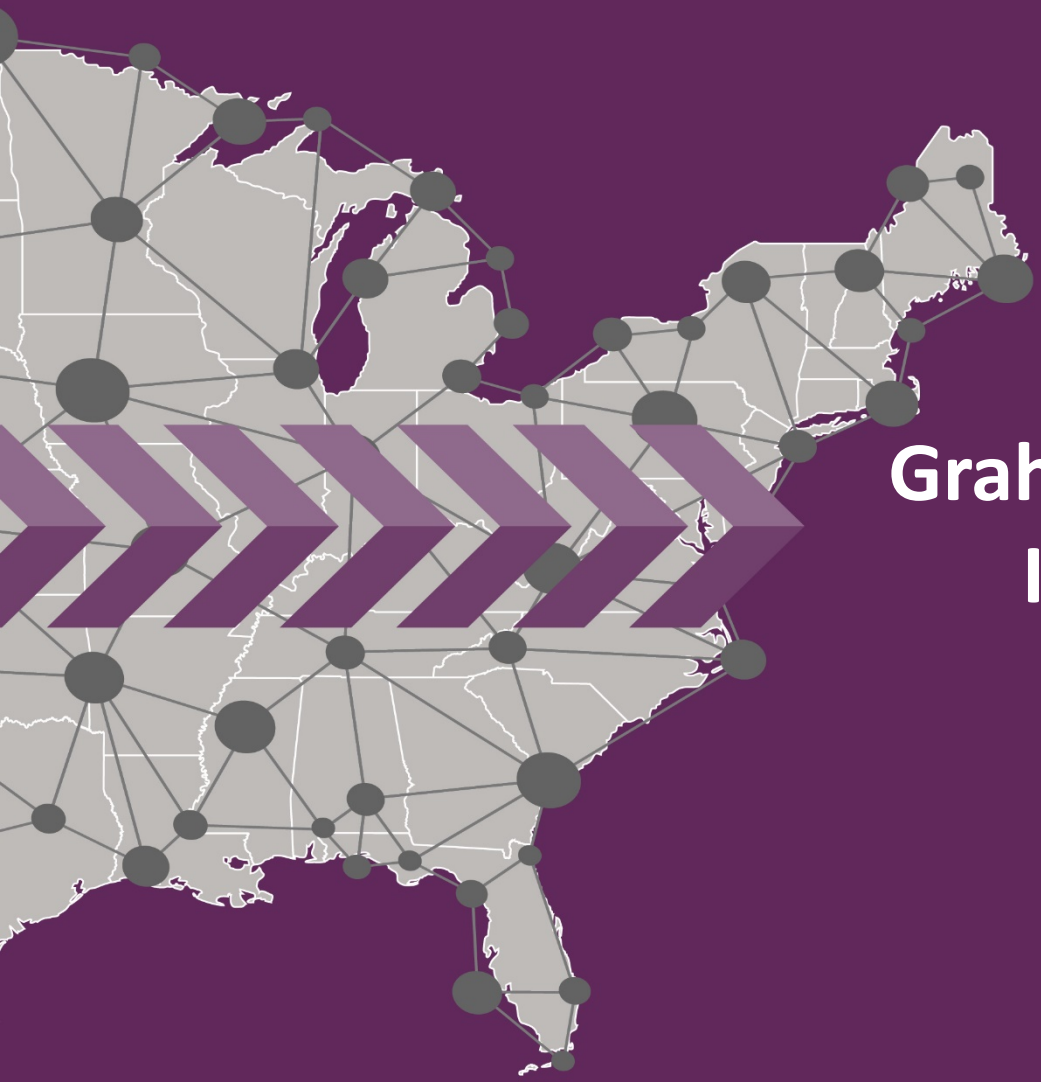


Understanding the Graham-Cassidy Proposal: Implications for States

Manatt Health

September 22, 2017

manatt

Robert Wood Johnson Foundation

WOODROW WILSON SCHOOL of Public & International Affairs

Full report available at: http://www.statenetwork.org/resource/update-state-policy-and-budget-impacts-of-new-graham-cassidy-repeal-and-replace-proposal

