Summary of the Graham-Cassidy-Heller-Johnson Proposal
As Released on September 25, 2017

This document summarizes the updated proposal from Senators Graham, (R-SC), Cassidy (R-LA), Heller (R-NV), and Johnson (R-PA), which was released on September 25, 2017 as an amendment in the nature of a substitute for H.R. 1628, the American Health Care Act, as passed in the House of Representatives on May 4, 2017.[1] It updates a similar proposal from these Senators released on September 15, 2017. Major differences between this proposed amendment and the September 15 version are listed on page 2 of this summary.

In general, the Graham-Cassidy proposal would repeal, effective January 1, 2020, the provisions of the Affordable Care Act (ACA) providing for premium tax credits, cost-sharing subsidies, and expansion of Medicaid eligibility while also creating a new Market-Based Health Care Grant Program to fund state health insurance coverage programs. A total of $1.176 trillion in funding would be provided for these grants for 2020 through 2026. The individual and employer mandates would also be repealed, effective beginning in 2016.

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[1] The proposed legislation is undated but includes the reference mark LYN17752.

List of differences in September 25th Graham-Cassidy draft (LYN17752) from the earlier version (LYN17709):

- *Short Term Assistance for States* (Sec. 106). Specifies that in distributing the short-term assistance for states in 2019 and 2020, 5 percent of funds would go to low-density states (in this version defined as states with fewer than 30 individuals per square mile) and the other 95 percent would be distributed based on the state's share of low-income individuals (with incomes between 45% and 133% of the federal poverty level[2] (FPL)). In the previous version, low-density was defined as fewer than 15 individuals per square mile.
- *Market-Based Health Care Grant Program* (Sec. 106 and Sec. 204).
    - A state must include in its application a description of "how the State shall maintain access to adequate and affordable coverage for individuals with pre-existing conditions." In the previous draft, the state would describe how it "intends to" maintain such access.
    - A state must include in its application a certification that it will ensure compliance with a number of provisions of federal law involving: extension of coverage for dependents through age 25; standards relating to benefits for mothers and newborns; parity for mental health and substance use disorder benefits; provision of coverage for reconstructive surgery following a mastectomy; and prohibition of health discrimination on the basis of genetic information. (Note: All but the first of these was enacted prior to January 1, 2009; the earlier draft would have prohibited waiver of these provisions.)
    - Instead of requiring the Secretary to grant waivers of federal insurance laws upon request of the state, the new version of Graham-Cassidy (in a new section 204) provides that for 2020-2026, a state receiving funds under the program may establish insurance rules for programs and mechanisms it is operating using those funds that conflict with certain ACA requirements. The listed ACA requirements that a state could replace with its own (or with none) include: the Essential Health Benefits (including the cost-sharing limits and required metal levels), the prohibition on rate discrimination based on area and the 3:1 limits on age rating; the requirement that insurers provide preventive services without cost-sharing; the single risk pool requirement; and the required offering of child-only plans. States would need to describe both the criteria and the degree to which issuers may vary premium rates While the previous version explicitly permitted rating variations

[2] Income would be defined as modified adjusted gross income, which includes a 5% income disregard. So, for example, thresholds of 45% to 133% of the FPL would effectively be 50% to 138% of the FPL.

based on health status, this version does not. However, variations based on health status are not specifically prohibited in this version. The previous version also included language prohibiting rate variation based on constitutionally prohibited categories, such as race or national origin; the later version omits this prohibition.
    - The formula for making state allotments is changed to generally provide for a slower transition to more uniform per capita funding. As in the earlier draft, the initial funding level for 2020 is distributed based on federal payments to a state or individuals in the state for Medicaid expansion and ACA subsidies to a formula tied to a state's share of low-income individuals. [Note that the total dollar amount appropriated for distribution among the states is specified in the bill, and is less than the January 2017 CBO baseline.] Under the previous draft, for 2026 a state's allotment would equal the total appropriation times the state's share of low-income individuals. In this draft, the transition is more gradual and for 2026 the state's allotment is 60% based on its share of low-income individuals and 40% based on its 2025 allotment.
    - The formula for state allotments is further modified with respect to adjustments. The "coverage value adjustment" is dropped. New adjustments are added for "high-spending low-density states" (fewer than 30 people per square mile and per capita costs more than 20% above the national average) and "late expanding states" (states adopting the ACA Medicaid expansion beginning in 2016 or later). The start dates of the population risk adjustment, and state-specific population adjustment and clinical risk adjustment are delayed. CMS is given authority not to make the clinical risk adjustment if data are not available.
    - States would have to use at least 50% of their allotments to assist individuals with incomes between 45% and 295% of the FPL[2].
    - CMS would notify states of their base period amounts by November 1, 2019.
    - A state's allotment could not increase year-to-year by more than 25%.
    - A formula for redistributing any unused allotments is provided; the distribution would be based on a state's share of low-income individuals (45% to 133% of FPL).
    - Clarifies that applications are approved and allotments are made for a calendar year.
- *Section 1332 waiver funding* (Sec. 106). For 2020 through 2022, a state with an approved waiver under section 1332 of the Patient Protection and Affordable Care Act (PPACA) would receive the same amount of funds that it would have received under the waiver, except the funds would come from an appropriation of $500 million made for 2020 for this purpose through the Market-Based Health Care Grant Program.
- *Eligibility Determinations.* Does not repeal Sections 1411 and 1412 of PPACA regarding eligibility determinations for Exchange coverage and advance payment of premium tax credits (Sec. 102 of earlier draft).
- *Medicaid FMAP*. Does not reduce Medicaid matching rate for Puerto Rico and other territories (Sec. 119 of earlier draft)
- *Medicaid Per Capita Cap* (Sec. 123). Changes the Medicaid per capita cap provision:
    - Does not include exemption from the caps for low-density states (Sec. 124 of earlier draft).

- Provides an option for certain states that expanded coverage to ACA adults between July of 2015 and July of 2016 to choose four instead of eight calendar quarters for their base period.
- Gives the Secretary the authority to make adjustments to a state's base year data if it determines that the state took actions to manipulate such data.
- Adds several reporting requirements that were included in the Better Care Reconciliation Act but were not in the earlier Graham-Cassidy draft. Includes reporting on inpatient psychiatric hospital services and on children with chronic medical conditions.

- *FMAP changes* (Sec. 129). Adds a new section raising federal matching for two states (understood to be Alaska and Hawaii) for which the Secretary issued a separate poverty guideline for 2017 that is higher than the poverty guideline applicable to all other states.
- *Tax provision changes.* Eliminates the provision that would have provided for tax-favored status for certain primary care services paid for out of HSAs and would have defined them as qualified expenses for purposes of the individual medical expense deduction (Sec. 113 of the previous draft).

Title I

Sec. 101. Elimination of Limit on Recapture of Excess Advance Payments of Premium Tax Credits

Limits on recapture of advance payments of premium tax credits would be repealed. Any advance payments of the current premium tax credits under section 36B of the Internal Revenue Code (IRC) to a household in excess of the final amount determined on the household's tax return would be fully subject to recapture, effective for tax years beginning with 2018. Under current law, the recapture is limited for individuals with income below 400% of the federal poverty level (FPL). Specifically, for the 2017 tax year, the "recapture" of excess advance payments is limited to the following amounts, which would be repealed:

2017 limits on recapture of advanced payments of premium tax credits		
Household income as % of FPL	Tax Filing Status	
	Single	All other
Less than 200%	$300	$600
At least 200% but <300%	$750	$1,500
At least 300% but <400%	$1,275	$2,550

Sec. 102. Premium Tax Credit

The premium tax credit currently available under section 36B of the IRC would be repealed effective for tax years beginning in 2020.

