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Breaking Down The Graham-Cassidy ACA-Replacement Proposal

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In the early hours of Friday, July 28, Republican-led efforts to repeal and replace the Patient Protection and Affordable Care Act were rebuffed on the Senate floor. By roughly 1:40 a.m., three Republican Senators — Susan Collins, R-Maine, Lisa Murkowski, R-Alaska, and, to the sound of Democratic applause and Republican gasps on the Senate floor, John McCain, R-Ariz. — had voted (alongside 48 Democrats) against their party's "skinny repeal" proposal, causing the measure to fail by a single vote (49-51). The proposal, which took the form of an amendment to the House's American Health Care Act (AHCA), would have replaced the House bill and renamed it the Health Care Freedom Act (HCFA).

The HCFA's demise has been widely characterized as a political dagger into the heart of ACA-repeal efforts — a signal that the whole endeavor has become the GOP's albatross. But the failed Senate vote does not foreclose Congressional Republicans' opportunity to use the filibuster-proof budget reconciliation process to send new health care legislation to the president's desk.¹ Rather, the AHCA was sent back to the Senate calendar instead of being voted down. And although the requisite 20 hours of debate over the AHCA permitted by the reconciliation rules have expired, amendments for other replacement proposals would not be considered "out of order" under the Senate rules — that is, they could still be taken up in roll call votes.

In the aftermath of the HCFA's defeat, the only remaining proposal that appears to have any chance at seeing a Senate vote is a complex overhaul

of the current ACA landscape from Republican Sens. Lindsey Graham, R-S.C., and Bill Cassidy, R-La. The crux of the Graham-Cassidy amendment ([available here](#)) is to replace the ACA's insurance subsidies and Medicaid expansion with comparatively smaller block grants to states. Those grants would be based on an extremely complex formula that shifts at least some funding away from expansion states towards rural and nonexpansion states. The states would have significant flexibility over how they use the funds to set up, provide and subsidize insurance coverage for their residents, but the proposal's opponents argue that it would amount to significant reductions of federal entitlement spending.

Graham-Cassidy would also make significant changes to the federal laws governing employer-sponsored health insurance (ESI), including to allow health savings accounts (HSAs) to pay for certain individual insurance premiums. Such a mechanism would allow employers to eliminate their traditional ESI plans, send their employees to the individual insurance market, and subsidize that insurance on a tax-free basis — an approach that is currently prohibited by the ACA.

This proposal currently appears to be Republicans' most viable path forward to ACA-replacement at this time. But it faces long odds at passing because of the same challenges that sunk prior proposals: complex reconciliation-content requirements that can only be overridden with potentially severe consequences, an American electorate trending in favor of the ACA, and conservative and moderate Republican factions with opposing — and seemingly intransigent — stances on which provisions they consider "deal breakers" versus "must haves."²

Employer-Sponsored Health Insurance

The Graham-Cassidy amendment proposes many of the same changes to the current ACA rules for ESI plans as the House-passed AHCA, the HCFA and the Senate's previously unsuccessful Better Care Reconciliation Act (BCRA):

1. Reducing the employer mandate penalties to \$0 retroactive back to 2016.³
2. Delaying the "Cadillac tax" on high-cost ESI plans until 2026.

3. Expanding contribution limits for HSAs, effective 2018, and make a number of other changes to the HSA rules generally effective in 2017.
4. Repealing the ACA's prohibition of tax-free reimbursements of most over-the-counter (OTC) medications by health FSAs, HSAs and similar arrangements, effective 2017.
5. Repealing the ACA's limit on employer deductions related to retiree prescription drug plans that receive retiree drug subsidy payments.

