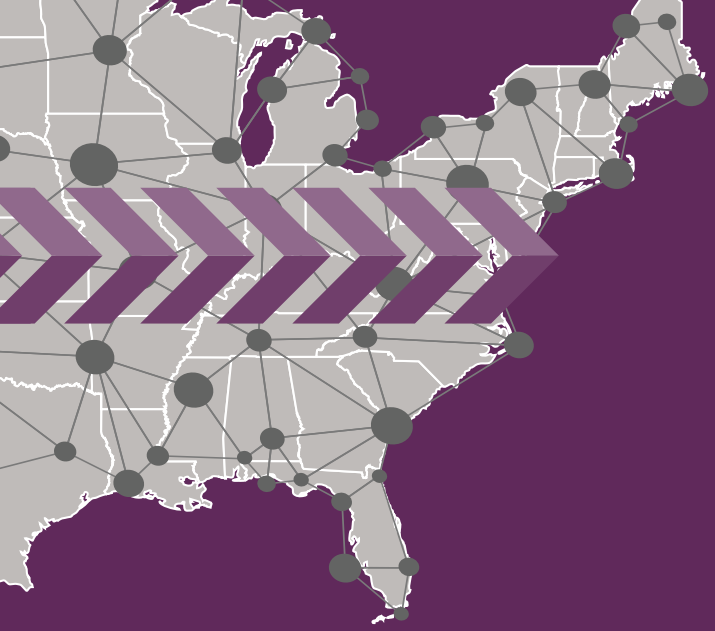

Repeal and Replace: Overview of Graham-Cassidy's Market-based Health Care Allotment

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IN THIS BRIEF

- ✓ The Graham-Cassidy proposal may become a vehicle for continued efforts to repeal and replace the Affordable Care Act.
- ✓ The proposal would effectively eliminate enhanced funding for Medicaid expansion, as well as federal subsidies (both tax credits and cost-sharing reductions) for Marketplace coverage.
- ✓ States instead would receive a block grant, referred to as a market-based health care allotment, that could be used for coverage, payments to providers or other purposes.
- ✓ In 2020, the block grant would provide 17 percent less federal funding than current law.
- ✓ A complex formula would be used to distribute block grant funds among states, generally favoring rural states with older populations, low per capita incomes, and low per capita federal spending.
- ✓ States would bear the full risk for any costs that exceed their grant.

Introduction

This brief provides an overview of the proposal developed by Senators Lindsey Graham (R-SC) and Bill Cassidy (R-LA) and filed on July 27th as a substitute for H.R. 1628, the American Health Care Act passed by the House to "repeal and replace" the Affordable Care Act (ACA). The proposal retains many features of the July 20th version of the Better Care Reconciliation Act (BCRA) released by Senate leadership (and rejected by the Senate on July 25th), including per capita caps on Medicaid spending and elimination of the individual and employer mandates. Also, like BCRA, it permits the Secretary of Health and Human Services (HHS) to revise age rating to 5:1 and removes waiver guardrails that limit changes to essential health benefits and other ACA consumer protections.

At a high level, the Graham-Cassidy proposal would replace federal funding for Marketplace coverage and some aspects of Medicaid with a capped allotment that would be distributed to states in the form of block grants. States would have significant flexibility to use their block grant funds for coverage, payments to providers or other health care-related purposes. As explained below, the proposal also alters the distribution of federal funds among states, sending dollars from expansion states and other states that receive a relatively significant share of federal tax credits for Marketplace coverage to non-expansion states and those with lower Marketplace participation and/or costs.

OVERVIEW OF PROPOSAL

The Graham-Cassidy proposal would, after 2019, eliminate all federal funding for premium tax credits and cost-sharing reductions as well as the enhanced federal funding for Medicaid expansion adults. Beginning in 2020, states would be provided with a block grant (referred to as a market-based health care allotment) that could be used in various ways to underwrite the costs of coverage and care, including to provide coverage or to pay providers directly for care.