In the interim, effective for tax years beginning in 2018, the definition of qualified health plan for purposes of the premium tax credit would be modified to exclude a plan that includes coverage for abortion other than for one necessary to save the life of the mother or with respect to a pregnancy that is the result of rape or incest.

Sec. 103. Modifications to Small Business Tax Credit

The small business tax credit provided under section 45R of the IRC would not apply to taxable years beginning after December 31, 2019.
In the interim, for taxable years beginning in 2018 and 2019, the credit would be modified to exclude plans that include coverage for abortions other than those necessary to save the life of the mother or with respect to a pregnancy that is the result of rape or incest.

Sec. 104. Individual Mandate

The penalty for individuals who fail to maintain minimum essential coverage (the "individual mandate") would be reduced to zero for months beginning after December 31, 2015.

Sec. 105. Employer Mandate

The penalty for employers failing to meet the shared responsibility requirements regarding health coverage under section 4980H of the IRC (the "employer mandate") would be reduced to zero for months beginning after December 31, 2015.

Sec. 106. Short Term Assistance for States and Market-Based Health Care Grant Program

Title XXI of the Social Security Act (The State Children's Health Insurance Program, or CHIP) would be amended to provide the two sources of funding for states described in what follows:

Short-term Assistance to Address Coverage and Access Disruption and Provide Support for States

For 2019 and 2020, Graham-Cassidy would authorize and appropriate funds for distribution by the Centers for Medicare & Medicaid Services (CMS) to participating health insurance issuers. (Funding would be $10 billion for 2019 and $15 billion for 2020.) The funds would be used for arrangements with issuers to assist in the purchase of health insurance coverage by addressing coverage and access disruption and responding to urgent health care needs within states. The funds appropriated would remain available until expended. No state matching requirements would apply to these funds.

For each year, 5 percent of funds would be distributed to low-density states (those with a population density of less than 30 individuals per square mile). The other 95 percent would be distributed to the other states taking into account the proportion of each state's population that are low-income individuals based on the most recent data available.

CMS would have 30 days from enactment to issue guidance to health insurance issuers regarding how to submit a notice of intent to participate in the program. An issuer would need to submit the notice of intent to participate for a year by March 31 of the previous year. CMS would determine the form and manner by which issuers would submit a notice of intent.

The notice of intent would include a certification by the issuer that the funds would be used to help stabilize premiums and promote state health insurance market participation and choice of plans offered in the individual market, and that other specified requirements were met. These include a certification that the funds would not be used by a state for an expenditure attributable to an intergovernmental transfer, certified public expenditure, or other expenditure used to finance the required non-federal share of expenditures for Medicaid or CHIP or any other provision of law. In addition, certain of the restrictions on the use of funds applicable to CHIP and specified at section 2105(c) of the Social Security Act (SSA) would apply to these payments; these prohibit use of funds for abortion, prohibit use of federal funds to meet non-federal matching requirements, and impose citizenship documentation requirements.

Market-Based Health Care Grant Program

Application and Certification Requirements

For 2020 through 2026, states could apply for Market-Based Health Care Grant Program funding based on allotments that are described below.

To be eligible for its allotment of funds for a calendar year, the state would submit to CMS an application by March 31 of the year preceding the grant year in a manner and form specified by CMS. If a state application was approved by CMS for a calendar year, it would be deemed to be approved for that year and each subsequent year through 2026. Only the 50 states and the District of Columbia would be eligible for allotments and payments (i.e., Puerto Rico and the territories would receive no funds). The grant application would describe how the state would use the funds to do one or more of the following:

(1) Establish or maintain a program or mechanism to help high-risk individuals purchase health benefits coverage,[3] including by reducing premium costs for plans offered in the individual market for individuals who do not have access to coverage offered through an employer. "High-risk individuals" is defined in this instance to mean those who have or are projected to have a high rate of utilization of health services, as measured by cost.
(2) 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 state health insurance market participation and choice in plans offered in the individual market.
(3) Provide payments for health care providers for the provision of health care services, as specified by CMS.
(4) Provide health insurance coverage by funding assistance to reduce out-of-pocket costs, such as copayments, coinsurance, and deductibles of individuals enrolled in plans offered in the individual market.

[3] The amendment does not define this term. However, title XXI of the Social Security Act, which this section of Graham-Cassidy amends, includes a definition (section 2110) of "health benefits coverage" in the context of the requirements on states to provide for child health assistance, i.e., payment for part or all of the cost of health benefits coverage for targeted low-income children that includes any of a specified set of health care services (e.g., hospital, physician services, etc.). (Abortion is included but only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.) Section 2210 of title XXI of the SSA also refers to section 2791 of the Public Health Service Act for the definition of "health insurance coverage."

(5) Establish or maintain a program or mechanism to help individuals purchase health benefits coverage, including by reducing premium costs for plans offered in the individual market for individuals who do not have access to coverage offered through an employer.
(6) Provide health insurance coverage for individuals who are eligible for Medicaid by establishing or maintaining relationships with health insurance issuers to provide such coverage.
(7) Establish coverage programs through arrangements with managed care organizations for the provision of health services to individuals who are not eligible for Medicaid or CHIP.

Included in the state application would be the following: (1) a description of how the state shall maintain access to adequate and affordable health insurance coverage for individuals with pre-existing conditions; (2) a certification that the Market-Based Health Care Grant dollars would be used only for the above listed activities and that none of that money would be used by the state for an expenditure attributable to an intergovernmental transfer, certified public expenditure, or any other expenditure to finance the non-federal share of expenditures required under any provision of law, including under the state's CHIP and Medicaid plans; ((3) a certification that the state will ensure compliance with sections 2714, 2725, 2726, 2727 and 2753 of the Public Health Service (PHS) Act, including with respect to programs and mechanisms funded by these allotments and (4) other information required by CMS. The PHS Act provisions for which compliance must be certified involve extension of coverage for dependents through age 25; standards relating to benefits for mothers and newborns; parity for mental health and substance use disorder benefits; provision of reconstructive surgery following mastectomy; and prohibition of health discrimination on the basis of genetic information.

Other requirements for states seeking Market-Based Health Care Grant Program funds are set forth in section 204, which is summarized below. In brief, a state applying for grant funds under the grant program that indicates it would use the grant funds to directly assist individuals buying coverage in the state's individual insurance market would be required to provide additional information regarding the insurance rules that would apply to that coverage (e.g., premium rating variation, benefit levels, and premiums for individuals with pre-existing conditions).

Market-Based Health Care Grant Allotments

For purposes of providing Market-Based Health Care Grant Program allotments to the states, the amendment would appropriate $146 billion for each of calendar years 2020 and 2021; $157 billion for 2022; $168 billion for 2023; $179 billion for 2024 and $190 billion for each of 2025 and 2026. For 2020, $10 billion of the appropriated amount would be reserved for advance payments to states as described under "Payment to States" below. CMS would allot to each state an amount determined for the state and year as described below. Amounts allotted to a state for a year would remain available[4] through December 31 of the second year following the allotment

[4] The amendment says that amounts would remain available to a state *for obligation* for two years following the allotment year. This conflicts with language that follows requiring that any amounts unobligated by April 1 of the year following the allotment year be returned to the US Treasury. It is likely that the authors intend that amounts would be available to a state *for expenditure* for two years following the allotment year. This is consistent with existing language in section 2105 of the SSA regarding CHIP grants.

year, except that no amounts allotted for any year before 2027 would be available for obligation by a state after December 31, 2026. Amounts allotted to a state for a year that remain unobligated by the state on April 1 of the following year would have to be returned to the U.S. Treasury.

Generally, a state could not use more than 15% of its grant allotment for the year to provide health insurance coverage for individuals who are eligible for Medicaid by establishing or maintaining relationships with health insurance issuers. However, the Secretary could permit a state to use up to 20% if the state applied to waive that restriction and the Secretary determined that the state was using the allotment to supplement and not supplant its own expenditures on Medicaid.

