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Affordable Care Act Repeal Legislation Summary

On May 4th, the House of Representatives voted on and passed the American Health Care Act, a bill that repeals and replaces the Affordable Care Act. The final vote was 217-213, with every Democrat and 20 Republicans voting against the measure. The bill now goes to the Senate, where it is unlikely to pass in its current form. In the Senate, Republicans are likely to need to make a number of changes to ensure that the bill meets the budget rules necessary to pass with a 51-vote majority (instead of the usual 60-vote threshold required for Senate passage). Additionally, moderates in the Senate have expressed significant concern about a number of the bill's provisions, including options for states to remove protections against age-rated premiums, pre-existing conditions, as well as the significant cuts to Medicaid included in the bill.

The legislation has undergone several modifications and amendments since our most recent memorandum in March; however, we note that these changes all address regulation of private insurance. Notably, the legislation now provides states with the option to waive certain ACA requirements, including restrictions on insurance premiums that are underwritten due to age or health condition, as well as a waiver of the ACA essential health benefits requirements. None of the amendments adopted since March resulted in any new changes to Medicaid, LTSS, or related programs. This memo outlines the legislation as it currently stands, including changes that were made by the most amendments.

As we noted before, the legislation raises a number of technical and operational questions about how the changes will be applied. Notably, the bill creates a new eligibility group for childless adults and sunsets the existing statutory group. The new group is broken into two categories: those who were enrolled before December 31, 2019, and would continue to receive the higher ACA FMAP, and those who enroll after this date at the standard Federal matching rate. Yet the bill does not clearly articulate whether states have the option to cover only one of such groups or whether a state would be required to enroll all individuals in both categories if they elect to cover this group.

Similarly, the block grant policy allows states significant flexibility with eligibility and enrollment policies (subject to some federal requirements). One question arising is whether EPSDT would continue to apply to children under the age of 18. The legislation requires states to provide "health care for children under 18" and also clarifies that the services in the block grant would be provided to this group instead of the "Medical assistance" defined by the Social Security Act (which includes the definition of EPSDT under 1905(r) of the Social Security Act). There is no definition of "health care for children under 18," but it appears that this would be different from the current EPSDT mandate in Medicaid.

We are updating our previous memo to reflect changes to the House legislation that have been made since the version we sent on March 21st. NASUAD will continue to provide updates to members as the legislation is sure to be amended in the Senate.

More information and the full bill text is available at: https://rules.house.gov/bill/115/hr-1628

Key Provisions in the American Health Care Act (the House ACA Repeal and Replace bill)

The legislation would effectively terminate the Affordable Care Act at the end of 2019, with a wide range of policies being terminated on December 31, 2019 with significant changes to the Medicaid and insurance marketplace taking effect simultaneously. This includes provisions such as:

- Repealing the ACA advanced premium tax credits (APTCs) which are used to subsidize the purchase of health insurance on the exchanges;
- Repealing ACA taxes, including the increased Medicare tax; the health insurer tax; and the medical device tax, among others (effective at the end of 2016):
    - The tax on high-cost health plans, known as the Cadillac tax, is delayed but not fully repealed. The new bill delays it until 2026 instead of the previous 2025 date;
- Establishing a new tax credit to purchase insurance that is based upon age rather than income:
    - The credit would vary from $2,000 for individuals younger than 30 to $4,000 for individuals over 60.
        - The tax credit is available for each individual in a family up to a maximum of $14,000 per household.
    - The updated legislation includes a gradual phase-out of the tax credits for individuals making more than $75,000 a year (or couples making more than $150,000). For every $1,000 in income above these thresholds, the credit decreases by $100.
- Providing incentives for continuous coverage – notably, allowing insurers to impose a 30% surcharge for individuals who have a gap in coverage;
- Eliminating the increased Federal match (FMAP) for 1915k/Community First Choice services;
- Removing increased FMAP for ACA expansion groups (note: this has a gradual attrition policy explained below);
- Creating an option for states to establish work requirements on certain adults without disabilities;
- Setting a per-capita cap on Medicaid expenditures, and providing states with the option to receive a block grant for certain populations; and
- Providing $130 billion in grants to states in order to establish programs that support the insurance marketplace and individuals with significant health conditions;
- Allowing states to apply for waivers of core ACA policies, including community-rating requirements, limit age-based premiums, and the essential health benefits requirements; and

- Providing an additional $8 billion over five years to subsidize the cost of insurance for high-risk individuals in states that apply for a waiver.