About State Health and Value Strategies

Staff members at Princeton University's Woodrow Wilson School of Public and International Affairs manage the State Health and Value Strategies Program, funded by the Robert Wood Johnson Foundation. State Health and Value Strategies supports state efforts to enhance the quality and value of health care by improving population health and reforming the delivery of health care services. The program connects states with experts and peers to develop tools to undertake new reform initiatives. The program engages state officials, providing lessons learned, highlighting successful strategies, and bringing together states and stakeholders. Learn more at www.statenetwork.org.

About the Authors

Patricia Boozang, Jocelyn Guyer, April Grady, Deborah Bachrach, and Gayle Mauser with Manatt, Phelps & Phillips, LLP prepared this presentation. Manatt Health, a division of Manatt, Phelps & Phillips, LLP, is an integrated legal and consulting practice with over 90 professionals in nine locations across the country. Manatt Health supports states, providers, and insurers with understanding and navigating the complex and rapidly evolving health care policy and regulatory landscape. Manatt Health brings deep subject matter expertise to its clients, helping them expand coverage, increase access, and create new ways of organizing, paying for, and delivering care. For more information, visit www.manatt.com/ManattHealth.aspx

Agenda

- **Overview of Major Graham-Cassidy Provisions**
- **Deep Dive on the Market-Based Health Care Grant Program**
- **Implications of the Market-Based Health Care Grant Program for States**
- **Questions**

The key focus of today's webinar is the Market-Based Health Care Grant Program – the new "block grant" portion of the Graham-Cassidy proposal.

Overview of Major Graham-Cassidy Provisions

Major Graham-Cassidy Provisions

Imposes block grants– The new Market-Based Health Care Grant Program replaces federal funding for Marketplace subsidies and Medicaid expansion coverage after 2019

Today's Focus

Provides new waiver authority – States could waive ACA consumer protections, e.g. eliminating EHBs, permitting insurers to vary premiums based on health, age or any factor other than sex or membership in a protected class

Repeals the individual and employer mandates – Retroactively repeals the individual mandate without any replacement, while retaining guaranteed-issue

Imposes per capita caps – Converts federal financing for the Medicaid program to a per capita cap