At least 50% of a state's allotment for a year would have to be used to provide assistance, under the permitted uses of funds described above, to individuals with income no less than 45% and no greater than 295% of the FPL[2].

Determination of Allotment Amounts

The amounts appropriated for the Market-Based Health Care Grant Program for 2020 through 2026 would be allocated among the states using specified formulas.

A state's 2020 allotment would equal the sum of the following four payment amounts from a "premium assistance base period" selected by the state and inflated, as described below:

- Federal payments made to the state for the Medicaid ACA adult expansion population or federal payments that would have been made under the ACA expansion provisions in the case of a state with a Medicaid waiver in effect as of September 1, 2017 to cover individuals that would meet the expansion group definition but limited to those with incomes up to 100% of the FPL.[5]
- Federal payments made to the state for operating a Basic Health Program.
- Advance payments for premium assistance tax credits made to individuals in the state under section 36B of the IRC.
- Federal payments for cost-sharing reductions provided to individuals in the state.

The premium assistance base period used to determine these amounts would consist of four consecutive fiscal quarters selected by the state within the time period beginning January 1, 2014 and ending with the first fiscal quarter of 2018 for which all necessary data are available. The state would have to identify this period by July 1, 2018.

Each of the four base-period component amounts would be increased by a growth factor for the period beginning with the last month of the state's chosen premium assistance base period to November 2019. The growth factor for the Medicaid component would be determined by the Medicaid and CHIP Payment and Access Commission (MACPAC), and for the other

[5] This appears to refer to Wisconsin.

components would be the medical component of the Consumer Price Index for all urban consumers.

A “high-spending low-density” adjustment would apply to any state that during the base period is low-density (defined as above as less than 30 individuals per square mile) and has health care spending per capita that is more than 20 percent above the mean for all states (as determined by CMS). For these states, the base period amount would be increased by the percentage by which the state’s health care spending per capita exceeds the mean for all states.

CMS would notify each state of its base period amount no later than November 1, 2019. If there is insufficient data to make these determinations, CMS would calculate a preliminary base period amount based on the most recent data available and notify states by the November 1, 2019 deadline of that amount, and then calculate the base period amount and notify states as soon as practicable after the necessary data become available.

For 2021 through 2026, each state’s allotment would equal the sum of two components: a fraction of the state’s allotment for the previous year and a fraction of the state’s “low-income population amount.” The low-income population amount would equal the total appropriation for the year times the state’s share of low-income individuals nationally, defined as citizens or legal residents with incomes greater than 45% of the FPL but less than 133% of the FPL. Specifically, a state’s allotment would equal:

- 2021: $9/10^{th}$ of the state’s 2020 allotment plus $1/10^{th}$ of the state’s low-income population amount for 2021
- 2022: $8/10^{th}$ of the state’s 2021 allotment plus $2/10^{th}$ of the state’s low-income population amount for 2022
- 2023: $7/10^{th}$ of the state’s 2022 allotment plus $3/10^{th}$ of the state’s low-income population amount for 2023
- 2024: $6/10^{th}$ of the state’s 2023 allotment plus $4/10^{th}$ of the state’s low-income population amount for 2024
- 2025: $5/10^{th}$ of the state’s 2024 allotment plus $5/10^{th}$ of the state’s low-income population amount for 2025
- 2026: $4/10^{th}$ of the state’s 2025 allotment plus $6/10^{th}$ of the state’s low-income population amount for 2026

If necessary, state allotments for a year (including all adjustments) would be prorated proportionately to assure that the total amount allotted to states under the Market-Based Health Care Grant Program does not exceed the total amount appropriated for this purpose for the year. If the total allotments are less than the amount appropriated, states would receive an adjustment as described below.

A state’s allotment for a year after 2020 could not exceed its allotment for the prior year by more than 25 percent.

Adjustments

A state's allotment could be subject to several adjustments.

- Beginning with 2023, CMS would be required to apply a population risk adjustment to the state allotments for each year. The adjustment is intended to reflect the clinical characteristics of each state's low-income population. The calculation is described further below. This adjustment could not increase or reduce a state's allotment for a year by more than 10%. It would be phased in so that the calculated adjustment amount would be reduced by 75% in 2021, 50% in 2022, and 25% in 2023. The full adjustment would apply in subsequent years. CMS would have the authority not to make the adjustment for any year for which it determines the data are insufficient to calculate this adjustment.
- Beginning with 2023, CMS could also apply a state-specific population adjustment factor. No later than July 31, 2021, CMS would have to develop a state-specific population adjustment factor that "accounts for legitimate factors that impact health care expenditures in a state beyond the clinical characteristics of low-income individuals in the state." Examples of factors that CMS may include are state demographics, wage rates, cost of care, and income levels. CMS could include other factors.
- A state would have its 2026 allotment reduced by the amount of any advance payments provided to the state in 2020, as described below under "Payments to States".
- Contingency funds would be made available with which the Secretary could increase the allotment for 2020 or 2021. Appropriations for this purpose total $6 billion for 2020 and $5 billion for 2021. Of these totals, 25% would be used for low-density states; 50% for non-expansion states (have not adopted the ACA Medicaid adult expansion as of September 1, 2017) that are not low-density; and 25% for expansion states that are not low density.
- For 2023 through 2026, a "late expanding state" would receive an increased allotment. These are states that provide for the ACA Medicaid expansion beginning after December 31, 2015. The amount of the adjustment would equal the total appropriation for this purpose for the year ($750 million for each of 2023 through 2026) times the state's share of all low-income individuals nationally (citizens or legal residents with incomes greater than 45% of the FPL but less than 133% of the FPL).
- For any year, if the total allotments sum to less than the appropriated amount, each state's allotment would be increased by an amount equal to the difference between the total appropriation and that sum times the state's share of all low-income individuals nationally (i.e., individuals with incomes greater than 45% of the FPL but less than 133% of the FPL).

Population risk adjustment would be based on clinical risk categories established by CMS by January 1, 2022. These categories would be mutually exclusive such that every low-income person would be assigned to a single clinical risk category; those assignments would also have to be completed by January 1, 2022. The methodology for creating the categories and assigning individuals would account for clinical characteristics that affect per capita health care expenditures. It would be based on information on individuals routinely collected in administrative claims data, and able to use data on pharmacy and functional health status once these data become routinely available. To the extent possible, the methodology would be one

that has been used by a state Medicaid plan to make per capita payments to managed care plans that include enrollees with complex pediatric conditions as well as Medicare and Medicaid dual eligibles. The methodology would account for multiple chronic conditions, would differentiate individuals into risk categories based on severity of illness, and would account for complex pediatric enrollees. Updates to the methodology would be made public no later than 15 days before the start of each calendar year.

The population risk adjustment would equal the state's population risk index times the unadjusted state allotment. Calculation of each state's population risk index would begin with determining a clinical risk factor for each clinical risk category. This factor would be equal to the ratio of average per capita expenditures across all states in the previous year for low-income individuals in the risk category to average per capita expenditures across all states for all low-income individuals in the category. For a state, for each clinical risk category, the clinical risk factor would be multiplied by the number of low-income individuals in the state in the clinical risk category and these products would be summed across all categories. The population risk index for the state would equal this sum divided by the number of enrollees in the state.

Payment to States

The CMS Administrator would pay each state from the allotment assigned to it an amount equal to the state's expenditures for the year on the activities identified in the approved application. Such payments could be made for six-month periods based on advance estimates of expenditures submitted by the state, with adjustments for previous under- or over-payments. CMS would be authorized to withhold or reduce payments to a state or recover previous payments to a state as appropriate if a determination is made that the state is not using funds in a manner consistent with the approved application or is inappropriately withholding payments to providers or health insurance issuers. States would have flexibility to claim payment for expenditures that were incurred in a previous year.

