September **2017**

Comparing Key Provisions: Affordable Care Act, American Health Care Act, and the Graham-Cassidy Proposal

In July 2017, the United States Senate rejected a series of proposals to repeal and replace the Affordable Care Act (ACA). On Sept. 13, 2017, Senators Lindsey Graham and Bill Cassidy introduced a new proposal to repeal and replace the ACA. The Graham-Cassidy proposal retains some similarities to the American Health Care Act, which passed the U.S. House of Representatives in May 2017, but includes some notable differences. The following table compares key provisions of the Affordable Care Act, American Health Care Act, and the Graham-Cassidy proposal. The Senate has until Sept. 30, 2017 to pass a repeal and replace package under the Fiscal Year 2017 budget reconciliation process, which requires a simple majority for passage. After the end of FY 2017, any repeal and replace legislation would most likely require 60 votes for passage.[1] On Sept. 25, the U.S. Congressional Budget Office (CBO) issued a preliminary report on a version of the Graham-Cassidy bill summarized in this brief. The CBO concluded that the bill would save at least $133 billion. However, it would result in millions of people losing health insurance. Additional, detailed analyses may be forthcoming.

Category	***Affordable Care Act***	***American Health Care Act*** (Passed U.S. House of Representatives: May 4, 2017)	***Graham-Cassidy*** (Introduced in the Senate: September 13, 2017)
Ensuring Continuous Coverage	Individuals who experience a lapse in coverage longer than 3 months pay individual mandate penalty ($695 or 2.5% of income above $10,000 in 2017).	Repeals the ACA's individual mandate penalty. Individuals who experience a lapse in coverage longer than 63 days would pay 30% higher premiums for one year upon re-enrolling in individual coverage.	Repeals the ACA's individual mandate penalty retroactively to 2016. Replaces with no other provisions to encourage the purchase of insurance.
Tax Credits for Individual Market Coverage	Provides income-adjusted, advanceable refundable tax credits for individual market coverage; income limit of 400% of the federal poverty level (FPL). Structure of tax credits accounts for the cost of insurance in a given geographic area. Tax credits determined based on cost of second-lowest cost silver plan, with an actuarial value of 70%. Tax credits cannot be used to purchase catastrophic plans offered on the Health Insurance Marketplace.	Starting in 2020, provides age-adjusted, advanceable refundable tax credits from $2,000 to $4,000 for individual market coverage; credits phase out at incomes of $75,000-$115,000. Tax credits are not linked to the cost of insurance.	Starting in 2020, repeals the ACA's tax credits and cost-sharing reductions for individuals purchasing individual market coverage, and eliminates Medicaid expansion. Replaces federal funding for these programs with a block grant system, under which states could use funds to: • Help high-risk individuals purchase coverage • Stabilize premiums and promote insurer participation in the individual market • Provide payments to health care providers • Reduce out-of-pocket costs for those with individual market coverage • Establish a program to help individuals purchase coverage on the individual market Block grants are allocated using a complex formula: • States receive a baseline amount based on federal funding provided to each state for ACA tax credits, CSRs, Medicaid expansion, and the Basic Health Program. • Each state's block grant is determined by the ratio of the number of individuals in the state with incomes of 50-138 % FPL to the total number of these individuals in all states. State funding is adjusted by several factors that change over time. • States that had previously expanded Medicaid would likely receive fewer block grant funds than under current law. Total funding for block grants is $146 billion in 2020, growing to $190 billion in 2026. After 2026, funding would expire absent Congressional re-authorization of the program.
Cost-Sharing Reductions	Provides cost-sharing reductions (CSRs) for individuals earning up to 250% of the federal poverty line.	Repeals CSRs in 2020; does not fund CSRs in the interim.	
Medicaid Expansion	Authorizes states to expand Medicaid for individuals up to 138% FPL with an enhanced federal match rate.	Allows Medicaid expansion to continue in states that have already expanded the program with enhanced federal matching rate until 2020 (90%). In 2020, the enhanced federal matching rate continues indefinitely for expansion enrollees covered as of Dec. 31, 2019, who do not have a lapse in coverage for longer than 1 month. All others would receive the traditional federal matching rate (65.15% for Michigan in 2016).	
Medicaid Funding Structure	Does not change underlying structure of the "traditional" Medicaid program, where the federal government guarantees matching funds for states' Medicaid expenses.	Shifts the entire Medicaid program to a per-capita cap system in 2020. Under a per-capita cap system, states would receive a fixed per-enrollee payment for different enrollment groups based on fiscal year (FY) 2016 expenses and payments would grow with medical inflation (plus one percentage point for elderly, blind, and disabled). States can apply for a waiver to instead choose a block grant system for children and non-disabled, non-elderly adults. States can impose work requirements on non-disabled, non-elderly, non-pregnant adult Medicaid enrollees.	Shifts the entire Medicaid program to a per-capita cap system in 2020. Caps are based on expenses for a state-chosen period of time consisting of eight consecutive quarters between Q1 of 2014 and Q2 of 2017. (States that expanded Medicaid in 2016 can choose a period of no less than four consecutive quarters.) Payments grow with medical inflation (plus one percentage point for elderly and disabled) until 2025, when growth rate decreases to CPI-U for adults and children, and medical inflation for elderly and disabled. Children with disabilities are exempt from caps. States can apply for a waiver to instead choose a block grant system for nondisabled, non-elderly adults. States can impose work requirements on non-disabled, non-elderly, non-pregnant adults. Limits retroactive Medicaid eligibility for non-elderly, non-blind, non-disabled individuals to the beginning of the month in which the individual applied for coverage.