- In 2020, the allotment would be $140 billion. At this funding level, the allotment is approximately $28 billion or 17 percent below projected current law federal funding of $168 billion for Medicaid expansion, Marketplace, and Basic Health Program coverage (see appendix for state estimates of current federal funding levels).
- If non-expansion states were to receive federal funding at levels comparable to current law for Medicaid expansion states, an additional $32 billion would be provided to these states (see appendix). Federal funding would total $200 billion, causing the size of the funding gap relative to the Graham-Cassidy allotment to increase to $60 billion.
- After 2020, the national funding level for the block grant would increase by about 2 percent each year, a rate that does not keep pace with medical inflation or account for growth in the number of people requiring coverage or services.
- The block grant ends entirely after 2026.

While the Graham-Cassidy proposal allows states to continue to receive the regular Medicaid matching rate for expansion, it creates a strong incentive for states not to do so. Specifically, the federal government will reduce a state's market-based health care allotment on a dollar-by-dollar basis for federal spending on Medicaid coverage for expansion adults.[1]

KEY DETAILS ON THE MARKET-BASED HEALTH CARE GRANT PROGRAM

Key details regarding the proposed block grant, which is referred to as the "Market-Based Health Care Grant Program" include:

- **Funding levels**
  - 2020 -- $140 billion
  - 2021 -- $143 billion
  - 2022 -- $146 billion
  - 2023 -- $149 billion
  - 2024 -- $152 billion
  - 2025 -- $155 billion
  - 2026 -- $158 billion

In addition, states are provided with $50 billion between 2018 and 2020 to help stabilize the individual market by supporting health insurance issuers.

- **Allowable uses of funds.** The proposal does not obligate states to provide coverage or services to any particular population. Instead it authorizes the funds to be used to:
  - Stabilize premiums and promote issuer participation in the individual market
  - Pay providers for health care services
  - Fund assistance to reduce out-of-pocket costs for people in the individual market
  - Help people buy coverage, including by paying individual market premiums
  - Provide health insurance coverage for Medicaid-eligible individuals by establishing and maintaining relationships with health insurance issuers, but limited to 10 percent of the state's allotment

To the extent states want to use the funds to retain a coverage structure, they are at risk for any costs that exceed the resources available through their block grants. Unlike in Medicaid and the current Marketplace subsidy structure, no additional resources are available, even if more people enroll, premiums in the individual market increase rapidly, the cost of services jump due to break-through treatments, or a public health crisis or natural disaster hits a state.

- **Initial distribution among states.** The proposal uses a complex formula that changes over time to distribute the national allotment among states. Initially, it is based on the following factors:
  - 10 percent distributed based on each state's share of people between 100 and 138 percent of the Federal Poverty Level (FPL)
  - 20 percent distributed based on each state's share of people between 45 and 64 years of age
  - 25 percent of funds reserved for states with a per capita income below $52,500
  - 1 percent reserved for states with population density below 15 people per square mile
  - 3.5 percent reserved for states with population density of 14 to 80 people per square mile
  - 5.5 percent reserved for states with population density of 80 to 115 people per square mile
  - 35 percent reserved for states with an expansion in 2017, distributed based on each qualifying state's proportionate share of individuals between 100 and 138 percent of FPL
  - In addition, the formula includes a low-income population adjustment that redistributes funds between relatively high and low spending states but does not apply to states with the lowest population density (below 15 people per square mile), as well as overall constraints on the extent to which a state's market-based health care allotment can exceed (no more than three times the amount) or fall beneath (no less than 75 percent of the amount) its federal payments in 2016 for Medicaid expansion coverage, Basic Health Program coverage, tax credit subsidies, and cost-sharing reductions.

Although the funding formula is complex, the Graham-Cassidy proposal generally sends more money to states that are rural, have older populations, have low per capita incomes, and have low federal spending per person. To finance increased spending for states with these characteristics, however, the formula reduces funding for other states.