For 2020, $10 billion of the $146 billion appropriated amount would be reserved for an "advance payment fund" from which the Secretary may, at a state's request, increase the state's allotment for 2020 by an amount that may not exceed 5% of the state's allotment. These increases would be prorated across receiving states if the requested amounts totaled more than $10 billion. The reserved funds would be available for this purpose until December 31, 2020. Any unused funds would be made available for state allotments in 2026. As described above, a state that receives an advance payment in 2020 would have that amount subtracted from its 2026 allotment. Any advance payment made to a state under this provision would not affect the state's 2021 allotment.

Certain of the restrictions on the use of funds under section 2105(c) of the SSA would not apply to the state payments for market-based health care grants. Those that would be retained prohibit the use of funds for abortion, prohibit the use of federal funds to meet non-federal matching requirements, and impose citizenship documentation requirements.

Other technical amendments are made to Title XXI meant to separate the new grant program from CHIP but still apply certain requirements to the new program.

Payments for Section 1332 Waivers

A state that prior to enactment of Graham-Cassidy was granted a waiver under section 1332 of PPACA would receive related payments from the Market-Based Health Care Grant Program for calendar years 2020 through 2022. A state's payments for these years would equal the amount the state would have received under the section 1332 waiver. A total of $500 million would be appropriated for this purpose in 2020, to remain available until December 31, 2023.

Sec. 107. Better Care Reconciliation Implementation Fund

The sum of $2 billion would be appropriated to a new fund within HHS to provide for administrative expenses in implementing the provisions of Graham-Cassidy.

Sec. 108. Repeal of Tax on Over-the-Counter Medications

Section 223(d)(2)(A) of the IRC would be amended to allow reimbursements from Health Flexible Spending Accounts (FSAs) and Health Reimbursement Arrangements (HRAs) and distributions from Health Savings Accounts (HSAs) or Archer Medical Savings Accounts (MSAs) to be used for over-the-counter medications, and those amounts would be excluded from the taxpayer's income. In the case of HSAs and MSAs, the provision would be effective for amounts paid with respect to taxable years beginning after December 31, 2016. In the case of health FSAs and HRAs, it would be effective for expenses incurred for taxable years beginning after December 31, 2016.

Sec. 109. Repeal of Increase in Tax on Health Savings Accounts

The tax imposed on distributions from HSAs for nonqualified medical expenses (section 223(f)(4)(A) of the IRC) would be reduced from 20% to 10%. The tax imposed on distributions from Archer MSAs (section 223(f)(4)(A) of the IRC) would be reduced from 20% to 15%. These changes would apply for distributions made after December 31, 2016.

Sec. 110. Repeal of Medical Device Excise Tax

Section 4191 of the IRC providing for an excise tax on medical devices would be amended so that the tax would not apply to sales after December 31, 2017.

Sec. 111. Repeal of Elimination of Deduction for Expenses Allocable to Medicare Part D Subsidy

Section 139A of the IRC currently provides that a deduction for qualified retiree health prescription drug expenses that would otherwise be allowable to a taxpayer (i.e., an employer) is not available if the taxpayer excludes from income qualified retiree prescription drug plan subsidies received from HHS with respect to those expenses (i.e. the taxpayer cannot deduct prescription drug expenses if the retiree also has prescription drug coverage through an employer that is subsidized by HHS). This section would be amended effective for taxable years beginning after December 31, 2016 to provide that such a taxpayer would be able to claim a deduction for

covered retiree prescription drug expenses even though that taxpayer excluded from income qualified retiree prescription plan subsidies received from HHS.

Sec. 112. Purchase of Insurance from Health Savings Accounts

The permissible use of HSA funds would be modified in two ways. First, funds could be used for medical care for children up to age 27, effective for expenses incurred after December 31, 2017. Second, funds could be used to pay for premiums for insurance coverage under a high deductible health plan beginning after December 31, 2017 to the extent that the payments are in excess of other tax-favored treatment. Specifically, HSA funds could be used to pay for (i) high deductible plan costs in excess of any premium tax credit amount provided under section 36B of the IRC, (ii) any amount allowable as a medical expense deduction, or (iii) any amount excludable from gross income with respect to employer coverage (including cafeteria plans).

Sec 113. Maximum Contribution Limit to Health Savings Accounts

Sections 223(b)(2)(A) and (B) of the IRC (relating to HSAs) would be amended to increase the maximum contribution limit to a qualified HSA (which, for 2017, is $3,400 for self-only coverage and $6,750 for family coverage) to the sum of the annual deductible and out-of-pocket limit permitted under the taxpayer's high deductible health plan. For 2017, those deductible/out-of-pocket limit amounts are $6,650 in the case of self-only coverage and $13,100 in the case of family coverage. As under current law, the basic HSA contribution limits would be increased by $1,000 for an eligible individual who has attained age 55 by the end of the taxable year. The changes would apply for taxable years beginning after December 31, 2017.

Sec. 114. Allow Both Spouses to Make Catch-up Contributions to the Same Health Savings Account

Section 223(b) of the IRC would be amended to provide that, if both spouses are eligible for catch-up contributions to their HSAs and either has family coverage, the annual contribution limit that can be divided between them would include the catch-up contribution amount of both spouses. (Catch-up contributions increase the basic HSA contribution limit by $1,000 for an eligible individual who has attained age 55 by the end of the taxable year.) The provision applies for taxable years beginning after December 31, 2017.

Sec. 115. Special Rule for Certain Medical Expenses Incurred Before Establishment of Health Savings Account

Section 223(d)(2) of the IRC would be amended by adding a new subparagraph (D) providing that if an HSA is established during the 60-day period beginning on the date that coverage of the account beneficiary under a high deductible health plan begins, then solely for purposes of determining whether an amount paid is used for a qualified medical expense, the HSA would be treated as having been established on the date that the coverage began. In other words, if a taxpayer with a high deductible health plan established an HSA within 60 days of the date that the high deductible plan coverage began, any payment made by the taxpayer from the HSA for a qualified medical expense incurred during that 60-day period would be excludable from their

gross income. This provision would apply with respect to coverage beginning after December 31, 2017.

Sec. 116. Exclusion from HSAs of High Deductible Health Plans Including Coverage for Abortion

Requirements for high-deductible health plans applicable to health savings accounts (i.e., the plans in which an individual must be enrolled to qualify for an HSA deduction) would be modified to prohibit coverage of abortion, other than an abortion necessary to save the life of the mother or any abortion with respect to a pregnancy that is the result of an act of rape or incest. This change would be effective for coverage under such plans beginning after December 31, 2017.

Sec. 117. Federal Payments to States

For the one-year period beginning on the date of enactment of Graham-Cassidy, States would be prohibited from using federal funds in making payments to a prohibited entity (whether the payments are made directly to the entity or through a managed care organization under State contract). The criteria for a prohibited entity, which are almost identical to the provision contained in the Better Care Reconciliation Act would include Planned Parenthood. However, Graham Cassidy lowers the dollar threshold for the definition of prohibited entities to include entities for which total federal and state Medicaid payments made in 2014 exceeded $1 million (as compared to $350 million in the Better Care Reconciliation Act). Thus, the prohibition will apply more broadly and potentially to different financial arrangements.

Restricted federal funds would be those made as direct spending (i.e., provided by law other than appropriation acts; entitlement authority; and the Supplemental Nutrition Assistance Program) and would include payments made to the states under section 1115 or 1915 waivers of the SSA.

