NASUAD
National Association of States United for Aging and Disabilities
202.898.2578 • www.nasuad.org

Affordable Care Act Repeal Legislation Summary

Background

On February 24, 2017, Politico released a copy of the ACA repeal and replacement legislation currently being drafted in the House of Representatives. The draft of the bill is dated February 10th, so there may have been substantive changes between the printing of this bill and current discussions underway. However, the legislation closely tracks with other policy documents released by House Republican leadership, such as the "Better Way" blueprint from Speaker Paul Ryan, as well as the briefing documents that were presented to the House Republican Caucus last week.

This represents a draft document that is still under discussion. Some of these policies may not become law, as ongoing lobbying from various organizations heats up. In the Senate, several Republicans have expressed reservations and concerns about some of the policies that were ultimately included in this draft bill. Additionally, the legislation includes repeals of many significant taxes and revenue devices without many major offsets. Thus, the cost-neutrality of the legislation (which is required for a bill passed via reconciliation), could present a challenge with this draft bill.

However, despite the fact that the legislation is unlikely to become law in its current form, we are providing you with this summary so that you can understand the different policies under discussion and assess the impacts on your state, your programs, and the individuals you serve. This is an ongoing and evolving situation. NASUAD will continue to provide updates to members as we learn more about this, and other, proposals to reform the nation's health care system.

Key Provisions in the 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, 2020 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 tax on high-cost health plans; the health insurer tax; and the medical device tax, among others;
- 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.
- 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);

- Setting a per-capita cap on Medicaid expenditures; and
- Providing $100 billion in grants to states in order to establish programs that support the insurance marketplace and individuals with significant health conditions.

Below, we provide additional detail on some of the policies included in this legislation:

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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	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 criteria (see California for example:	Codifies that the Medicaid expansion is optional, as the law was never updated to reflect the Supreme Court ruling. Ends the ability of states to expand this group to an income level above 138 percent FPL, effective January 1, 2020. 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;

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	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.	• 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.
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 • Other adults who are not included in the prior groups.	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 for each of these groups by increasing the FY2019 baseline by the medical care component of the Consumer Price Index for Urban Consumers (CPI-U) up to the current

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	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	year, and adding one percentage point. The calculation is done each year, so the 1% increase is not compounding and would have a diminished impact over time. For example, if the CPI-U from FY2019-2020 is 2.1%, the inflation index would be 3.1%. And it the CPI-U FY2019-2023 is 8.6%, the inflation index would be 9.6%. The baseline of FY2019 is set using FY2016 per-capita spending information. The FY2016 calculation is adjusted using the medical component of CPI-U between 2016-2019 plus one percentage point. 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. 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.
Public Health and Prevention Fund	The Affordable Care Act established the Prevention and Public Health Fund to provide expanded and sustained national	The legislation would end funding for the Fund after September 30th, 2018 (FY18). Any

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	investments in prevention and public 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.	unused funding at the end of FY18 would be rescinded.
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 $285 million for FQHCs.
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.
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	Excluded providers are those that meet the following criteria (including all subsidiary organizations): • A 501(c)(3) organization;

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	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.	• 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.
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. 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 market; • Promoting access to preventive services, dental care, and/or vision services; • Providing assistance to reduce out-of-pocket costs for insured individuals. In FY18-19, funds are provided to states based on a formula that accounts for the number of individuals eligible for ACA premium tax credits and the amount that the state's average premium costs exceed the national average. In later years, HHS is directed to establish a formula that accounts for low-income individuals in the state.

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		Beginning in FY2020, states have a 7% matching requirement for these funds. This increases by 7% each year, ending at a 50% matching requirement in FY2026.
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.	The legislation would increase this limitation to a 5-to-1 ratio, or a state-defined limit, beginning in 2018.
Essential Health Benefits (Non-Medicaid)	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. EHB is included as a requirement for many health plans.	The bill would repeal EHB requirements and allow state-defined EHBs, beginning in 2018.