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Evolution of Repeal and Replace

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The Republican evolution on health care over the course of 2017 has tested the resolve of the party's years-long effort to repeal and replace the Affordable Care Act (ACA). The Republican goal of repeal and replace has reached a fever pitch, with days to go before we may come to a resolution on this nearly eight-year drive.

For the most part, the Republican health care effort has been based on the idea of repealing the individual mandate and employer mandate, and ACA-related taxes. This is a very expensive starting point in discussions but has been a part of each successive repeal proposal to date. Those "cost saving" policies include eliminating the Medicaid expansion option (which, in all fairness, is something Republicans wanted to do anyway), and also, converting the program into a per-capita cap or block grant.

It has been Republicans' goals in health care reform to reduce the deficit, provide greater options to consumers, alleviate the burden on health care stakeholders and small businesses, and provide greater flexibility to states who know what's best for their states. But in the end, the bottom line objective has always been getting something called "repeal and replace" passed.

Let's explore the evolution of the repeal effort — taking a look at where we've been and where we could be heading.

THE AMERICAN HEALTH CARE ACT

Let's rewind the clocks back to March 2017 for a moment. House Republicans unveiled their two bills originating from the Ways & Means and Energy & Commerce Committees on March 6th, based off the FY17 reconciliation instructions passed by both chambers in mid-January. The bills, known collectively as the American Health Care Act (AHCA), would have dramatically transformed the Medicaid program, converting it into a per-capita cap financing structure by 2020.

The AHCA did not repeal the ACA's insurance reforms totally, leaving in place requirements that health plans cover preexisting conditions (with the option for states to waive), guarantee availability and renewability of coverage, continue to cover adult children up to age 26, and cap out-of-pocket expenditures. It also kept the ACA's prohibitions against health status underwriting, and lifetime and annual limits. The legislation replaced the individual mandate with a late enrollment penalty, eliminating one of the most unpopular provisions of the ACA, and did away with the cost-sharing reduction payments, along with a slew of taxes that were designed to help finance the ACA.

The bill underwent several scrubbings to appease conservative and moderate Republicans, but still came up short for the originally scheduled vote set on March 24, 2017. Over the next month and a half, Mark Meadows, Chair of the Freedom Caucus, and New Jersey Rep. Tom MacArthur, a member of the Tuesday Group, worked to introduce an amendment to the AHCA to secure votes of conservative holdouts. Their amendment would have allowed states to apply for waivers from the ACA's essential health benefit and go beyond the AHCA's 5-to-1 age rating requirements, an increase from the ACA's 3-to-1 requirements. Additionally, states could have waived the community rating requirements, which would only be available for consumers who did not maintain continuous coverage. CBO conducted an analysis of the waiver and found that half of the U.S. population could live in states that would take up such a waiver, jeopardizing affordable coverage for older Americans and people with preexisting conditions. A second amendment was released in tandem, led by Representative Fred Upton, which would have created an $8 billion stability fund for years 2018-2023, for states permitting insurers to charge higher health premiums for individuals as a result of a waiver.

The AHCA would have converted Medicaid financing to a per-capita cap structure beginning in fiscal year 2020. There would've been per enrollee caps for five enrollment groups, which would be based on 2016 expenditures divided by full-year equivalent enrollees in each category and trended forward to 2019 by CPI-medical. The Meadows-McArthur amendment also gave states the option to elect for a Medicaid block grant for certain populations for a period of 10 years. The legislation would also have phased out the enhanced funding for the Medicaid expansion. These reforms would have amounted to a reduction of

approximately $880 billion in Medicaid spending by 2026 and resulted in 14 million people losing Medicaid coverage benefits, according to the Congressional Budget Office (CBO).

In March, when the White House tried to push back against the original CBO score, one Senator defended CBO by likening it to an independent arbiter. “You have to have an umpire, even if the umpire occasionally gets it wrong, because otherwise you are only accepting analysis by people with motivations define certain answers, and so I am very reluctant to disregard what the CBO score is.” That senator was Bill Cassidy of Louisiana.

In the run up to the vote, the Senate was still largely quiet on health reform, allowing the House process to run its course. Some senators were even skeptical, which led to the now well-known ‘Jimmy Kimmel test.’ As Senator Cassidy put it, “Will the child born with congenital heart disease be able to get everything she or he would need in that first year of life? I want it to pass the Jimmy Kimmel test.”