Other Key Medicaid Provisions

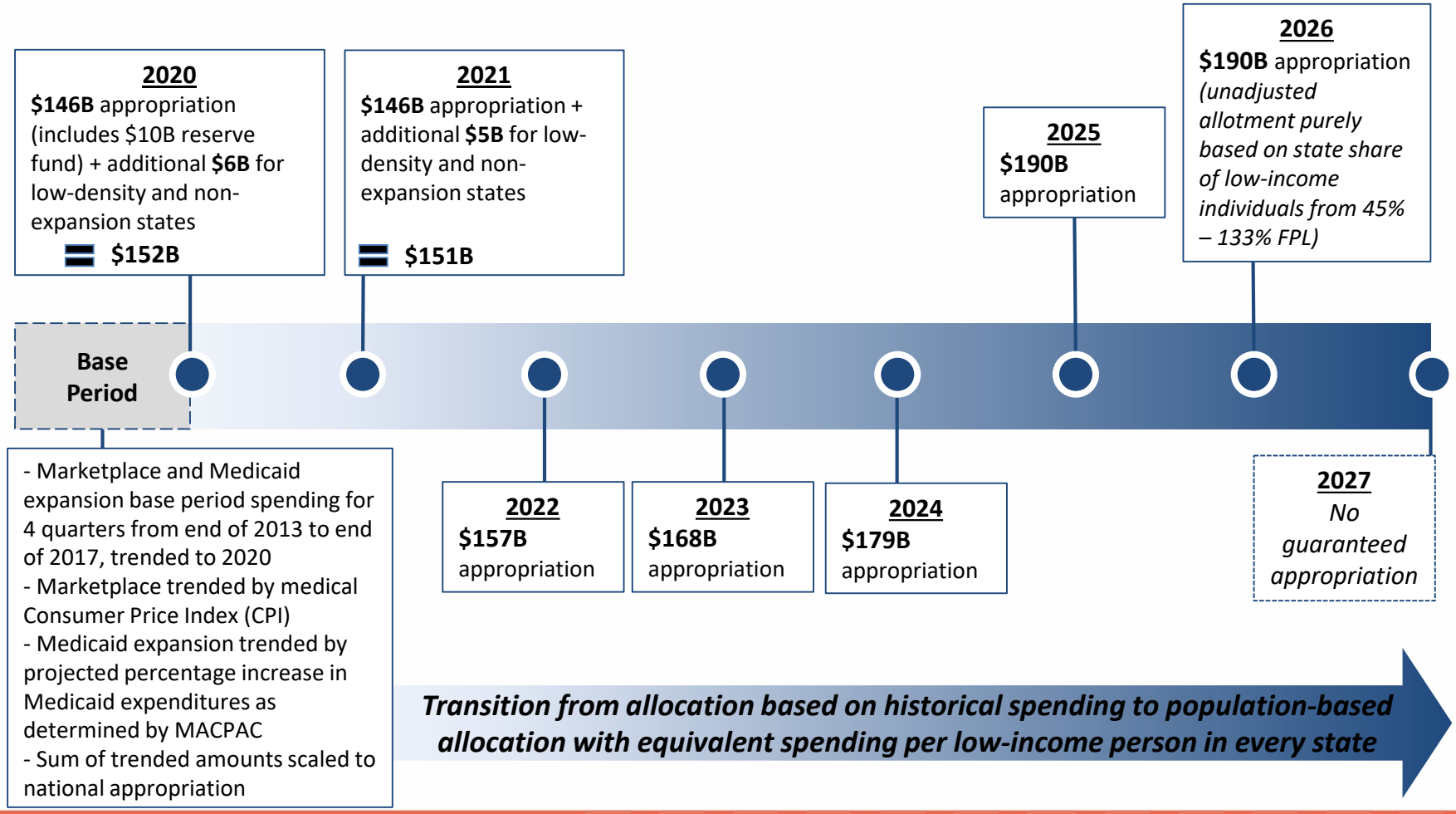
- **Terminates Medicaid expansion** – Beginning in 2020, no statutory pathway to expand Medicaid for parents above 1996 welfare levels or for childless adults, even at regular match (with the exception of grandfathered Native American populations, under certain circumstances)
- **Medicaid DSH cuts go into effect** – States with block grant shortfalls (i.e., when a state's allotment grows by less than medical CPI relative to the state's 2020 allotment) in any year from FY 2021 – FY 2025 are eligible for a decrease in the state's DSH cut for that year by the amount of the shortfall up to the full amount of the cut
- **Further limits provider taxes** – Cuts back states' ability to use provider taxes by codifying and reducing the allowable provider tax safe harbor from FY 2021 through FY 2025, gradually reducing the allowable threshold from 6% (under current regulations) to 4% in FY 2025 and beyond

Deep Dive on the Market-Based Health Care Grant Program

Key Features of the Market-Based Health Care Grant Program

Duration	▪ 2020-2026; no funding in 2027 and beyond absent new appropriation
Allocation of Federal Funding	▪ 2020: based on state historic spending for Marketplace subsidies, BHP and Medicaid expansion ▪ 2021-2026: block grant dollars increasingly distributed based on state share of low-income individuals (45% and 133% FPL) and other adjustments, some at Secretary discretion ▪ 2020-2026: 6.4% decrease in funding at the national level, relative to current law ▪ Significant redistribution of the remaining resources among states
State Financial Participation	▪ No state match is required
State Flexibility	▪ Significant state flexibility to use funds for broad range of health care related purposes (ranging from coverage to provider payments) ▪ States responsible for operationalizing the new program(s)