Below, we provide updated detail on some of the policies included in this legislation, with a specific emphasis on changes to Medicaid and LTSS policy. Provisions and policies that have changed since our analysis of the legislation on March 6th are noted in red:

Provision	Description of the Issue	Policy in the Draft Legislation
The Medicaid Community First Choice (CFC) Option. Also known as the 1915(k) state plan benefit.	1915(k) allows states to provide HCBS through the Medicaid state plan to individuals who meet the state's institutional level of care requirements. Services include attendant care supports and related services, which includes purchase of items that could be substituted for human assistance. Participating states receive a 6 percent FMAP increase for CFC services. Eight States currently participate (CA, CT, MD, MT, NY, OR, TX, WA). For more information: https://www.medicaid.gov/medicaid/hcbs/authorities/1915-k/index.html	Retains 1915(k) services and eligibility; terminates the 6 percent FMAP increase, effective January 1, 2020.
Medicaid expansion	The ACA expanded Medicaid to individuals under 65 who are not eligible for Medicare and who have incomes below 138 percent FPL, which was made optional by a Supreme Court Ruling. The Federal government financed 100 percent of the costs for the first three years. The matching rate gradually lowers to 90 percent, where it stays indefinitely. While this expansion was largely targeted to adults without disabilities, some states have explicitly allowed individuals who access Medicaid through this group to receive LTSS if they meet clinical eligibility	~~Codifies that the Medicaid expansion is optional for states, as the law was never updated to reflect the Supreme Court ruling. Does not repeal the expansion.~~ Sunsets the expansion group at 1902(a)(10)(A)(i)(VIII) created by the ACA effective December 31, 2019. Creates a new optional eligibility group at Section 1902(a)(10)(A)(ii)(XIII) for two categories of individuals: grandfathered expansion enrollees and expansion enrollees. Grandfathered enrollees must meet two criteria:

	criteria (see California for example: http://www.disabilityrightsca.org/pubs/555101.pdf). The Medicaid expansion excludes people on Medicare, but individuals receiving SSDI who are in the 24 month waiting period for Medicare could be included in this group.	1) Were enrolled in Medicaid as of December 31, 2019; and 2) Did not have a break in Medicaid eligibility for more than a month. Beginning in January 1, 2020, states will only receive the increased ACA matching rate for services to individuals who are grandfathered enrollees. All other enrollees in the new eligibility group will receive the regular state FMAP. The bill also limits the ACA increased FMAP so that it applies only to states that expanded the program before March 1, 2017 (thus denying the increased matching to any states that add the ACA expansion group in the future). Ends the ability of states to expand Medicaid to childless adults with income above 138 percent FPL, effective January 1, ~~2020~~ 2017. Places significant restrictions on the increased matching rate for states that expand. The matching rate continues through January 1, 2020. After 2020, the matching rate continues for individuals who meet the following criteria: • Qualified for the enhanced matching rate as ACA newly eligible; • Were enrolled in Medicaid prior to January 1, 2020; and • Did not have a break in enrollment for more than one month after 2020. Essentially, this will lead to a gradual attrition and eventual elimination of the enhanced FMAP for the newly-eligible ACA group. States can still elect to cover Medicaid for the ACA expansion population, but will not