Sec. 118. Medicaid

Sunset of ACA Expansion Provisions. Graham-Cassidy would sunset the Medicaid expansion provisions of the ACA on December 31, 2019 for states that provided such coverage as of July 1, 2016, or on September 1, 2017 for all other states. The sunset would apply both to the Medicaid coverage pathway for non-elderly adults whose income is below 133% of federal poverty level (FPL) (section 1902(a)(10)(A)(i)(VIII) of the SSA)[6] as well as the pathway for those whose income is above 133% of the FPL (section 1902(a)(10)(A)(ii)(XX)).

A new optional eligibility group would become available beginning January 1, 2020 for members of an Indian Tribe who were enrolled in Medicaid on December 31, 2019 under 1902(a)(10)(A)(i)(VIII). Qualifying Indian Tribe members could remain enrolled as long as they do not have a break in coverage. States would specify the length of the break in coverage but it could be no less than 6 months.

[6] Taking into account standard income disregards, the income limitation for this eligibility pathway is 138% FPL.

Elimination of Enhanced Matching Rate for Childless Adults. The proposal would eliminate the enhanced federal matching payment rate for expansion enrollees at the end of calendar year (CY) 2019. Under current law, the enhanced federal matching share of program costs (the EFMAP) for this population is equal to 95% for CY 2017, descending to 93% for CY 2019 and 90% for CY 2020 and each year thereafter.

Elimination of Enhanced Match for Early Adopter States. The proposal would also amend the formula for enhanced federal matching payment percentages for "early adopter states," or those states that expanded Medicaid for low-income adults before March 23, 2010. Under current law, for those states, the federal match is phasing up from the state's regular FMAP for medical assistance services to the EFMAP for ACA expansion enrollees so that for CY 2017, a state will receive 80% of the difference between those two percentages; in CY 2018, they will receive 90% of that difference; and beginning in CY 2019 a state will reach the full EFMAP for ACA expansion enrollees. Under Graham-Cassidy, an early adopter state would stop phasing up at the 2018 percentage – or 90% of the difference between the state's regular FMAP and the EFMAP. For CY 2019, 90% would apply. Beginning with CY 2020, a state's regular FMAP would apply.

Sunset of Medicaid Essential Health Benefits Requirement. The requirement that benefits provided to ACA expansion enrollees include the coverage of essential health benefits would be eliminated after December 31, 2019.

Presumptive Eligibility. The ACA provision requiring states to allow hospitals to make presumptive eligibility determinations for all categories of Medicaid beneficiaries would be repealed beginning January 1, 2020. Any existing elections by hospitals to conduct presumptive eligibility determinations under this provision would cease to be effective beginning on that date.

In addition, Graham-Cassidy would eliminate the option for states to provide for presumptive eligibility for certain other groups beginning December 31, 2019. States would no longer be allowed to provide for presumptive eligibility for older foster care children; certain families qualifying under Transitional Medical Assistance (section 1931 of the SSA); and for adults qualifying under the ACA expansion groups (which would sunset, as described above.)

States would continue to have the option under separate authority to authorize "qualified entities" including hospitals to make presumptive eligibility determinations for children, pregnant women, and women qualifying on the basis of having breast or cervical cancer.

Enhanced Federal Matching Payments for Attendant Care Services. The proposal would eliminate the additional six percentage point federal match for states that provide community-based attendant services and supports. Standard federal matching rates would apply to state spending on those services beginning January 1, 2020.

Coordination with Exchanges. Graham-Cassidy would eliminate, beginning January 1, 2020, requirements that states coordinate with state health insurance Exchanges.

Sec. 119. Reducing State Medicaid Costs [Retroactive Eligibility]

The requirement that states provide for 3 months of retroactive eligibility would be shortened for certain Medicaid beneficiaries. Under current law, Medicaid eligibility begins at the start of the third month before the month in which the person made their application. Under Graham-Cassidy, for Medicaid beneficiaries who are under age 65, not blind or disabled, effective on October 1, 2017, eligibility would begin at the start of the second month before the month in which the individual made their application.

Sec. 120. Eligibility Redeterminations

Beginning on October 1, 2017, states would have the option, when determining eligibility for ACA expansion groups (sections 1902(a)(10)(A)(i)(VIII) and 1902(a)(10)(A)(ii)(XX) of the SSA) whose financial eligibility is based on modified adjusted gross income, to re-determine Medicaid eligibility as often as every 6 months or more frequently.

Federal matching payments for state spending attributable to increasing the frequency of re-determining eligibility would be increased by five percentage points for states for calendar quarters beginning on October 1, 2017 and ending on December 31, 2019.

Sec. 121. Optional Work Requirement for Nondisabled, Non-elderly, Non-pregnant Individuals

States would be permitted to elect, beginning October 1, 2017, to condition medical assistance for adult beneficiaries who are non-disabled, non-elderly, and not pregnant, on their satisfaction of a work requirement.

Work requirements under this section are those defined in section 407(d) of the SSA (pertaining to federal requirements for the Temporary Assistance for Needy Families program) and include unsubsidized employment, subsidized private or public sector employment, on-the-job or vocational training, job search and job readiness assistance, community services programs, vocational education, job skills training, education related to employment and secondary school attendance.

A state could not apply work requirements to pregnant women for 60 days post-partum; children under age 19; individuals who are the only parent or caretaker of a child under the age of 6 or the only parent or caretaker of a child with a disability; individuals under age 20 who are married or the head of the household and who maintain satisfactory attendance at school or participate in education directly related to employment; those participating in an inpatient or intensive outpatient drug addiction or alcohol treatment program; or to full time college students.

The administrative matching rate would be increased by 5 percentage points for the costs of carrying out work requirements.

Sec. 122. Provider Taxes

Under current Medicaid law, states are prohibited from enacting provider taxes that hold the providers harmless by guaranteeing, directly or indirectly, that the providers will be repaid for the amount of taxes they pay. The test for such a guarantee, however, does not apply to those taxes for which the tax rate falls below 6% of the provider's net patient revenue. This provision is commonly referred to as the "safe harbor." The Graham-Cassidy proposal would gradually reduce the safe harbor to 4%. The safe harbor would be reduced to:

- 5.6% for FY 2021;
- 5.2% for FY 2022;
- 4.8% for FY 2023;
- 4.4% for FY 2024; and
- 4% for FY 2025 and thereafter.

Sec. 123. Per Capita Allotment for Medical Assistance

(a) Section 1903A of the SSA Per Capita-Based Cap on Payment for Medical Assistance
Federal financing of the Medicaid program would be modified by instituting a cap on federal payments for most program spending as described in new section 1903A of the SSA.

Application of Per Capita Cap on Payment for Medical Assistance Expenditures. An aggregate cap would be applied to most federal payments for state Medicaid programs beginning with fiscal year 2020. To the extent that a state Medicaid program makes payments in excess of its aggregate cap for the portion of the program subject to the cap, federal payments to that state in the following fiscal year would be reduced by the federal share of the amount by which state program spending exceeded the aggregate cap.

The Secretary would have the authority to exclude from a state's cap, during the period from January 1, 2020 to December 31, 2024, spending for a Public Health Emergency. Each state experiencing a Public Health Emergency during that period would be limited to excluding only the additional costs to Medicaid in the areas affected by the emergency attributable to the emergency. That would be calculated based on the costs of Medicaid for 1903A (defined below) enrollees during the emergency compared to costs for those enrollees during a recent fiscal period before the emergency took effect. The Secretary would only be authorized to subtract, in aggregate, no more than $5 billion for all states and Public Health Emergencies during the period.

The proposal includes definitions for *excess aggregate medical assistance expenditures*, *excess aggregate medical assistance payments*, *federal average medical assistance matching percentage*, and *per capita base period*. Under the amendment, the base period for the application of the caps would be a period of eight consecutive fiscal quarters that may start with the first fiscal quarter of 2014 and end as late as the third fiscal quarter of 2017 (or, for states that expanded coverage to ACA expansion adults between July 1st of 2015 and July 1st of 2016, a period of no fewer than four fiscal quarters). State would select the base period and inform the Secretary of their choices by January 1, 2018.

