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Health and Human Services

STANDING COMMITTEE

NATIONAL CONFERENCE of STATE LEGISLATURES

Info Update, Sept. 22, 2017

Over the past few weeks there has been significant activity on health care policy in the U.S. Senate. A group of senators have introduced another bill—the Graham-Cassidy-Heller-Johnson Amendment—to repeal parts of Affordable Care Act (ACA). The introduction comes up against a Sept. 30 deadline by which the option to vote on health care reform with only a simple majority expires. After this date 60 votes would be required, meaning Democrats would need to be on board.

There also has been movement on the Children's Health Insurance Program (CHIP), with leadership in the Senate Finance Committee coming to a bipartisan agreement to extend until 2022 funding for the program, which currently also expires at the end of this month. With Sept. 30 approaching fast, the Congressional Budget Office was asked to score the Graham-Cassidy-Heller-Johnson proposal before CHIP, with a Senate Majority Leader Mitch McConnell (R-Ky.) proposing a voice for next week. The future of both bills remains uncertain. See further details and resources on both below.

Graham Cassidy Heller Johnson Amendment: On Sept. 13, Senators Lindsey Graham (R-S.C.), Bill Cassidy (R-La.), Dean Heller (R-Nev.) and Ron Johnson (R-Wis.) introduced an amendment to the Better Care Reconciliation Act. This replaces an earlier proposal by Graham and Cassidy and other Senate health care reform bills. VTo view the full text.,

ACA Repeal Changes: The amendment would allow states to waive current rules under the ACA that requires insurers to provide a list of essential health benefits and require insurance premiums to be the same for all people regardless of health status. It would also repeal the optional Medicaid expansion option passed under the ACA to create equal payments among all

states. Any state that elected to have Medicaid expansion would no longer be able to cover adults under this expansion after 2020.

While there would be changes to current law several parts would remain: This includes: Part D Medicaid coverage; reductions to Medicare provider and Medicare Advantage payments; increased Medicare premiums for those making more than $85,000/individual and above $170,000/couple; the Center for Medicare and Medicaid Innovation that's working to establish quality and payment delivery system changes; the requirement that coverage can be provided to children through their parent's plan up until the age of 26; and the prohibition on providing insurance based on gender-ratings or pre-existing health conditions remains and cannot be waived by states.

Financing: The current Medicaid program would be restructured as a block grant program to states creating the Market-based Health Care Grant Program. The program would provide $1.176 trillion over seven years and allow states to create their own health care programs. There would be a cap on federal funding starting in 2020. Under this new funding structure states would receive a lump sum of funds that could be distributed in the form of tax credits, subsidies, health savings account premiums and other ways determined by states that fit the particular needs of their populations.

In addition to health care coverage states could address several other issues by creating programs to help high-risk individuals, promote state marketplaces and stabilize insurance premiums.

Financing Under Per Capita Cap: Under the per capita cap system, state's total medical assistance costs will be the sum of the per enrollee amounts for the elderly, the blind and disabled adults, children and other adults, with each multiplied by the number of enrollees in these groups. Medicaid payments will be determined by the base year per-enrollee with states selecting eight consecutive quarters of expenses from FY 2014 until the third quarter of FY2017. If a state exceeds Medicaid costs for a fiscal year their payment amounts will be reduced the following year by the overspent amount. Changes in per capita cap funding will be delayed for states with low-density populations including: Alaska, Montana, North Dakota, South Dakota and Wyoming. The creation of the Medicaid Flexibility Program in FY 2020 will allow states the option to choose either a block grant or per capita cap for nonelderly and nondisabled adults for

five years. States will be required to provide a number of health services including hospital care, home health care, mental health and substance abuse disorder services among others.

For further details on financing including future federal formulas to determine federal payments to states refer to the Kaiser Family Foundation's most recent review of the legislation.

New Programs and Initiatives:

The proposal:

- Creates of a Home and Community Based Services (HCBS) demonstration program providing $8 billion from 2020-2023; the secretary of HHS will choose 15 states to receive these funds.
- Increases the federal match to 100 percent for medical services provided to tribal enrollees receiving services from non-Indian providers, and a reduction of the federal match rate for territories from 55 to 50 percent in January 2020.
- Allows states to reassess enrollment eligibility every six months with an administrative match of 5 percent from October 2017 to December 2019 for states engaging in frequent redeterminations.
- Allows states to add a work requirement option as part of Medicaid eligibility except for the elderly, disabled or pregnant adults.
- Allows anyone to purchase catastrophic health plans, starting in 2019.
- Creates a federal reinsurance program for 2019- with $10 billion in funding and in 2020- with $15 billion in funding.
- Makes several changes proposed to HSA accounts—increasing the contribution limit that can be contributed to an HSA account for individual and family coverage, and allowing catch-up contribution up to $1,000 can be made by anyone over the age of 55.

Summary of CHIP Activity and Legislation: While authorization for CHIP funding expires at the end of September 2017, studies show funding will not start to run out in most states until December 2017. On Sept. 7, 2017, the Senate Finance Committee held a hearing on CHIP that featured three witnesses: Leanna George a mother of a CHIP recipient, Dr. Anne L. Schwartz, executive director of the Medicaid and CHIP Payment and Access Commission; and Linda Nablo from the Virginia Department of Medical Assistance Services. Soon after, the committee

announced a bipartisan agreement—the “Keep Kids’ Insurance Dependable and Secure Act of 2017,” or the “KIDS Act of 2017” (S. 1827). Click here for the full legislative text of the KIDS Act of 2017.

The legislation provides CHIP funding for five years, and winds down the current increased Federal Medical Assistance Percentages (FMAP rate). The increased FMAP rate of 23 percent , which was adopted under the Affordable Care Act, will stay in effect until FY 2019, then lower to 11.5 percent for FY 2020 and return to a traditional matching rate for 2021 and 2022.Currently Arizona, District of Columbia, Minnesota and North Carolina are expected to run out CHIP funding by December if legislation is not passed before the end of September, with more states to follow before the end of December. Because of recent hurricane and flooding events, states like Texas and Florida are reporting the possibility of running out of CHIP funds sooner due to an increased use of services. With recent Senate activity around health care reform legislation, CBO will not be able to score the CHIP legislation until they have scored the Graham-Cassidy-Heller-Johnson proposal. This has left some uncertainty as to when a vote will be scheduled on the KIDS Act of 2017.