		receive the higher Federal match for individuals who enroll after 2020. They would instead receive their state's regular FMAP. The provision also ratchets down increased FMAP that was provided to certain states (such as New York and Massachusetts) that expanded their Medicaid program to childless adults before the ACA passed.
Mandatory Eligibility Level for Children age 6-18	This is an income based eligibility group for children, and is not a LTSS or disability-related eligibility group. However, some children with disabilities may access Medicaid through this poverty-related group instead of via a disability group	The bill reverts back to the pre-ACA mandatory minimum eligibility level of 100% FPL. ACA had raised this to 133% FPL. Eligibility levels for children of other ages are not impacted.
Medicaid Benchmark Plans include Essential Health Benefits	The ACA amended Medicaid Benchmark Benefit Plans, also known as Alternative Benefit Plans, to require that they include the Essential Health Benefit package. EHBs are provided to all individuals who are eligible for Medicaid via the ACA expansion, and states can elect to establish EHBs for other populations. The EHB includes benefit requirements such as rehabilitative and habilitative services, in addition to other health care benefits. Such supports can be beneficial to individuals with disabilities and/or chronic conditions.	The bill removes this requirement, effective January 1, 2020.
Medicaid "Per-Capita Caps"	This is a new policy, which sets upper spending limits on Medicaid based upon total enrollees. The per-capita caps are divided up by category of eligibility, which includes: • Individuals age 65 or older; • Individuals who are blind or have a disability; • Children under the age of 19 who are not eligible via a CHIP program; • Individuals who qualify as newly eligible for the ACA expansion; and	Beginning in FY2021, the FMAP for a state will be reduced if it spends above the target limits in the prior year. FY2020 is the first year that the spending limits would apply. The policy would reduce the quarterly Federal payments to a state by ¼ of the previous year's overage (effectively spreading out the reduction over the entire calendar year). The policy creates a spending baseline of FY2019 for each of the five eligibility categories. The spending limit is calculated

	• Other adults who are not included in the prior groups. This policy excludes several groups of individuals from the per-capita caps: • Individuals eligible for Medicaid via a combined CHIP program; • Individuals receiving Indian health services; • Persons on Medicaid via breast and cervical cancer eligibility; • Partial-benefit dual eligible individuals; • Individuals receiving Medicaid payments for employer-sponsored insurance premiums/cost-sharing; • Undocumented immigrants who receive Medicaid-funded emergency care services. The policy also excludes several types of expenditures from the spending cap, including: • Disproportionate Share Hospital Payments; • Medicare cost-sharing payments; • Increased safety-net payments for providers in non-expansion state (that are created by this legislation).	for each of these groups by increasing the prior year spending caps for each category by one of two calculations: • For children, expansion enrollees, and other adults without disabilities: the medical care component of the Consumer Price Index for Urban Consumers (CPI-M). • For older adults and individuals who are blind or have a disability: the medical care component of the Consumer Price Index for Urban Consumers (CPI-M) plus one percentage point. The baseline of FY2019 is set using FY2016 per-capita spending information. The FY2016 calculation is adjusted using the medical component of the consumer price index (CPI-M) between 2016-2019. Allowable supplemental payments that are not attributable to a specific person or service are calculated separately as a percentage of total expenditures and distributed across all population groups for purposes of calculating the per-capita caps. The amendment on 3/20 also explicitly excluded Vaccinations for Children under section 1928 of the Social Security Act. States must provide CMS with reporting information on the medical assistance expenditures and enrollment information for each of the five eligibility categories used to calculate per-capita caps. States are provided with 100% FMAP for MMIS/eligibility system design, implementation, and installation as well as

		operations/maintenance in FY2018-FY2019 to support the development of systems to meet the reporting requirements. States are also provided with a 10% increase to Medicaid administration matching (for a total of 60% match) for expenses directly related to implementing the new data requirements.
Flexible Block Grant Option	The legislation on 3/20 creates a new option for states to elect to receive a block grant. States would voluntarily accept a block grant proposal for a 10-year period, which could be extended for additional 10-year periods. States that elect to not extend a block grant would revert to per-capita cap policy, with adjustments calculated as if the block grant had never been implemented.	The block grant option would not apply to the entire Medicaid program. Block grants would be allowed for one of the two options: • Both children and non-pregnant, non-expansion adults (as defined by the per capita cap policy above). • Only non-pregnant, non-expansion adults. States do not have an option to include older adults and people with disabilities in the block grants. The legislation states that individuals who are disabled (as defined by the Medicaid state plan) would not be included in this block grant, even if they fall into one of the block grant categories. Block grants are calculated based upon the per capita caps established for FY2019 multiplied by the number of enrollees in FY2019. Then, the total amount is multiplied by the average state FMAP for the FY2019 (which is calculated as part of the per-capita cap process). This sets the initial block grant amount at the Federal expenditures calculated for the per-capita caps, based on the number of enrollees in 2019. There is no subsequent adjustment for enrollment. Block grant amounts are increased each year by the consumer price index for all urban consumers (CPI-U). This is different from the CPI-M increase in per capita caps.