Formula for Market-Based Health Care Grant Program



Adjustments to State Allotments

There are two ways state allotments are adjusted, and a third way the HHS Secretary may choose to make adjustments

1. **Population Risk**: Based on clinical risk categories into which low-income individuals in each state are classified in accordance with a methodology to be developed by the Secretary of HHS; this adjustment is required for 2021+

2. **Coverage Value**: The actuarial value of coverage funded by the state with block grant dollars; required for 2024+

3. **State-specific Population**: The HHS Secretary has discretion to further adjust allotments according to a "population adjustment factor" that could include demographics, wage rates, income levels, or other factors; optional for 2021+

The size of and specifications for the state-specific population adjustment are open-ended; ***while states are provided significant flexibility, the federal government retains substantial control over how to distribute the funds among states.***

Special Provisions for Selected Groups of States

Graham-Cassidy includes provisions aimed at modifying the block grant and per capita cap changes for selected groups of states

Additional funding in 2020 and 2021 block grant allotments for low-density and non-expansion states

- $6 billion in 2020; $5 billion in 2021
- 25% reserved for low-density states (those with fewer than 15 people per square mile); 75% for non-expansion states

Exemption from the per capita cap for low-density states

- Exempts these states if their block grant amount for a given year is: 1) less than the state's 2020 block grant amount indexed by medical CPI; or, 2) determined by the Secretary of HHS to be insufficient
- Since the exemption criteria are based on the block grant, which is not authorized beyond 2026, the low-density states may be subjected to the per capita cap in 2027 and beyond even if exempt in earlier years

For non-expansion states, adds the enhanced Medicaid expansion funding that such states would have received for individuals up to 100% FPL if the state covered such individuals at the regular matching rate under a Medicaid 1115 waiver that was in effect as of September 1, 2017.

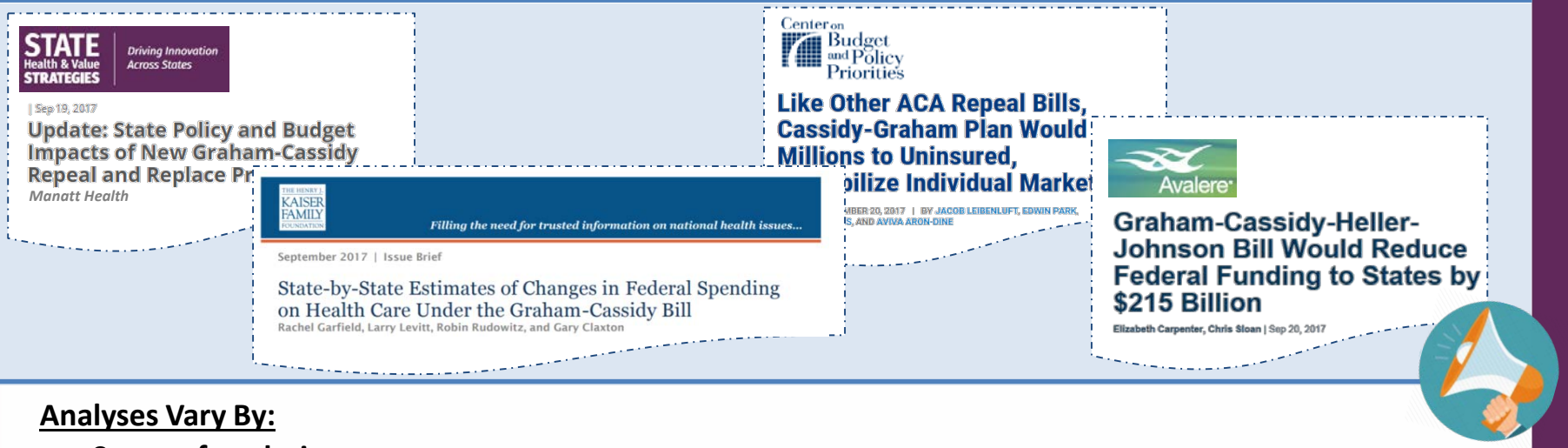
LOW DENSITY STATES:

Alaska
Montana
North Dakota
South Dakota
Wyoming

Appears to be relevant only to Wisconsin

Estimates of State Impact

All estimates to date point in the same direction: the majority of states will lose federal funding under Graham-Cassidy, with some experiencing particularly large losses.



Analyses Vary By:

- **Scope of analysis**: impact of the block grant alone vs. the block grant and Medicaid per capita caps
- **Base year:**
  - For example, estimates posted by Senator Cassidy's office show change in block grant over time, not block grant relative to current law
  - Manatt relies on CBO's September 2017 estimate of Marketplace federal subsidies from 2017-2027, which are lower compared to the March 2016 CBO estimate; CBO will be required to use March 2016 estimate for scoring.
- **Assumptions regarding impact of adjustments**

Overview of Manatt SHVS Analysis

The purpose of the Manatt SHVS analysis is to help states understand the fiscal impact of the Market-Based Health Care Grant Program (block grant); two analyses were conducted:

1 Unadjusted Block Grant Allotments

- Unadjusted block grant allotments were calculated using formulas called for in the bill
- Key assumptions:
  - States choose calendar year 2017 as base period to trend forward
  - For each state, current law Marketplace grows at rates projected by CBO as of September 2017
  - MACPAC projection for base period trend will be similar to current law national Medicaid growth

2 *Illustrative* Price Adjusted Allotments

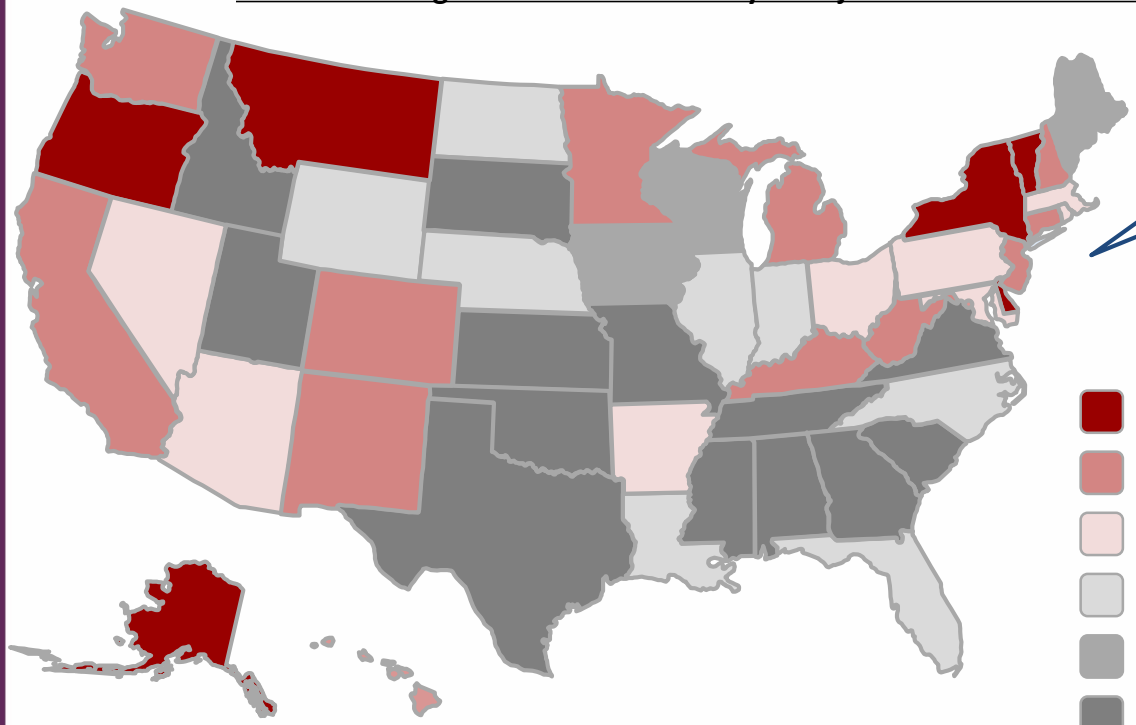
- We used a Medicare price index to adjust allotments to account for differences in wages, input costs, and similar factors that impact healthcare spending
- This analysis demonstrates the magnitude of funds that could be shifted across states based on adjustments to allotments
- In practice, adjustments may be smaller or larger than that modeled; these assumptions are necessarily uncertain