Adjusted Total Medical Assistance (MA) Expenditures. Several definitions necessary for calculating caps and spending subject to caps are provided in 1903A(b) of the proposal.

- Defines "Adjusted Total MA Expenditures" for a state as follows:
  - For a state's base period, adjusted total MA expenditures are MA expenditures (defined below) excluding DSH payments, Medicare cost sharing payments, and spending for public health emergencies multiplied by the 1903A base period population percentage[7]; and
  - For 2019 or a subsequent fiscal year, adjusted total MA expenditures are MA expenditures excluding DSH payments, Medicare cost sharing payments and spending for public health emergencies. They specifically *exclude* payments for pediatric vaccines and specifically *include* non-DSH supplemental payments and other supplemental payments such as delivery system reform incentive payments and uncompensated care fund payments (referred to as "pool payments"). With respect to non-DSH supplemental and pool payments (defined in (d) below), the proposal would treat all of those payments as being attributable to 1903A enrollees.
- MA Expenditures would be defined as those payments reported by medical service category on Form CMS-64.
- The 1903A Base Period Population Percentage would be defined as the percentage of MA spending reported on Form CMS-64 for calendar quarters in the state's per capita base period that are attributable to 1903A enrollees (defined below) to be Medicaid beneficiaries who fall into four groups: Elderly; Blind or Disabled (excluding children who are blind and disabled); Children; and Other non-elderly, non-disabled, non-expansion Adults.

Since the base period can be comprised of four or more quarters, amounts that states report for a base period that is longer than 4 quarters would be adjusted to a four-quarter average. The Graham-Cassidy draft would give the Secretary the authority to adjust data received by a state if it determines that a state took actions after the date of enactment to diminish the quality of data (including, for example, by making retroactive adjustments to payments) for quarters in its base period.

Target Total MA Expenditures. The provision describes each state's cap, or target total MA expenditures for 2020, as equal to the sum of four amounts – each the product of a provisional target per capita amount for 2019 for each enrollee category increased by the applicable annual inflation factor for 2020 multiplied by the number of 1903A enrollees in each group. For years after 2020, each state's cap, or target total MA expenditures, would be equal to the target per capita MA expenditures for the prior year increased by the applicable annual inflation factor.

For fiscal years (FYs) 2020 - 2024, the applicable annual inflation factor would be equal to the medical component of the Consumer Price Index (medical-CPI) for two of the groups: non-disabled children, and other adults. For the other two groups, the elderly and those who are blind

[7] It is unclear if amounts for the base period are intended to include or exclude non-DSH and pool supplemental payments and payments for the Vaccines for Children's program.

or disabled excluding children, the index would be equal to the medical-CPI plus 1 percentage point.

For FY 2025 and thereafter, the applicable annual inflation factor for two of the groups: non-disabled children, and other adults would be the CPI for all urban consumers (CPI-U). For the other two groups, the elderly and those who are blind or disabled excluding children, the index would be equal to the medical-CPI.

Adjustments to State Expenditures to Promote Equity. Beginning in FY2020, target total MA expenditures for certain states would be adjusted upward or downward depending on each state's spending in the prior year. For FYs 2020 and 2021, this adjustment would be made by comparing a state's per capita MA spending for all individuals subject to the per capita caps together rather than in four separate categories. For all other years, the adjustments would be made based on per capita spending for each category of enrollees.

The Secretary would be required to make the following adjustments in a way that would not result in a net increase in federal payments and would not apply these adjustments to any state with a population density of fewer than 15 people per square mile.

- A state with per capita MA spending for the prior year for a category of enrollees that is higher than the mean per capita spending for all states for that group of enrollees and for that year by 25% or greater would be subject to a reduction in its target per capita MA expenditures for that category for the fiscal year. The reduction would be by a percentage between 0.5% and 2%. (The precise percentage reduction is left to the discretion of the Secretary.)
- Likewise, a state with per capita MA spending for the prior year for a category of enrollees that is lower than the mean per capita spending for that group of enrollees for that year by 25% or more would be subject to an increase in its target per capita MA expenditures. The increase would be by a percentage between 0.5% and 3%. (Again, the precise percentage reduction is left to the discretion of the Secretary.

The adjustment made to per capita MA spending amounts under this section would be disregarded when determining a state's target MA spending amounts for the next year.

Calculation of FY 2019 Provisional Target Amount for Each 1903A Enrollee Category. This section of the proposal describes how provisional target per capita amounts for 2019 would be calculated. It also provides definitions for several other factors used for adjusting the per capita amounts.

- *Provisional per capita target amount for each 1903A enrollee category*. For each of the four 1903A enrollee groups, the average MA spending per capita for the state for FY 2019 would be calculated by dividing FY 2019 MA payments (minus non-DSH supplemental and pool payments) for 1903A enrollees by the number of 1903A enrollees and increasing those amounts by the non-DSH supplemental and pool payment percentage.

- Non-DSH supplemental payments are payments to providers that are not DSH payments; are not made with respect to a specific item or service; are in addition to payments for specific items or services; and are compliant with requirements related to upper payment limits (defined in section 1903(d)(4)(A)(ii) of the SSA). Pool payments are those that are not DSH payments; not made with respect to a specific item or service; are in addition to payments for specific items or services; and are authorized under a waiver that funds delivery system reform, uncompensated care pools, certain designated health programs or a similar expenditure (defined in section 1903(d)(4)(A)(iii) of the SSA).
- The state's non-DSH supplemental and pool payment percentage would be defined as the state's spending for non-DSH supplemental and pool payments in the base period divided by the state's total adjusted medical assistance spending in the base period as described in new 1903A(b)(1)(A)[8]. These amounts would be divided by two to adjust to four quarters.

Those amounts are then adjusted up or down by the following ratio to match reported overall spending for 2019:

$$\frac{(\textit{Overall average per capita for } 2019 \ \mathbf{X} \ \textit{The number of } 1903A \textit{ enrollees in } 2019)}{\textit{Adjusted total medical assistance in } 2019}$$

- A base year *overall average per capita amount* would be calculated for each state based on adjusted total MA spending for the base year for the state divided by the number of 1903A enrollees on the state's program in that year. That amount for each state would be inflated to 2019 using the CPI-U (from the last month of the state's base period to September of FY 2019) to produce a FY 2019 *overall average per capita* amount for each state.

- *Notice*. The Secretary would provide notice to each state no later than January 1, 2020 of the amount of the adjusted total MA expenditures for the base year, the number of 1903A enrollees for the base period, the average per capita MA spending for the base period, the provisional FY 2019 per capita target amount as well as the non-DSH supplemental and pool payment percentage.

1903A Enrollee; 1903A Enrollee Category. The four enrollee groups that would be subject to per capita caps are:

- Enrollees who are 65 years of age or older;
- Enrollees who are blind or disabled (those eligible for medical assistance on the basis of being blind or disabled who are not 65 years and not under age 19);
- Non-disabled children under 19 years of age;
- Other non-elderly, non-disabled, non-expansion adults.

[8] As noted above, it is unclear if amounts for the base period are intended to include all non-DSH and pool supplemental payments and payments for the Vaccines for Children program raising concerns that the authority to make some non-DSH supplemental and pool payments will be lost.

The following categories of enrollees would not be considered 1903A enrollees and therefore not subject to caps: children under age 19 who are eligible for medical assistance on the basis of being blind or disabled; individuals covered under a CHIP Medicaid expansion program; individuals who receive medical assistance through an Indian Health Service facility; women receiving Medicaid coverage due to screening under the Breast and Cervical Cancer Early Detection Program; and partial benefit enrollees. Partial benefit enrollees are those receiving only family planning services; tuberculosis-related services for those infected with TB; those unauthorized aliens receiving coverage for Medicaid emergency medical care; individuals who are dually eligible for Medicaid and Medicare and for whom Medicaid pays only Medicare premiums and cost-sharing; and individuals receiving Medicaid premium assistance.