		States that do not spend their entire block grant can roll-over the funding to the next fiscal year, provided that they do not elect to terminate the block grant and more back to per-capita caps. Payments made to states from the block grants are based upon the state's enhanced FMAP rate for CHIP.
		
		States must submit a plan to CMS that outlines:
		• Which of the two groups [described above] the block grant will cover;
		• Eligibility requirements for individuals in the block grant group(s);
		• Information about services, including:
		  ○ Types of services and items covered;
		  ○ Amount, duration, and scope of coverage;
		  ○ Cost-sharing requirements; and
		  ○ Method for delivery of services.
		
		If a state chooses block grants for populations, certain groups must be covered – including current mandatory pregnant women (no less than 133% of FPL) and children (currently no less than 133% FPL, but this legislation proposes to lower it to 100% FPL for children age 6-18). This includes the requirement that kids born to a mother on Medicaid be deemed eligible for one year.
		
		The state must also cover specific services, including:
		• Hospitals;
		• Surgical care;
		• Medical care;

		• OB and prenatal care; • Drugs, medicines, and prosthetic devices; • Other medical supplies and services; and • Health care for children under 18. The legislation states that the services in the plan will be provided to this group in lieu of Medical assistance, as defined by the social security act. There is no definition of "health care for children under 18," but it appears that this would be different from the current EPSDT mandate in Medicaid. Lastly, in addition to the new flexibility with benefits and eligibility, the state would also have the ability to not apply core Medicaid policies to groups in the block-grant. These include statewideness requirements, comparability of services, freedom of choice, and reasonable/comparable eligibility standards and procedures.
Permitting States to Apply a Work Requirement	Creates a new policy allowing work requirements for certain individuals who are not an: • Older adult; • Individual with a disability; • Pregnant woman; or • Child.	Beginning on October 1, 2017, states may elect to establish work requirements as a condition of receiving medical assistance for certain individuals. States may determine the time period for these work requirements to apply. Uses the TANF definition of work requirements (Section 407(d) of the Social Security Act). This includes both subsidized and unsubsidized employment; on-the-job training; job search activities; and various employment-related education and skills training activities. States may not apply this requirement to:

		• A woman who is pregnant, or is in a 60-day period after the pregnancy ends; • Individuals under the age of 19; • Individuals who are the only parent/caretaker relative of children under the age of 6 or a child with disabilities; • A married individual or head of household under the age of 20 who is in school leading to employment. Provides a 5% increase to Administrative matching rate for expenses attributable to implementing this section.
Hospitals Providing Presumptive Eligibility	Under the ACA, eligible Hospitals were allowed to provide presumptive eligibility determinations to individuals that were likely to be Medicaid eligible. This enabled potentially-eligible persons to enroll in Medicaid at the Hospital in order to defray medical costs and uncompensated care. This provision largely applies to individuals in non-ABD groups, as the disability determination could prevent immediate eligibility determinations; however, some older adults or persons with disabilities may qualify for presumptive eligibility.	Ends the requirement for states to allow eligible Hospitals to provide presumptive eligibility determinations, effective January 1, 2020.
Counting Lump Sum Payments for MAGI eligibility	This would impact individuals who are determined eligible under the Modified Adjusted Gross Income calculations. MAGI groups do not have asset tests. Medicaid eligibility is determined based on income at a certain point in time; thus, individuals who receive a large lump-sum payment in one month can become eligible for Medicaid (or re-establish eligibility) in the following month. While MAGI generally applies to eligibility categories for individuals under age 65	This provision would count lump-sum income from sources such as a lottery, gambling, or an inheritance, in excess of $80,000 over multiple months, thus preventing individuals from re-establishing Medicaid eligibility as quickly. Under the legislation, individuals could have income from a large payment (exceeding $1,260,000) counted for up to 10 years.