Importantly, the Graham-Cassidy amendment would also allow HSA funds to be used to pay premiums for high-deductible health plans in the individual insurance market. The combination of this change and the elimination of the employer mandate penalties would have an enormous impact on the ESI landscape: employers could terminate their comprehensive major medical plans and instead subsidize their employees' individual insurance coverage with tax-free HSA contributions.⁴

A more detailed explanation of how these changes might impact ESI, employers and their employees can be found in my Law360 article titled "[Potential Impact Of Senate Health Care Bill: A Closer Look](#)" (June 28, 2017). Similar to the AHCA and BCRA, the Graham-Cassidy amendment would leave intact many ACA mandates that apply to ESI coverage, such as the prohibitions against use of pre-existing condition exclusions, and annual and lifetime limits on in-network essential health benefits; caps on initial eligibility waiting periods; and the requirement for ESI plans to cover in-network preventive health services at no cost to participants.

Repeal of Various Individual Market and Medicaid Provisions

Graham-Cassidy proposes, among others, the following major changes to the individual insurance market and Medicaid rules:

1. Retroactively reducing the individual mandate penalties to \$0 for 2016 and subsequent years.⁵
2. Eliminating the ACA's premium tax credits, small business tax credits, cost-sharing reduction (CSR)

payments, and Medicaid expansion effective starting in 2020.⁶

3. State innovation waivers that appear to include the ability for insured plans to waive the requirement to cover all of the essential health benefits.
4. Starting in 2019, catastrophic coverage plans, with very high deductibles, could be offered by insurance companies to everyone — not just those who are under age 30.

Block Grants to Replace Repealed Individual Market and Medicaid Funds

As a replacement of the ACA's premium tax credits, CSR payments and Medicaid expansion with block grants, states would be eligible to receive block grants to subsidize insurance coverage (including cost-sharing) beginning in 2020 — and only through 2026 (because of limitations under the reconciliation rules).⁷ These grants would initially total \$140 billion per year, but would be subject to annual increases of \$3 billion through 2026 (\$158 billion).⁸ A state would have to submit a one-time application to receive block grants through 2026, and the state would have considerable discretion over how it chooses to use the funds it receives. The Graham-Cassidy amendment lists the following permissible uses:

1. To fund a high-risk pool.
2. To assist insurers in stabilizing premiums in the individual market.
3. To "provide payments for health care providers for the provision of health care services" (i.e., pay doctors, hospitals and other providers directly). The amendment gives the [Centers for Medicare & Medicaid Services](#) discretion to determine the parameters and scope of this broad category ("[a]s specified by the Administrator [CMS].").
4. To reduce out-of-pocket costs (e.g., deductibles and co-payments) under individual market plans. This category would arguably include a state's provision of subsidies equivalent to the ACA's CSR payments.

5. To "establish or maintain a program" to help an individual obtain insurance, including by reducing individual market premiums for those who do not have ESI.
6. Provide insurance coverage that wraps around a State medical assistance program.

Importantly, those funds would not be subject to as many restrictions as the ACA's premium tax credits under Internal Revenue Code Section 36B. So states would have the option to make available and subsidize less comprehensive plans than those currently on the ACA's health insurance exchanges.

The amount of a state's grant would be determined using an extremely complex formula, with initial parameters for 2020 that would change in subsequent years. The formula would be subject to various adjustments (some at CMS' direction) that must be budget-neutral except for certain low-population-density states. The starting point of a state's 2020 allotment is essentially based on the following factors:

1. 10 percent of the total annual allotment (\$140 billion) is tied to the state's share of the nationwide population of who would have been eligible under the ACA's Medicaid expansion in 2020. This category appears geared towards benefiting nonexpansion states, many of which are Republican-controlled.
2. 20 percent of the total annual allotment is tied to the state's share of the nationwide population of individuals who are at least age 45 and not older than age 65.
3. 25 percent of the total annual allotment is available for states that had an average age per capita income of less than \$52,500 in 2016. This category uses a calculation similar to number one above, except that it only takes into account states with per capita incomes under the specified threshold.
4. Three smaller allotments would be available for states with low average population densities (measured using 2016 data). Those allotments essentially are (1) 1 percent of the total annual allotment is potentially allocable to states with population

densities of fewer than 15 individuals per square mile; (2) 3.5 percent for states with population densities of more than 14 (but fewer than 80) individuals per square mile; and (3) 5.5 percent population densities of more than 79 (but fewer than 115) individuals per square mile. These three components appear designed to benefit large, rural states (e.g., Alaska and Wyoming).