[1] It is possible that budget reconciliation, requiring a simple majority for passage, could be used for repeal and replace legislation in FY 2018 if it is not used for other issues.

Category	*Affordable Care Act*	***American Health Care Act*** (Passed U.S. House of Representatives: May 4, 2017)	***Graham-Cassidy*** (Introduced in the Senate: September 13, 2017)
Health Savings Accounts (HSAs)	Individuals/families can contribute up to $3,400/$6,750 into health savings accounts.	Increases HSA contribution limits; spouses can make additional contributions.	Increases HSA contribution limits up to current limits for deductibles and out-of-pocket costs ($6,550 for individuals, $13,100 for families); spouses can make additional contributions. Individuals can use HSA funds to pay for high-deductible health plan (HDHP) premiums. HSAs may not be used to purchase HDHPs that cover abortion.
Private Insurance Market Regulations	Requires private insurance plans to comply with the following requirements: • **Age Bands:** Plans can vary rates between the oldest and youngest enrollees by no more than 3:1. • **Guaranteed Issue and Community Rating:** Plans cannot deny individuals coverage or charge more for coverage based on health status. • **Essential Health Benefits:** Private insurance plans must provide coverage for 10 categories of services. Applies to Medicaid, individual, and non-grandfathered small group plans. • **Medical Loss Ratio:** Private insurance plans must spend 80% of premium revenue on health care and quality improvement for individual and small group plans, and 85% for large employer groups.	Widens age bands to 5:1. Allows states to apply for three types of waivers: • Starting in 2018, widen age bands for the individual and small group market beyond the 5:1 ratio proposed in AHCA. • Starting in 2019, opt out of community rating requirements, allowing insurers to underwrite policies for certain individuals based on health status if the state is operating a program under AHCA's Patient and State Stability Fund. This would only apply to individuals with a lapse in coverage greater than 63 days. Individuals who maintain continuous coverage cannot be underwritten based on health status. • Starting in 2020, determine essential health benefits for the individual and small group market.	Allows states receiving funding under the block grant program to apply for the following waivers for coverage provided through the program: • Allow insurers to vary premiums based on age beyond the existing 3:1 age band. • Opt out of community rating requirements, allowing insurers to underwrite policies for certain individuals based on health status. Insurers are still prohibited from denying coverage based on health status. • Determine state requirements for essential health benefits for plans offered in the individual and small group markets. • Opt out of Medical Loss Ratio requirements for insurers offering plans in the individual and small group markets.
Market Stability and Risk Pool	Starting in 2014, prohibited plans from denying coverage based on pre-existing conditions or engaging in medical underwriting. Created temporary federal high-risk pool from 2010-2013 until individuals with pre-existing conditions could purchase coverage on Health Insurance Marketplaces.	AHCA initially provided $100 billion over nine years to establish the Patient and State Stability Fund (PSSF). States could use these funds for a variety of purposes to stabilize insurance markets, including establishing high-risk pools. After subsequent amendments, total PSSF funding increased to $138 billion: $15 billion earmarked for maternity coverage, newborn care, and behavioral health; $15 billion to create a federal "invisible risk sharing program" covering claims over $10,000 for individuals with certain health conditions (to be determined by the CMS Administrator); and $8 billion over the 2018-2023 period to lower premiums and out-of-pocket costs for individuals with pre-existing conditions living in community rating waiver states who have had a lapse in coverage longer than 63 days and purchase individual market coverage.	Creates a short-term market stabilization program, funded at $10 billion in 2019 and $15 billion in 2020. The CMS Administrator would use these funds to establish arrangements with insurers to address disruptions in coverage and respond to urgent health needs in states.
Taxes and Fees	Enacts a number of taxes and fees: • "Cadillac" tax: 40% tax on high-cost employer-sponsored plans • 2.3% excise tax on sales of medical devices • 0.9% Medicare payroll tax increase for households earning more than $200,000 • 3.8% tax on unearned income for high-income households • 10% tax on indoor tanning services • Annual fee for producers and importers of brand-name pharmaceuticals • Annual fee for health insurance providers	Repeals ACA taxes and fees in 2017. Cadillac tax would be delayed until 2026.	Repeals the ACA's medical device excise tax in 2018. Retains other ACA taxes and fees.