	without disabilities, some people who become eligible via MAGI groups have disabilities and LTSS needs.	
Removal of Retroactive Eligibility	Medicaid policy allows eligibility to be established for three months prior to the date of application, if the individual met all of the Medicaid eligibility requirements during that three-month period. Under this policy, medical expenses incurred prior to application for Medicaid can potentially be covered by the individual, including older adults and people with disabilities. A recent court ruling in Ohio stated that this policy should apply to LTSS as well. This would likely impact some older adults and people with disabilities, particularly those who have lived in an Assisted Living Facility or other covered Medicaid LTSS setting in the 3 months prior to their application and/or those who utilized Hospital services before being determined eligible.	Beginning October 1, 2017, retroactive eligibility would be repealed. Medicaid eligibility would be established in (or after) the month when a person applies for the program.
~~Removal of Interim Coverage pending Immigration Documentation~~ Note: this provision was added after the initial leaked draft, but was removed by the amendment issued prior to the House floor vote.	~~Current policy requires that states provide Medicaid to individuals who attest to being a citizen (or legal immigrant not barred from receiving Medicaid) and meet all other eligibility criteria. These individuals are given a reasonable opportunity to provide documentation proving citizenship.~~	~~The proposal would change the law to require that documentation be provided prior to the individual receiving Medicaid services. States could still provide a reasonable timeframe for individuals to provide documentation, but would not receive any FFP for services delivered prior to the documentation being received. This provision would take effect six months after the law is enacted.~~
Removal of Ability to Increase Home Equity Exclusion	For the purposes of determining Medicaid eligibility in categories that have an asset test (which includes LTSS and eligibility categories for older adults and people with disabilities), Medicaid excludes a certain amount of home equity from the applicant's assets. In 2017, the first	The legislation would remove the ability to increase the exclusion above the minimum rate; thus all states would set their home equity exclusions at the $560,000 rate (and, in future years, at the dollar amounts calculated using the CPI-U inflationary factor).

	$560,000 is excluded from the asset test. States have the option to increase the exclusion to an amount that is no more than $840,000. These amounts are indexed each year based on CPI-U.	The provision would take effect 180 days after the law is enacted, except that states who require a state plan amendment to enact the policy would be given additional grace time until after their next legislative session.
Excluded providers from Medicaid	This provision is a new policy which creates a new payment exclusion for certain providers of abortion services. The payment exclusion lasts for 1 year from the enactment of the law. It is unlikely to directly impact LTSS providers, but may limit the sources of care that some individuals are able to utilize.	Excluded providers are those that meet the following criteria (including all subsidiary organizations): • A 501(c)(3) organization; • Is an "essential community provider" under the ACA that is primarily engaged in family planning services, reproductive health, and related care; • Provides abortions that are not due to rape, incest, or a life-threatening condition to the mother; and • Received more than $350 million from Medicaid programs in FY2014 throughout all affiliates, subsidiaries, successors, etc.
Repeal of Medicaid DSH Cuts	Hospitals that provide a disproportionate amount of care to low-income, uninsured, and/or Medicaid eligible individuals can qualify for supplemental DSH payments. DSH payments are capped at an annual allotment for each state. The ACA reduced aggregate DSH cuts based on the expectation that Hospitals would serve fewer uninsured individuals. The cuts were delayed several times by subsequent legislation.	The legislation rescinds the DSH cuts and returns national DSH levels to pre-ACA amounts in two waves. States that did not expand Medicaid under the ACA would have their DSH allotments restored in 2018. States that expanded Medicaid would have the DSH levels restored in 2020.
Additional Payments under DSH		Provides increased funds for safety net providers in states that did not expand Medicaid during ~~calendar~~ Fiscal years 2018-2022. Allocates $2 billion a year for those five years ($10b total) for these payments. Eligible states receive 100% FMAP for these payments for the first four years and 95% for

		the fifth year. Funds for states are determined by the ratio of individuals with income below 138% FPL across the non-expansion states. Payments to individual providers are limited to the costs incurred providing services to uninsured and Medicaid-eligible individuals.
Requires More Frequent Eligibility Determinations for Expansion Populations		Beginning October 1, 2017, states would be required to do eligibility redeterminations at least every 6 months for individuals in the ACA Medicaid expansion. ~~Increases civil monetary penalties for individuals who knowingly enroll in the program when they are not eligible.~~ Provides states with a 5% increase to Federal matching funds attributable to implementing this requirement from October 1, 2017 – December 31, 2019.
State Innovation Fund	This is a new policy that creates a grant program and funds it with $100 billion over a nine year period. The funding is $15 billion in FY2018 & FY2019, and $10 billion in the following seven years. There are a number of things that states can use the funding to achieve, many of which are targeted to individuals who are high-risk and/or projected to have high utilization. The innovation funds focus on stabilizing the private marketplace and do not include reference to long-term services and supports. While older adults and individuals with disabilities are not necessarily a targeted population, they are likely to fall into one or both of those groups.	Allocates $100 billion over the nine-year period beginning in FY2018 for grants to states in order to: • Provide financial assistance to high-risk individuals; • Creating incentives to stabilize insurance prices; • Reducing cost of providing insurance to individuals who are expected to have high utilization; • Increasing insurance company participation in the individual and small group markets; • Promoting access to preventive services, dental care, and/or vision services; • Providing direct payments to health care providers for the provision of certain services. The services would be defined by HHS; and