5. 35 percent of the total allotment is essentially tied to states that accepted the Medicaid expansion in 2017. As explained below, the allotment category phases out in 2026, which would appear to reduce the funds available for expansion states significantly.

CMS would be allowed to adjust the 2020 parameters using a separate, complex formula that essentially caps the amount by which a state's 2020 allotment can exceed its projected 2026 allotment.

For calendar years 2021 through 2024, a state's allotment would essentially be equal to its share of the total allotment for that year (e.g., \$143 billion for 2021) based on the 2020 parameters described above, plus an increase based on the rate of medical inflation (the medical care component of the urban consumer price index from Oct. 1 of the prior year to Oct. 1 of the allotment year). For the 2025 calendar year, however, the state's allotment would only be increased by the urban CPI. Given the current trend in health care costs, states would likely receive comparatively smaller increases in allotments after 2024 — consistent with the Republican maxim that the federal government must rein in entitlement spending.

In a significant deviation from prior allotments, a state's 2026 calendar year allotment would be calculated using parameters similar to its 2020 allotment — without taking into account the 2020 parameters for Medicaid expansion states. So beginning in 2026, the 35 percent that was previously tied to expansion states would essentially be allocated among the other components of the formula (e.g., the state's share of individuals between ages 45 and 64).⁹ This redistribution would appear to reduce the funds that were available to expansion states (e.g., California) significantly.

Lastly, the proposal permits CMS to adjust state allotments for "additional significant factors." The provision grants CMS discretion to determine those factors, which "may include" a state's population of older individuals and disease burdens (relative to other states); and "variations in regional costs of care."

The [Congressional Budget Office](#) has not scored the impact of replacing the premium tax credits, CSR payments and enhanced Medicaid funds with Graham-Cassidy's proposed block grants, but there has been speculation that those amounts would be significantly lower than what is currently available to states under the ACA — particularly for expansion states. Nonexpansion states, however, would likely see an increase in available funds compared to current levels. The net impact of the proposal's cuts and caps is arguably a deterioration of the middle-class tier of federal health care entitlements: ACA subsidies are currently available to individuals with incomes up to 400 percent of the federal poverty level, and it is questionable whether the funds available under Graham-Cassidy would be sufficient for states to continue subsidizing coverage for all individuals in that income range.

Short-Term State-Assistance Funds

The Graham-Cassidy amendment would also provide \$20 million in 2018, \$20 million in 2019 and \$15 million in 2020 to CMS to fund health insurance arrangements designed for the same purposes as the state arrangements eligible to receive block grants described above (e.g., high-risk pools). Like the state grants, insurers would need to apply to receive these funds.

Other Changes

Some of the other changes proposed by the Graham-Cassidy amendment include:

- Like the AHCA and BCRA, the proposal imposes what would essentially equate to a one-year ban on federal funds to [Planned Parenthood](#) (and possibly other organizations that meet the same, very specific criteria as Planned Parenthood).
- Allowing states to impose work requirements on Medicaid recipients.

Some ACA Taxes Left Intact

The proposal would not eliminate all of the ACA's taxes. Surviving taxes would include, for example, the additional Medicare tax and net investment income tax, both of which only apply to higher-income taxpayers. Earlier iterations of the BCRA and AHCA proposed cutting those two taxes, but the tax cuts were later removed (in part to reduce the perception that those bills would effectively loot the Medicaid coffer to fund tax breaks for wealthy Americans).

