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Graham-Cassidy-Heller-Johnson Summary

On Wednesday, September 13, 2017, Senators Lindsey Graham (R-S.C.), Bill Cassidy (R-La.), Dean Heller (R-Nev.) and Ron Johnson (R-Wisc.) introduced their bill, which is being referred to as "Graham-Cassidy", in a final attempt to repeal and replace the Affordable Care Act (ACA). The bill has many similarities to the Better Care Reconciliation Act (BCRA), which failed narrowly in the U.S. Senate this July. For example, both the Graham-Cassidy bill and BCRA proposed to convert Medicaid into a block grant program, give states the option to implement health care block grants for certain populations and repeal cost-sharing reduction (CSR) payments.

However, there are some key differences between Graham-Cassidy and BCRA. Like BCRA, the Graham-Cassidy bill proposes to repeal the Medicaid expansion by the end of 2019, but also allowed states that expanded Medicaid earlier than the ACA to get a match rate of 90 percent in 2018 and 2019; after 2019, the match rate would be reduced to zero percent. The bill would also wind down Medicare provider taxes, but at a higher rate. Unlike BCRA, the new bill does not repeal all of the ACA's taxes, but instead repeals only the individual mandate, the employer mandate, the tax on health savings accounts and the medical device tax.

On the individual marketplace side, the Graham-Cassidy bill allows for individuals to purchase a catastrophic plan, allows waivers for insurance companies to offer plans with smaller set of benefits than required by the ACA, and allows for waivers for insurance companies to charge higher premiums, except on the basis of gender. These provisions were not included in the BCRA proposal.

The largest change in Graham-Cassidy compared to the other Republican proposals is the inclusion of a Market Based Health Care Grant Program, which would set aside approximately $1.2 trillion in block grants by 2026. The goal of the program is to equalize federal contribution of Medicaid funding across states, expansion and non-expansion states. In calendar years 2019 and 2020, $10 billion and $15 billion, respectively, would be provided each year to "assist in the purchase of health benefits coverage and access disruption and responding to urgent health care needs within states."

Beginning in calendar year 2021, a new block grant formula would be implemented to distribute state funding based on the number of individuals eligible for Medicaid. In short, the funding is based on the total number of eligible Medicaid beneficiaries between 50 and 138 percent of Federal Poverty Level (FPL), and adjusted over time based on factors including severity of illness, demographics, wage rates, and income levels. Funding would be used to:

- Establish or maintain a program to help high-risk individuals purchase health benefits coverage
- Establish or maintain a program to enter into arrangements with health insurance issuers to assist in the purchase of health benefits coverage by stabilizing premiums and promoting market participation and plan choice in the individual market
- Provide payments for health care providers for the provision of services specified by the CMS Administrator
- Provide health insurance coverage by funding assistance to reduce out-of-pocket costs for individuals with individual health insurance coverage
- Establish or maintain a program or mechanism to help individuals purchase health benefits coverage
- Up to 20 percent of the funds can be used to provide health insurance coverage for individuals who are eligible for medical assistance under a State plan under Medicaid by establishing or maintaining relationships with health insurance issuers to provide such coverage

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