Special Payment Rules. Medical assistance spending under waivers approved under SSA section 1115, SSA section 1915, or any other provision of Medicaid would be subject to the per capita caps in the same manner as if such payments had been made under the usual Medicaid program. The per capita caps described in this section would supersede any other payment limitations that apply under those waivers.

If a state failed to satisfactorily submit data on spending and enrollees the Secretary would calculate and apply the caps as if all 1903A enrollee categories for which the spending and enrollee data were not satisfactorily submitted were a single 1903A enrollee category, and the growth factor otherwise applied would be reduced by one percentage point.

Recalculation of Certain Amounts for Data Errors. The Secretary would be permitted to adjust several amounts used to calculate caps based on an appeal by a state filed in such form, manner, time, and containing such information as specified by the Secretary. Any adjustment that the Secretary determines is valid may be made except that the adjustment could not result in an increase of the target total medical assistance expenditures in excess of 2%. Amounts that would be permitted to be adjusted would be: excess spending amounts, federal average medical assistance percentages, non-DSH supplemental and pool payment percentages, adjusted total MA payments and the number of Medicaid enrollees and 1903A enrollees for the base period, 2019 and subsequent fiscal years.

Required Reporting and Auditing of CMS-64 Data; Transitional Increase in Federal Matching Percentage for Certain Administrative Expenses. For each quarter beginning on or after October 1, 2018, states would be required to include data on medical assistance spending within such categories of services and enrollees as the Secretary determines are necessary and for which the Secretary provides “timely” guidance published as soon as possible after the date of the enactment.

The proposal would also require the Secretary to modify CMS-64 forms and requires states to begin submitting data on inpatient services provided in an institution for mental disease for which payment would become available under section 126 of Graham-Cassidy and on the number of children enrolled in Medicaid or CHIP who are under age 21 and who have a chronic medical condition or serious injury that: (1) affects two or more body systems; (2) affects cognitive or physical functioning (such as reducing the ability to perform the activities of daily

living); and (3) either requires intensive healthcare interventions and intensive care coordination or meets the criteria for medical complexity under existing risk adjustment methodologies.

The Secretary would be required to audit each state's reporting of the number of individuals and spending reported through the CMS–64 report for a state's base period, FY 2019, and each subsequent fiscal year. The Secretary could use a representative sample for such audits. The HHS Inspector General would also be required to conduct an audit of each state's spending no less frequently than once every three years.

Temporary Increase in Federal Matching Percentage to Support Improved Data Reporting Systems**.** The federal share of costs for certain activities would be increased. The proposal would provide raise the federal matching percentages for calendar quarters beginning on or after October 1, 2017 and before October 1, 2019 by:

- 10 percentage points (to 100%) for the design, development, and installation of mechanized claims processing and information retrieval systems; and
- 25 percentage points (to 100%) for the operation of such systems.

If the state does not meet those criteria in a year after 2020, then per capita caps would go into effect.

(b) Ensuring Access to Home and Community Based Services. The legislation would establish a new four-year demonstration program under section 1915 of the SSA. Beginning on January 1, 2021, the Secretary could make allotments to participating states in an aggregate amount not to exceed $8 billion for payment adjustments for providers of home and community based services. Selected states would be able to use those funds without a state matching contribution.

A state would need to submit an application as established by the Secretary. In choosing participating states, the Secretary would be required to give priority to the 15 states with the lowest population density.

Participating states would need to collect and report information determined necessary by the Secretary and to report demonstration expenditures on existing Medicaid reporting forms.

Sec. 124. Flexible Block Grant Options for States

Graham-Cassidy would establish new SSA section 1903B providing states with an option, beginning no earlier than FY 2020, to conduct a Medicaid Flexibility Program (MFP). Under the MFP, a state would have greater flexibility to define Medicaid services for non-elderly, non-disabled, non-expansion adults (1903A adults who are subject to the per capita caps as described above) and would be subject to a ceiling on federal payments for their spending.

State Application. A state's application would need to describe the program; how it would satisfy federal requirements; the conditions of eligibility for program enrollees; the types, amount, duration, and scope of services offered; and how current enrollees would be notified of their transition to the new program. The description would also need to include statements certifying that the state agrees to submit regular enrollment data and timely and accurate data to

the Transformed Medicaid Statistical Information System (T-MSIS); annual evaluations and reports on quality; and additional information as required by the Secretary. It would also need to describe the information technology systems plan indicating the capability of the state to support the program and the goals of the program. Goals must include those related to quality, access, rate of growth targets, consumer satisfaction, and outcomes. The application would be required to include a monitoring and evaluation plan and a process for the state to take actions on unmet goals.

Before a state's application could be submitted to the Secretary, the state would have to make it publicly available for a 30-day period of public notice and comment, including public hearings. The Secretary would be required to specify a deadline for states to submit an application that would begin in the next fiscal year, but that deadline could be no earlier than 60 days after the Secretary publishes state block grant amounts. The Secretary would also be required to make the application publicly available for a 30-day notice and comment period.

Financing. For the initial year of a state's block grant, the state would be subject to a cap on federal Medicaid spending for non-elderly, non-disabled, non-expansion adults. The cap would be equal to the usual Medicaid federal matching percentage of the product of:

- the target per capita MA expenditures for the state for the year for those adults, and
- the number of 1903A enrollees in that group two years prior increased by the percentage increase in the state's overall population in the preceding fiscal year (except that this number could not exceed the number of such enrollees in the state's per capita base period).

For any subsequent year, the block grant amount would be equal to the amount for the previous fiscal year increased by the percentage increase in the CPI for all urban consumers.

Federal Payment and State Maintenance of Effort. Under the block grant alternative, for each calendar quarter, a state would receive federal matching funds for spending on block grant enrollees up to the block grant cap. The federal share of that spending would be equal to the state's standard federal matching percentage applicable under the Medicaid program. A maintenance of effort requirement would ensure that a minimum percentage of spending under the MFP program is for targeted health assistance (defined below).

Graham-Cassidy would provide for additional funds for states operating an MFP program during a public health emergency. In the case of such a state, and to the extent that the state has targeted health assistance spending in excess of its cap, the state would be able to receive additional funds equal to the state's usual federal matching percentage of the extra costs to the program less the amount of such spending during the most recent fiscal year for which no public health emergency declaration was in effect.

Program Requirements. Under the MFP, a state would be required to specify the types of items and services, the amount, duration and scope of such services, the cost-sharing with respect to such services, and the method for delivery of block grant health care assistance. In making these specifications, the state would need to provide assistance for individuals who would otherwise be eligible for Medicaid that is at least 95% of the aggregate actuarial value of benchmark coverage

or benchmark-equivalent coverage under existing Medicaid and for those individuals, must cover "targeted health assistance" which would include --

- Inpatient and outpatient hospital services;
- Laboratory and X-ray services;
- Nursing facility services for those over age 21;
- Physician services;
- Home health services;
- Rural health clinic and Federally-qualified health center services;
- Family planning services and supplies;
- Nurse-midwife services;
- Certified pediatric and family nurse practitioner services;
- Freestanding birth center services;
- Emergency medical transportation;
- Non-cosmetic dental services;
- Pregnancy-related services including post-partum for a 12-week period beginning on the last day of the pregnancy; and
- Mental health and substance use disorder coverage that complies with parity requirements under the Public Health Services Act as applicable to group health plans.

The state may provide other additional optional services. If a state chooses to cover prescription drugs, Medicaid rebates would apply. Cost-sharing may apply so long as in aggregate it does not exceed 5% of a family's income.