A Narrow Path Forward, Paved With Many Unknowns

The Graham-Cassidy amendment is currently the only Republican ACA-replacement proposal that has gained some political traction and has not already been rejected outright. Like its predecessors, the amendment seemingly faces long odds in the Senate and House — both of which are controlled by slim, factious Republican majorities that have struggled to obtain a consensus on any particular proposal. But the Republican-led charge to replace the ACA remains very much alive — even in the face of its major defeat at the end of last month. And many of the concepts in the Graham-Cassidy amendment are likely to appear in whichever proposal Republicans float next.¹⁰ Given Graham's close ties with McCain, one of the three "no" votes who sunk the HCFA, some have speculated that a Graham-backed proposal could secure the votes necessary to pass in the Senate (unless there are new, additional defections by Republican Senators).

¹ The authorization to use reconciliation for ACA replacement is based on reconciliation instructions that were included in a fiscal year 2017 budget resolution Republicans passed earlier this year. There is some debate over when this authorization expires: (1) Sept. 30, the end of fiscal year 2017; or (2) once Congress passes a new resolution, such as the fiscal year 2018 resolution Republicans plan to use for tax reform. Neither deadline has passed to date.

² To date, the approach of flouting the reconciliation rules (often labeled as a "nuclear option"), which I described in detail in my June 28 article ([available here](#)), has not gained traction among Republican leaders. While acting as the presiding officer during the AHCA debate that ended on July 28, neither Senate Majority Leader Mitch McConnell, R-Ky., nor Vice President Mike Pence disregarded the Senate Parliamentarian (i.e., allowed impermissible provisions to make it into the HCFA and other unsuccessful amendments). Arguably, a

number of aspects of the Graham-Cassidy amendment would be considered "extraneous" (i.e., impermissible) under a reconciliation requirement referred to as the "Byrd Rule" (essentially because of their nonbudgetary nature). Absent use of the nuclear option, those provisions would need to be removed from the amendment to preserve its reconciliation-eligible status.

³ As explained in my prior articles, the elimination of the employer-mandate penalties and affordability-based premium tax credits would likely eliminate (or at least simplify) employers' reporting requirements under Internal Revenue Code Sections 6055 and 6056 (Forms 1094 and 1095). Currently, most large employers must provide complex data on full-time employee status, ESI coverage and ESI "affordability" for the IRS to enforce the employer mandate, individual mandate and the ACA subsidies. So without the employer mandate penalties and affordability-based tax credits, this complex employee and ESI information would arguably be irrelevant.

⁴ Currently, there is no mechanism for employers to subsidize individual insurance coverage for their active employees; with very few exceptions, the ACA prohibits those arrangements. (HSA contributions would not otherwise satisfy the employer mandate requirement to offer “minimum essential coverage,” so the elimination of employer mandate penalties is also necessary for employers to be able to replace their traditional ESI plans with HSA contributions.) Sponsoring a major medical plan places significantly higher legal-compliance and administrative burdens on the employer than the “hands off” approach of paying for employees’ individual insurance premiums. Of course, not every employer would take advantage of this opportunity to replace their current medical coverage with HSA contributions. Rather, such an employer would likely take into account a number of factors, including the nature, size, and diversity of its workforce (e.g., specialized vs. low wage); industry benchmarks; and the stability (or lack of stability) of the individual insurance market.

⁵ The impact of reducing the individual and employer mandate penalties to \$0, each a maneuver to comply with the Byrd Rule, is substantively the same as repealing those mandates entirely.

⁶ The proposal would also make the premium tax credit nonadvanceable and subject to Hyde Amendment restrictions beginning in 2018.

⁷ The automatic lapse of a provision after 10 years is commonly referred to as a “sunset,” an approach that is arguably required here to comply with the budget reconciliation rules.

⁸ Unused grant amounts would remain in the Treasury to reduce the federal deficit.

⁹ The block-grant provision also includes an adjustment formula for a state’s “low income” allotment, which essentially appears to be geared towards further “leveling the field” for Medicaid expansion states and nonexpansion states.

¹⁰ Graham stated on Wednesday, Aug. 2nd, that some changes to the proposal might be forthcoming.

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