In the end, the House passed a bill, with the Meadows-MacArthur and Upton amendments, on May 4th by a near party-line vote of 217-213.

THE BETTER CARE RECONCILIATION ACT

Fast forward to June 22nd. The Senate unveiled its version of repeal and replace known as the Better Care Reconciliation Act (BCRA) of 2017, which would subsequently undergo several revisions. The Senate bill would have replaced the individual mandate with a continuous coverage requirement, meaning if a person had a break in coverage of more than 63 days in the previous year they would have a six-month waiting period to apply for coverage. This was stricter than the AHCA, which simply imposed a one-year penalty on individuals who failed to maintain continuous coverage. The bill would also impose restrictions on tax credits being used to purchase insurance coverage that covered abortion. It would also have eliminated the requirement that states cover essential health benefits in their Medicaid alternative benefit plans.

On Medicaid, BCRA would have phased out the enhanced FMAP for states that adopted expansion as of March 1, 2017, from 90% in CY 2020 to 75% in 2023, sliding to the regular state match rate in 2024 and subsequent years. Beginning in 2020, BCRA would have limited federal Medicaid funding via per-capita caps, based on the sum of the costs per enrollee for five beneficiary groups multiplied by the number of enrollees in the group and the state’s federal match rate. Initially, the caps would have grown by the Consumer Price Index for medical care for adults and children and the CPI-M plus one percentage point for elderly and disabled groups. Starting in 2025, per enrollee amounts for all groups would have increased by CPI for urban consumers, a historically lower rate. BCRA would also have allowed states the option to choose block grant financing for non-expansion Medicaid adults. States could have imposed conditions of eligibility on their Medicaid programs.

BCRA did attempt to respond to the devastating substance abuse emergency by appropriating $44.78 billion for FY2018 through FY2026 for grants to states to support substance use disorder treatment and recovery services. Additionally, for years FY2018 through FY2022, BCRA would have appropriated $50.4 million annually for research on addiction.

The CBO estimated this bill would have resulted in 22 million people losing health insurance coverage by 2026, with Medicaid spending being cut by $756 billion. By 2026, spending on Medicaid would have been reduced by 26%.

One of the biggest changes during the subsequent revisions was an amendment authored by Sen. Ted Cruz known as the Consumer Freedom Option. This amendment would have allowed an insurer to sell a plan that was not compliant with ACA requirements as long as it offered plans at each tier (gold, silver, bronze) for a plan year. Insurers could waive a number of ACA requirements pursuant to state law, and as such would not participate in the ACA’s risk adjustment program with compliant plans. In an effort to woo senators, the amendment also included $182 billion over nine years to establish a State Stability and Innovation Program. For years 2018-2021, $50 billion would have been used for reinsurance. For years 2019-2026, $132 billion would have been available for reinsurance, reducing costs of insurance for high-risk individuals, helping reduce out-of-pocket costs, and reducing direct payments to providers.

A number of BCRA’s provisions were cited by the Senate Parliamentarian as being subject to the Byrd rule, meaning they would need 60 votes to pass. While the Senate Majority Leader’s office referred to the ruling as a guidance which would help inform subsequent drafts, the Parliamentarian ruling simply made BCRA unworkable, forcing the Republicans to seek out a new path forward. BCRA, with the Consumer Freedom Option, ultimately failed to move forward by a vote of 43-57.

OBAMACARE REPEAL AND RECONCILIATION ACT OF 2017 (ORRA)

In an effort to find consensus among the Republican conference, the Senate introduced ORRA, a near identical bill to the 2015 repeal bill that former President Obama vetoed, which would have repealed the ACA’s coverage requirements but delayed the repeal until 2020. This legislation would have eliminated the penalties associated with the individual and employer mandates, ended the ACA’s premium tax credits and cost-sharing reduction payments, and eliminated the majority of ACA’s taxes, including the Medicare payroll tax surcharge and unearned income taxes on individuals making more than $200,000 a

year, which was not included in BCRA. CBO projected ORRA would increase the number of uninsured by 32 million, and ORRA failed to advance by a vote of 45-55.

HEALTH CARE FREEDOM ACT (SKINNY REPEAL)

Next up, the Health Care Freedom Act was unveiled as an amendment, given BCRA being turned into Swiss cheese by the Senate Parliamentarian. This legislation, commonly referred to as skinny repeal, retained the Medicaid expansion, suspended the employer mandate for eight years, suspended the medical device tax for three years, retained a number of ACA insurance reforms like guaranteed issue, and kept the essential health benefit requirements and the prohibiting of underwriting for preexisting conditions.