Implications of the Market-Based Health Care Grant Program for States

States Gaining or Losing Federal Funding

States that expanded Medicaid and/or spend more on coverage for low-income individuals tend to lose more.

Federal Funding Under Graham-Cassidy Unadjusted Block Grant in 2026

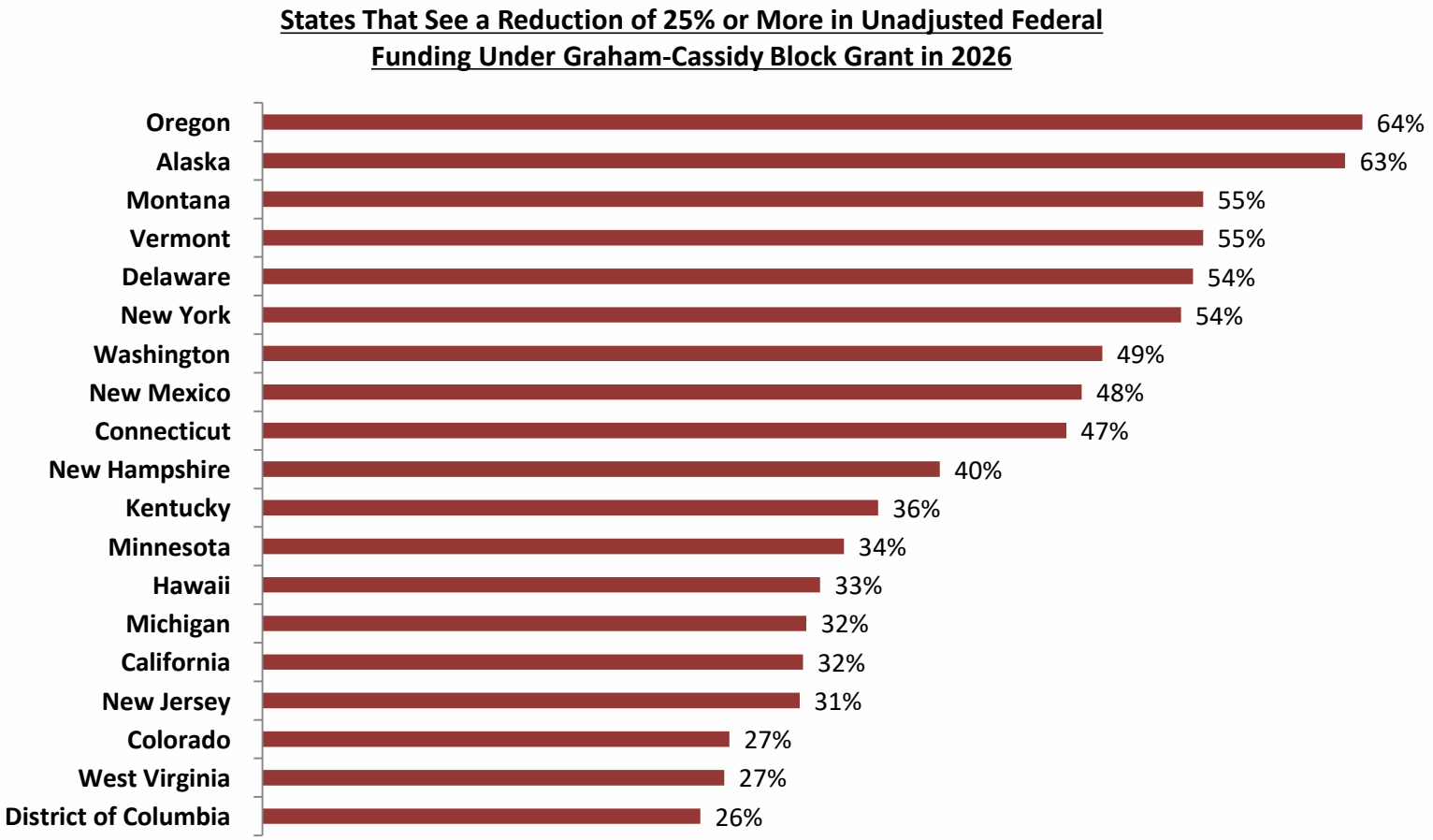


While 22 states would receive more federal funding under their unadjusted block grant amount than under current law, they would still face cuts as a result of the Medicaid per capita cap.

- States that **lose** >50% of federal funding (6)