- **Changes in distribution formula over time.** From 2021 through 2025, the proposal instructs the Secretary of HHS to decrease the allotments for states where the amount per low-income person is at least 15 percent above the national average and increase them for states where the amount is at least 15 percent below the national average. For 2026, the Secretary would adjust the allotments to ensure that no state receives funding that is more than 10 percent above or below the national average. There is a budget neutrality requirement for these adjustments, and the adjustment would not apply to states with a population density of less than 15 individuals per square mile.
- **Indexing over time.** The legislative language indicates that each state's market-based health care allotment would be indexed by medical CPI through 2024 and then by CPI. However, it also sets national allotments at a level that increases at only about 2 percent a year, which is well below medical CPI in most years and can even be below CPI. As a result, it is not clear that states would be guaranteed an allotment that grows with medical CPI through 2024 or by CPI in 2025. (Note also that individual states might receive an increase or a decrease based on the low-income population adjustment, but this provision must be budget neutral across all states.)
- **State spending requirements.** The proposal includes a state spending requirement that begins at three percent in 2020 and increases to five percent in 2024 and beyond. There is no state maintenance of effort or non-supplantation language that would prevent a state from using the block grant to pay for items and services currently supported by other sources of funding.

CONCLUSION

The Graham-Cassidy proposal is sweeping and requires close review by states, especially given the smaller pool of federal resources that would be available for coverage overall and the redistribution of the reduced federal funds among states. States will face continued expectations to provide coverage, but will need to do so with substantially fewer resources than are available under current law. Particularly in the long term, given that national amounts for the new block grants would be indexed at a rate below general inflation and then terminated after 2026, this could create significant fiscal and political pressure on state policymakers. Unlike some of the capped funding proposals debated during the repeal effort, Graham-Cassidy would in fact provide new state flexibility, including to re-purpose federal dollars away from coverage to payments to providers or other health care-related initiatives. While the flexibility will be welcome news to most state policymakers, the lack of a clear connection to coverage and minimal federal requirements puts the funding at greater risk for cuts in the future.

Appendix:

Estimated Federal Spending on Marketplace and Medicaid Expansion Coverage, FFY 2020						
State	Marketplace premium tax credits and cost-sharing reductions[1] and Basic Health Program[2]	Medicaid expansion coverage, current expansion states[3]	Subtotal, excluding Medicaid for non-expansion states	Medicaid expansion coverage, current non-expansion states[4]	Reduction in Marketplace with Medicaid expansion, current non-expansion states[5]	Total, including Medicaid for non-expansion states net of Marketplace reduction
United States	$81,909,000,000	$86,022,000,000	$167,931,000,000	$55,183,000,000	$(22,738,000,000)	$200,376,000,000
Alabama	$1,756,000,000	$-	$1,756,000,000	$1,907,000,000	$(881,000,000)	$2,782,000,000
Alaska	$284,000,000	$337,000,000	$621,000,000	$-	$-	$621,000,000
Arizona	$1,420,000,000	$3,000,000,000	$4,420,000,000	$-	$-	$4,420,000,000
Arkansas	$347,000,000	$1,416,000,000	$1,763,000,000	$-	$-	$1,763,000,000
California	$9,464,000,000	$18,400,000,000	$27,864,000,000	$-	$-	$27,864,000,000
Colorado	$693,000,000	$1,869,000,000	$2,562,000,000	$-	$-	$2,562,000,000
Connecticut	$753,000,000	$1,449,000,000	$2,202,000,000	$-	$-	$2,202,000,000
Delaware	$193,000,000	$615,000,000	$808,000,000	$-	$-	$808,000,000
District of Columbia	$5,000,000	$376,000,000	$381,000,000	$-	$-	$381,000,000
Florida	$12,103,000,000	$-	$12,103,000,000	$8,095,000,000	$(7,271,000,000)	$12,927,000,000
Georgia	$3,236,000,000	$-	$3,236,000,000	$5,169,000,000	$(1,852,000,000)	$6,553,000,000
Hawaii	$117,000,000	$556,000,000	$673,000,000	$-	$-	$673,000,000
Idaho	$652,000,000	$-	$652,000,000	$857,000,000	$(472,000,000)	$1,037,000,000
Illinois	$2,113,000,000	$2,795,000,000	$4,908,000,000	$-	$-	$4,908,000,000
Indiana	$705,000,000	$2,110,000,000	$2,815,000,000	$-	$-	$2,815,000,000
Iowa	$389,000,000	$544,000,000	$933,000,000	$-	$-	$933,000,000
Kansas	$655,000,000	$-	$655,000,000	$1,199,000,000	$(271,000,000)	$1,583,000,000
Kentucky	$397,000,000	$3,688,000,000	$4,085,000,000	$-	$-	$4,085,000,000
Louisiana	$1,148,000,000	$1,654,000,000	$2,802,000,000	$-	$-	$2,802,000,000
Maine	$578,000,000	$-	$578,000,000	$245,000,000	$(184,000,000)	$639,000,000
Maryland	$792,000,000	$1,560,000,000	$2,352,000,000	$-	$-	$2,352,000,000
Massachusetts	$921,000,000	$2,159,000,000	$3,080,000,000	$-	$-	$3,080,000,000
Michigan	$1,504,000,000	$4,360,000,000	$5,864,000,000	$-	$-	$5,864,000,000
Minnesota	$1,003,000,000	$1,618,000,000	$2,621,000,000	$-	$-	$2,621,000,000
Mississippi	$601,000,000	$-	$601,000,000	$1,538,000,000	$(392,000,000)	$1,747,000,000
Missouri	$1,778,000,000	$-	$1,778,000,000	$3,096,000,000	$(834,000,000)	$4,040,000,000
Montana	$445,000,000	$647,000,000	$1,092,000,000	$-	$-	$1,092,000,000
Nebraska	$804,000,000	$-	$804,000,000	$695,000,000	$(264,000,000)	$1,235,000,000
Nevada	$441,000,000	$1,154,000,000	$1,595,000,000	$-	$-	$1,595,000,000
New Hampshire	$185,000,000	$386,000,000	$571,000,000	$-	$-	$571,000,000
New Jersey	$1,626,000,000	$3,647,000,000	$5,273,000,000	$-	$-	$5,273,000,000
New Mexico	$219,000,000	$1,924,000,000	$2,143,000,000	$-	$-	$2,143,000,000
New York	$5,070,000,000	$12,046,000,000	$17,116,000,000	$-	$-	$17,116,000,000