Skinny repeal did repeal the individual mandate, but left cost-sharing subsidies in place, along with most benefit design requirements. One of the most notable provisions of skinny repeal was providing greater flexibility to utilize Section 1332 waivers, in addition to accelerating the review process of these waivers.

At the time, this was the only option out of everything else out there that stood a chance of passing. But it was a stark difference from the House and Senate effort to date. The main selling point was that Republicans just needed to get to a conference with the House to sort out the details.

In the end, this was the package that came closest to passage, but Sens. Susan Collins and Lisa Murkowski voted no, along with Sen. John McCain's photo-finish thumbs down to end the debate.

GRAHAM-CASSIDY (-HELLER-JOHNSON)

The failure of all the other proposals has led us to where we are today. Graham-Cassidy is arguably the most aggressive effort by Republicans to repeal and replace the ACA yet. The bill eliminates the individual mandate effective January 1, 2016, and does not include a provision to promote continuous coverage. It also reduces the penalty for large employers that do not provide health benefits to zero, retroactive to January 1, 2016.

This legislation breaks from previous bills by eliminating the ACA's Medicaid expansions, premium tax credits, cost-sharing reduction payments, small business tax credits, and Basic Health Program as of 2019 to fund state-designed health care programs. The money for the block grant, totaling $1.12 trillion, would be distributed through a complex formula that would change over time (2020-2026). Each state would be assigned a base period amount based on the federal funding provided through the expansion, the Basic Health Program, and ACA's premium tax credits and CSRs during four consecutive quarters prior to 2018 chosen by the state. The funding formula would pit states against each other, primarily rewarding states that did not expand Medicaid and harming states that did expand Medicaid. It also sets up for an unprecedented funding cliff in 2026, and would lead to extremely different health care landscapes in the states.

While the bill has a prescribed list of allowable activities for the block grant program, states have significant flexibility in doing what they want with the block grant funding. Fox example, a state can use the funding to simply write constituents a check with no market reforms or structuring, have its Medicaid managed care organizations cover people above Medicaid under a different label, implement a single-payer system, use the funding to make up losses under the Medicaid per capita cap, or theoretically do nothing at all with the funding. The bill also includes waivers from these requirements which would allow insurers to charge different premiums based on health status and age, but not gender. States could also obtain waivers from the ACA's essential health benefit requirements and the ACA's medical loss ratio rebate requirements.

On Medicaid, Graham-Cassidy eliminates the expansion group at the end of December 2019, meaning these individuals would likely be shifted into commercial insurance which is more costly than Medicaid, a program that states create under the block grant, or become uninsured. While states can use the short-term fund for premium stabilization and cost-sharing reduction assistance, states can seek waivers to allow insurers to eliminate certain ACA protections.

This legislation also permits states to make eligibility redeterminations every six months for individuals eligible for Medicaid through the expansion or the state option for coverage for individuals with income that exceeds 133% of the FPL. It also permits states to require nondisabled, non-elderly, and non-pregnant individuals to satisfy a work requirement as a condition for receipt of Medicaid medical assistance. The legislation seemingly incentives states to implement work requirements by including a five percentage point increase to the match for administrative activities.

Graham-Cassidy would also convert the federal Medicaid financing mechanism into a per capita cap model and includes an option for states to block grant Medicaid.

COMPARATIVE CHART

The Kaiser Family Foundation has developed a chart comparing the Graham-Cassidy and BCRA replacement proposals with the ACA. Click **here** to see the foundation's guide (scroll down to view the chart).

CONCLUSION

It's hard to believe the health care rollercoaster we have all been on this year. We have joked that a dead cat named "RepealandReplace" thrown on the Senate floor would get 47 Senate Republican votes. This fact and the looming deadline of September 30th create the situation we are in today with Graham-Cassidy. The bill does not go as far as other bills in repealing the various ACA-related taxes. However, it still cuts Medicaid; it (currently) does not address the nationwide substance abuse crisis, as other legislation did; it still fails the Jimmy Kimmel test for preexisting conditions; and it leaves policy open-ended for states such that they could go in any number of directions.

Between now and September 30th, we will learn how this story plays out.

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Authors