- States (and DC) that **lose** 25-49.9% of federal funding (13)
- States that **lose** 0.1-24.9% of federal funding (8)
- States that **gain** 0.1-24.9% of federal funding (8)
- States that **gain** 25-49.9% of federal funding (3)
- States that **gain** >50% of federal funding (13)

Source: State Health and Value Strategies. "Update: State Policy and Budget Impacts of New Graham-Cassidy Repeal and Replace Proposal." September 2017

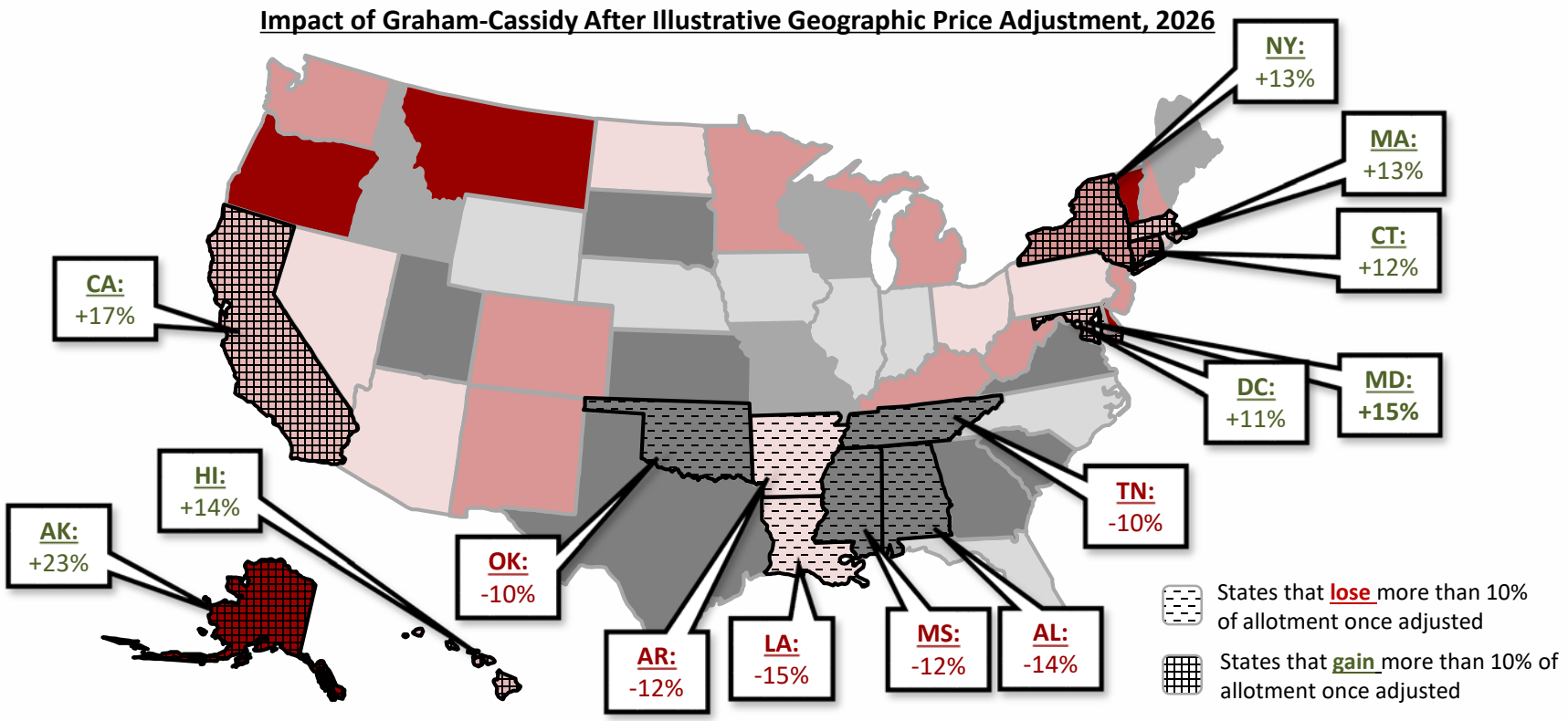
States with a Greater than 25% Loss in Funding in 2026