An MFP approved by the Secretary must be conducted for no less than one program period (five consecutive fiscal years) and may be continued by the state without resubmitting an application so long as the state provides notice to the Secretary and does not make significant program changes. Only the state can terminate the program but must have a transition plan approved by the Secretary to do so. If terminated, the per capita caps described above would apply.

A state conducting an MFP would need to provide coverage to individuals who would otherwise be eligible for Medicaid and must use modified adjusted gross income in accordance with existing Medicaid requirements for income determinations.

Under an MFP, a state would be required to provide for simplified enrollment processes, coordinate with Exchanges, and provide a fair process for appealing eligibility determinations. MFPs would not be required to meet Medicaid state-wideness, comparability of benefits, and freedom-of-choice requirements.

The proposal provides definitions of terms applicable to the MFP including *Medicaid Flexibility Program*, *program enrollee*, *program period*, *state*, and *targeted health assistance.*

Sec. 125. Medicaid and CHIP Quality Performance Bonus Payments

Graham-Cassidy would provide $8 billion in funding for Medicaid and CHIP quality performance bonus payments to be made available to states for FY 2023 through FY 2026. States and the District of Columbia would qualify for quality performance bonus payments if (i) the Secretary determines that the state's adjusted total MA spending for the fiscal year is lower than the target total MA level for that fiscal year and (ii) if the state provides information on applicable quality measures and a plan for spending the bonus payments on quality improvement activities. The Secretary would determine a formula for computing the allotments for qualifying states based on the state meeting performance (including improvement) goals on quality measures for the performance period, as determined by the Secretary. The Secretary would be required to identify and publish peer-reviewed quality measures including health care and long-term care outcome measures that are quantifiable, objective, and take into account clinically appropriate measures of quality for the different types of patient populations receiving benefits under Medicaid or CHIP. The measures would be made available pursuant to rulemaking after consultation with state Medicaid agencies.

Sec. 126. Optional Assistance for Certain Inpatient Psychiatric Services

Beginning October 1, 2018, states would have the option to cover inpatient psychiatric hospital services for individuals between 21 and 65 years of age under their Medicaid programs. Under existing law, states already have the option to cover those services for children. Under the proposed state option, the services could be provided in psychiatric hospitals for an individual for a period not to exceed 30 days in a month and 90 days in any calendar year. The proposal would provide for a 50% federal contribution toward the cost of those services for a state that takes up the option.

Sec. 127. Enhanced FMAP for Medical Assistance to Eligible Indians

Under existing law, the federal matching share of costs for services provided through an Indian Health Service Facility is 100%. Graham-Cassidy would extend the 100% federal matching share to include all services provided by any provider under a Medicaid state plan to an individual who is a member of an Indian tribe and eligible for assistance under the state's Medicaid program.

Sec. 128. Non-Application of DSH Cuts for States with Low Market-Based Health Care Grant Allotments; One-time DSH Allotment Increase for 2026

Under current law, allotments for FYs 2018 through 2026 for states to use for disproportionate share hospital (DSH) payments are subject to a specified set of reductions. Graham-Cassidy would provide for smaller DSH allotment reductions for certain states. For FYs 2021 through 2025, each state that experiences a "grant shortfall amount" would have their DSH allotment reductions lowered by that shortfall amount. The grant shortfall amount would be equal to the amount by which the state's Marketplace Health Care grant amount for the fiscal year is below

the state's 2020 Marketplace Health Care grant amount increased by the change in the medical-CPI from 2020 to the year before the fiscal year involved.

In addition, each state with a grant shortfall in FY 2026 would receive a one-time increase in their DSH allotment for that year. The FY 2026 DSH allotment for the state would be increased by the total of all of that state's DSH reductions for FY 2018 through 2025 less any reduction to those amounts because of a grant shortfall during the period.

Sec. 129. Determination of FMAP for High-Poverty States

Graham-Cassidy would increase the federal matching share of payments for Medicaid medical assistance for two states. The two states which would qualify for the higher payments are those for which the Secretary issued a separate poverty guideline for 2017 that is higher than the poverty guideline applicable to other states. (Understood to be referring to Alaska and Hawaii.) The state with the highest separate poverty guideline (likely to be Alaska) would have its matching rate increased by 25% of the weighted average of the federal matching percentages for all other states that do not have a separate poverty guideline. The state with the second highest separate poverty guideline would have its matching rate increased by 15% of the same amount. The higher matching rates would be available beginning with the second fiscal quarter of 2018. The increase would not apply to payments that are already paid at the higher CHIP matching rate (under section 2105(b)).

TITLE II

Sec. 201. The Prevention and Public Health Fund

Funding for the Prevention and Public Health Fund, would be eliminated after 2018. Current law authorizes and appropriates (by fiscal year) the following: $900 million each for 2018 and 2019; $1 billion each for 2020 and 2021; $1.5 billion for 2022; $1 billion for 2023; $1.7 billion for 2024; and $2 billion for 2025 and each year thereafter.

Sec. 202. Community Health Center Program

An additional $422 million for the CHC Program would be appropriated for fiscal year 2017. (The provision would be effective as if included in section 221(a) of the Medicare Access and CHIP Reauthorization Act of 2015.)

Sec. 203. Repeal of Cost-Sharing Subsidy Program

The cost-sharing subsidy program provided under section 1402 of PPACA would be repealed effective for plan years beginning on or after December 31, 2019.

Sec. 204. Conditions for Receiving Market-Based Health Care Grant

For any of calendar years 2020 through 2026, a state receiving funds under the Market-Based Health Care Grant Program set forth in section 106 of Graham-Cassidy could establish its own insurance rules for individual market coverage instead of those specified under federal law if certain conditions were met. The federal laws that the state could replace with its own rules are those described below and such rules would apply only to a health insurance issuer in that state offering coverage in the individual market with funding from the Market-Based Health Care Grant Program that provided a direct benefit to an individual.

The provisions of federal law (all enacted by the ACA) which a state could replace with its own rules (which presumably could include not providing for alternative rules) are the following:

(1) the required Essential Health Benefits (EHBs) including the ten categories of required benefits, the limitation on enrollee cost-sharing and the required levels of actuarial value (i.e., metal levels) for the EHBs;

(2) the prohibition on discriminatory rating as it relates to variations in rating (i.e., pricing of premiums) based on the area in which the individual resides (or small group is located) and the 3:1 limit on age rating for adults;

(3) that an issuer that offers the EHBs at the required levels of actuarial value also offer a child only plan;

(4) that an issuer cover certain preventive services without enrollee cost-sharing; and

(5) that an issuer consider all enrollees in all health plans other than grandfathered health plans offered by an issuer in the individual market, including those enrollees not enrolled through the Exchange, to be members of a single risk pool.

A state applying for grant funds under section 106 that indicated it would use the grant funds to directly assist individuals buying coverage in the state's individual insurance market[9] would be required to provide additional information. Specifically, in its application, a state would describe:

(1) The criteria by which, and the degree to which, a health insurance issuer of health insurance coverage could vary premium rates, except an issuer could not vary rates for this coverage on the basis of sex or genetic information.

(2) Whether, and the degree to which, an issuer could require an individual, as a condition of enrollment or continued enrollment, to pay a premium or contribution greater than the premium or contribution for a similarly situated individual enrolled in the coverage.

(3) The benefits or levels of benefits which an issuer of the coverage would be required to include.

(4) The number of risk pools in which an issuer could group individuals enrolled in the coverage.

[9] A state would not be required to provide these descriptions if it is only seeking to use the grant funds for stabilizing premiums or encouraging market entry and plan choice; the direct provision of health care services; or providing individual coverage to individuals eligible for Medicaid through health insurance issuers.