Estimated Federal Spending on Marketplace and Medicaid Expansion Coverage, FFY 2020 Continued						
State	Marketplace premium tax credits and cost-sharing reductions[1] and Basic Health Program[2]	Medicaid expansion coverage, current expansion states[3]	Subtotal, excluding Medicaid for non-expansion states	Medicaid expansion coverage, current non-expansion states[4]	Reduction in Marketplace with Medicaid expansion, current non-expansion states[5]	Total, including Medicaid for non-expansion states net of Marketplace reduction
North Carolina	$5,822,000,000	$-	$5,822,000,000	$4,661,000,000	$(2,656,000,000)	$7,827,000,000
North Dakota	$114,000,000	$181,000,000	$295,000,000	$-	$-	$295,000,000
Ohio	$1,003,000,000	$4,207,000,000	$5,210,000,000	$-	$-	$5,210,000,000
Oklahoma	$1,484,000,000	$-	$1,484,000,000	$1,942,000,000	$(592,000,000)	$2,834,000,000
Oregon	$797,000,000	$3,643,000,000	$4,440,000,000	$-	$-	$4,440,000,000
Pennsylvania	$2,927,000,000	$3,595,000,000	$6,522,000,000	$-	$-	$6,522,000,000
Rhode Island	$142,000,000	$400,000,000	$542,000,000	$-	$-	$542,000,000
South Carolina	$1,700,000,000	$-	$1,700,000,000	$1,995,000,000	$(849,000,000)	$2,846,000,000
South Dakota	$255,000,000	$-	$255,000,000	$339,000,000	$(84,000,000)	$510,000,000
Tennessee	$2,161,000,000	$-	$2,161,000,000	$2,339,000,000	$(892,000,000)	$3,608,000,000
Texas	$6,740,000,000	$-	$6,740,000,000	$15,205,000,000	$(3,279,000,000)	$18,666,000,000
Utah	$874,000,000	$-	$874,000,000	$1,066,000,000	$(332,000,000)	$1,608,000,000
Vermont	$166,000,000	$386,000,000	$552,000,000	$-	$-	$552,000,000
Virginia	$2,348,000,000	$-	$2,348,000,000	$3,961,000,000	$(1,008,000,000)	$5,301,000,000
Washington	$727,000,000	$4,248,000,000	$4,975,000,000	$-	$-	$4,975,000,000
West Virginia	$323,000,000	$1,052,000,000	$1,375,000,000	$-	$-	$1,375,000,000
Wisconsin	$1,690,000,000	$-	$1,690,000,000	$646,000,000	$(553,000,000)	$1,783,000,000
Wyoming	$239,000,000	$-	$239,000,000	$228,000,000	$(72,000,000)	$395,000,000