Source: State Health and Value Strategies. "Update: State Policy and Budget Impacts of New Graham-Cassidy Repeal and Replace Proposal." September 2017

Potential Impact of an Adjustment for Price

Allowable adjustments to the block grant amounts could result in significant changes to the distribution of federal resources among states.



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Key Takeaways

- **Graham-Cassidy is far reaching and complex; many provisions beyond the new block grant will impact state health care policy, delivery and funding.**
- **The Graham-Cassidy block grant would decrease funding at the national level and result in substantial redistribution of the remaining resources among states.**
- **Over 2020 to 2026, under the block grant, states would receive $81.6B less in federal funding for health care costs of low and moderate income residents, a reduction of 6.4 percent.**
  - In 2026, national funding for the block grant is 8.9 percent below current law spending projections.
- **The majority of states would receive less funding under the block grant.**
  - 32 states would receive less federal funding in 2020 under the unadjusted amount of the block grant. By 2026, some states fare better, but the majority (27 states) continue to face a loss.
  - Over the 2020 to 2026 period, 29 states receive less in federal funding with an average reduction of 19 percent.
- **The block grant results in redistribution of fund from expansion states and states with higher medical costs to non-expansion states; adjustments create room for further redistribution of funds among states, and a major unknown for state budgets.**
- **The per capita cap proposal further reduces federal Medicaid funding for states, increasing financial risk and budget pressure.**
- **In 2020, states would assume responsibility for administering block grant programs to address the health care needs and costs of the 23 million people insured through Medicaid and subsidized coverage today.**

Source: State Health and Value Strategies. "Update: State Policy and Budget Impacts of New Graham-Cassidy Repeal and Replace Proposal." September 2017

We Welcome Your Questions

Patricia Boozang
pboozang@manatt.com
212-790-4523

Deborah Bachrach
dbachrach@manatt.com
212-790-4594

Jocelyn Guyer
jguyer@manatt.com
202-585-6501

Heather Howard
heatherh@princeton.edu
609-258-3596

April Grady
agrady@manatt.com
202-585-6552

Daniel Meuse
dmeuse@princeton.edu
609-258-3596

www.statenetwork.org