		• Providing assistance to reduce out-of-pocket costs for insured individuals. Additionally, $15 billion funds are provided to assist with maternity and behavioral health (including substance abuse) prevention and treatment. Another $15 billion are provided for an "invisible risk sharing" program that is intended to reduce premiums in the individual marketplace. An additional $8 billion over five-years was added to support premium payments for high-risk individuals (ie: creation of a subsidized high-risk pool) in states that apply for a waiver of the ACA's community-rating, age rating, and/or essential health benefits requirements. In total, $138 billion is provided to support these various initiatives intended to reduce the cost of insurance in the private market place. States can elect to develop their own program or have a default federal program established. Both options require state match, but at different levels. In 2018 and 2019, there are two components to the formula for allocating funds to states: • 85% of the allocation is based upon incurred claims for costs in the individual market; • 15% is allocated based upon states that saw an increase in uninsured individuals below 100% FPL or that have fewer than three plans offering

		coverage on the 2017 health care exchange. In subsequent years, the HHS secretary is directed to set allocations based upon a factor that takes into account the cost of care, the risk profile of the population, the number of low-income uninsured individuals, and health plan competition. Beginning in FY2020, states that establish their own programs have a 7% matching requirement for these funds. This increases by 7% each year, ending at a 50% matching requirement in FY2026. States that use the default program have a 10% match beginning in 2020, increasing by 10% each year until it reaches 50%, where it remains until 2026.
Age Rating Provisions	Under the ACA, insurers are prohibited from charging more than a 3-to-1 variation on premiums based upon an individual's age. This means that older adults cannot be charged more than 3 times the insurance cost of a younger individual. AARP commissioned a report by Milliman to assess the impact of this policy proposal. The report concluded that increasing the rating provision from the ACA level to 5-to-1 would lower premiums for people in their 20s by about 25% and increase premiums for people 65 and older by the same percentage. http://www.aarp.org/content/dam/aarp/ppi/2017-01/Milliman%20ACA%20Age%20Bands_2.7.17.pdf	~~The legislation would increase this limitation to a 5-to-1 ratio, or a state-defined limit, beginning in 2018.~~ States are able to apply for waivers to set the age-rating bands at any level they see fit.
Public Health and Prevention Fund	The Affordable Care Act established the Prevention and Public Health Fund to provide expanded and sustained national investments in prevention and public	The legislation would end funding for the Fund after September 30th, 2018 (FY18). Any unused funding at the end of FY18 would be rescinded.

	health, to improve health outcomes, and to enhance health care quality. The fund was initially provided with $15 billion over a 10-year period; however, legislation following the ACA reduced the funding allocations. ACL has received resources from this Fund to support several of its activities, including chronic disease self-management, falls prevention, and Alzheimer's education and outreach. Other CDC programs have focused on diabetes and stroke prevention, which are significant for older adults.	
Federally Qualified Health Centers	FQHCs provide a wide range of community-based health supports. While they are generally not directly related to LTSS provisions, they provide many supports to low-income individuals on Medicaid. This includes older adults and people with disabilities.	The proposed bill extends some enhanced funding for FQHCs under section 330 of the Public Health Services Act. The ACA originally included enhanced funding, which was extended by subsequent legislation. In FY2017, FQHCs received an additional $3.6 billion under this section. The legislation allocates an additional $422 million for FQHCs.
AHCA Implementation Fund	New fund to help HHS implement the policies	Allocates $1 billion for Federal administrative expenses to implement the changes required by the legislation.