Projected Impacts of AHCA and Graham-Cassidy

On May 24, 2017, the Congressional Budget Office (CBO) released an estimate of the American Health Care Act's projected impacts on health insurance coverage and the federal budget.[1] The CBO is expected to release preliminary estimates of the Graham-Cassidy legislation the week of September 25, 2017. However, this assessment will likely not include point estimates of the bill's impact on the federal deficit, health insurance coverage, or premiums.[2] CHRT will update this fact sheet when CBO estimates are released.

CBO Estimates

Category	***American Health Care Act*** (Passed U.S. House of Representatives: May 4, 2017)
Impacts on Coverage and Premiums	Compared to under current law, increases uninsured by 14 million in 2018. 23 million more individuals would be uninsured by 2026 relative to current law. Changes would largely result from lower Medicaid enrollment. Compared to under current law, increases individual market premiums by 15% to 20% in 2018 and 2019. However, by 2026 premiums would be 10% lower than under current law.
Impacts on Federal Budget	Compared to under current law, reduces the federal deficit by $119 billion over 10 years ($1.1 trillion decrease in spending, $992 billion decrease in revenues). Federal Medicaid spending would be reduced by $834 billion over 10 years.

Additional Analysis

While CBO estimates of the impact of Graham-Cassidy on the federal budget, health insurance coverage and health insurance premiums are forthcoming, the Center for Budget and Policy Priorities (CBPP) has conducted an initial assessment of the bill's impacts on federal funding for Medicaid and financial assistance for Marketplace coverage.[3] The table below describes CBPP's estimates of potential impacts of this legislation on federal funding to states.

Category	***Graham-Cassidy*** (Introduced in the Senate: September 13, 2017)

Impacts on Federal Spending	Compared to projected federal spending on ACA tax credits, CSRs, and Medicaid expansion under current law, states would receive $239 billion less in federal funds under the Graham-Cassidy block grant system from 2020 to 2026.
	
	Federal Medicaid spending under the Graham-Cassidy per capita cap system would be $175 billion less from 2020 to 2026 than under current law. Medicaid spending would be reduced further in later years due to the smaller annual growth factor for per capita caps that would take effect in 2025.
	
	In 2026 alone, states would receive $80 billion less in federal funding than under current law as a result of both the block grant and per capita cap systems:
	• 15 states would see increases in federal spending in 2026 under Graham-Cassidy block grants and per capita caps.
	  ○ All of these states have opted not to expand Medicaid to date.
	• 36 states (including D.C.) would see decreases in federal spending in 2026 under Graham-Cassidy block grants and per capita caps.
	  ○ **All states** that have expanded Medicaid to date would see decreased federal funding in 2026.
	  ○ **Michigan** would receive $3.041 billion less in federal funding in 2026 than under current law.

ENDNOTES

[1] "Cost estimate for H.R. 1628, American Health Care Act of 2017," Congressional Budget Office, May 24, 2017: https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/americanhealthcareact.pdf

[2] "CBO aims to provide preliminary assessment of Graham-Cassidy bill by early next week," Congressional Budget Office, September 18, 2017: https://www.cbo.gov/publication/53116

[3] Jacob Leibenluft, Edwin Park, Matt Broadus, and Aviva Aron-Dine, "Like Other ACA Repeal Bills, Cassidy-Graham Plan Would Add Millions to Uninsured, Destabilize Individual Market," Center for Budget and Policy Priorities, September 18, 2017: https://www.cbpp.org/research/health/like-other-aca-repeal-bills-cassidy-graham-plan-would-add-millions-to-uninsured

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Suggested Citation: Foster Friedman, Megan; Udow-Phillips, Marianne. *Comparing Key Provisions: Affordable Care Act, American Health Care Act, and the Graham-Cassidy Proposal* (Ann Arbor, MI: Center for Healthcare Research & Transformation, September 2017)