1. Reflects national growth as projected by CBO, applied to state-level amounts. Estimate based on:
   - 2017 Marketplace statistics for all states (https://downloads.cms.gov/files/effectuated-enrollment-snapshot-report-06-12-17.pdf);
   - 2016 cost-sharing reductions (CSR) data for 38 healthcare.gov states (https://aspe.hhs.gov/health-insurance-marketplace-cost-sharing-reduction-subsidies-zip-code-and-county-2016) , with national average applied to CSR enrollees in remaining states (https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/Effectuated_Quarterly_Snapshots.html);
   - January 2017 CBO baseline for national totals (https://www.cbo.gov/sites/default/files/recurringdata/51301-2017-01-medicaid.pdf).
2. MN and NY provide Basic Health Program coverage for certain individuals who would otherwise be eligible to purchase coverage through the Marketplace. Estimates of federal funding reflect projections in state budget documents (https://mn.gov/dhs/general-public/publications-forms-resources/reports/financial-reports-and-forecasts.jsp; https://www.budget.ny.gov/pubs/archive/fy18archive/enactedfy18/FY2018EnactedFP.pdf).
3. Estimate based on Manatt Medicaid Financing Model (for background, see http://www.statenetwork.org/resource/understanding-the-senates-better-care-reconciliation-act-of-2017-bcra-key-implications-for-medicaid/). Note that the national figure differs from CBO baseline for ACA subsidies (https://www.cbo.gov/sites/default/files/recurringdata/51298-2017-01-healthinsurance.pdf) in part because CBO: (1) assumes that additional states have expanded by 2020 and (2) only breaks out federal spending on Medicaid expansion for individuals who were made eligible by the ACA. Spending from the Manatt Medicaid Financing Model includes newly eligible individuals in the expansion adult group but also those who were eligible under pre-ACA rules, for whom states may receive enhanced federal match (AZ, DE, HI, MA, MN, NY, VT, WA) and/or regular federal match (AR, CO, CT, IL, IN, IA, MI, NH, NY, ND, OH, OR, PA; in all but IN, NY, and OR the estimated share of expansion group enrollees at regular match is less than 10 percent).
4. Reflects federal spending if these states were to cover the expansion adult group and had fully ramped up enrollment. Estimate based on:
   - Medicaid enrollment assuming moderate take-up from Urban Institute Health Policy Simulation Model (http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2017/rwjf436919);
   - Medicaid spending per enrollee from Manatt Medicaid Financing Model
5. Reflects reduction in Marketplace subsidies that would occur if individuals between 100%-138% FPL move to Medicaid expansion coverage. Estimate based on:
   - 2016 data on Marketplace enrollees between 100%-138% FPL and other income ranges (https://data.cms.gov/Marketplace-Qualified-Health-Plan-QHP-/2016-Qualifying-Health-Plan-Selections-by-Household/n4mh-474r);
   - 2017 data on average tax credits and premiums (https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/Plan_Selection_ZIP.html);
   - 2016 data on CSRs by AV level (https://aspe.hhs.gov/health-insurance-marketplace-cost-sharing-reduction-subsidies-zip-code-and-county-2016).

Endnotes

1. As the proposal is currently drafted, it appears that amounts received through the Medicaid block grant option that is included in the underlying BCRA proposal would not be counted in determining the market-based health care allotment reduction. It is unclear whether this was a deliberate allowance for expansion states to obtain Medicaid block grants for their expansion populations while still receiving their full market-based health care allotments, or whether it was a drafting error to be corrected in a future version of the proposal. The latter may be more likely, as 35 percent of the 2020 national amount for market-based health care allotments is reserved for states that had expanded as of 2017 (suggesting that the allotment is seen as a substitute for—rather than an addition to—Medicaid expansion funding). In addition, summaries of the legislation circulating on social media indicate that allotments would "replace" federal funding for Medicaid expansion and Marketplace coverage.

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