



STATEMENT FOR THE RECORD

**Submitted to the
Senate Finance Committee**

The Graham-Cassidy-Heller-Johnson (GCHJ) Proposal

September 25, 2017

America's Health Insurance Plans
601 Pennsylvania Avenue, NW
Suite 500, South Building
Washington, D.C. 20004

Blue Cross Blue Shield Association
1310 G Street, NW
Washington, D.C. 20005

On behalf of the two largest associations representing the community of health plans across the United States—America’s Health Insurance Plans (AHIP) and the Blue Cross Blue Shield Association (BCBSA)—we appreciate the opportunity to comment on the Graham-Cassidy-Heller-Johnson (GCHJ) legislation, which proposes a block grant approach to replacing the financial assistance provisions of the Affordable Care Act (ACA) and also calls for a per capita cap Medicaid financing system beginning in 2020.

AHIP is the national association whose members provide coverage for health care and related services to millions of Americans every day. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access and well-being for consumers.

BCBSA is a national federation of 36 independent, community-based and locally-operated Blue Cross and Blue Shield companies that collectively provide health care coverage for one in three Americans. BCBS companies have an 85-year history providing coverage across all markets in their local communities and are major providers of health coverage in the individual market and in the majority of Exchanges.

In previous separate statements for the committee’s September 12 hearing, we outlined our recommendations on steps that can be taken in the short-term to provide relief to consumers, reduce uncertainty, and stabilize the individual health insurance market. We continue to believe it is important for Congress to focus on stabilizing the individual market for 2018 and 2019 to ensure that Americans have high quality, affordable coverage options. This approach would help consumers obtain the coverage and care they need, while providing Congress and the states an opportunity to fully consider and debate longer-term reforms.

For today’s hearing, our statement focuses on: (1) principles that Congress should consider in developing legislation that would reform and affect the coverage and care of millions of Americans; (2) policy and operational concerns associated with the GCHJ proposal; (3) the negative impact the bill would have on low-income and vulnerable populations covered through Medicaid; and (4) initial research findings showing that this proposed legislation would harm many consumers who obtain coverage through the individual health insurance market and the Medicaid program.

Principles for Legislation Addressing Coverage and Care for the American People

Throughout this debate, our organizations have been committed to engage in a collaborative, constructive way to address existing challenges in health care, particularly in the individual market. We have offered recommendations and solutions that will best deliver on the goals we share: More choices, lower premiums, help for those who need it, and lower costs for hardworking taxpayers.

We believe that legislative proposals that would reform and affect the coverage and care of millions of Americans should meet certain principles.

First, reforms must stabilize the individual insurance market. Stability in the individual market has always been challenging, and we are committed to making this market work. The most important solution for short-term stability is to fund cost-sharing reduction benefits, which help millions of lower-income people afford the care they need. Long term, adopting proven models of success—for example, elements of the successful Medicare Part D program, such as reinsurance for high dollar claimants—could deliver greater stability, lower costs for taxpayers, higher consumer satisfaction, and better health outcomes.

Second, Medicaid reforms must ensure the program is efficient, effective, and has adequate funding to meet the health care needs of beneficiaries. Medicaid serves a diverse population of over 70 million Americans, including some of the most medically vulnerable among us. Any Medicaid reforms must guarantee that states have sufficient resources to ensure the continuity of coverage and care that beneficiaries depend on. State flexibility can improve the program, but solutions must ensure the sustainability of Medicaid and affordability in the individual market given how people often move between programs.

Third, reforms must guarantee access to coverage for ALL Americans, including those with pre-existing conditions. No one should be denied or priced out of affordable coverage because of their health status. To ensure that coverage is more affordable for everyone, strong protections must be coupled with strong incentives that encourage individuals to maintain continuous coverage.

Fourth, reforms must provide sufficient time for everyone to prepare – from doctors, hospitals, and health plans to consumers, patients, and policymakers. States need time to plan, analyze, and make decisions that could have profound effects on their residents, local health care systems, and on their state budgets. Once this is finalized, states need to implement the operational infrastructure, and health plans need time to develop new coverage options or modify existing ones and have them approved prior to making them available in the market. Concurrent with this activity, health care providers need time to understand how changes will affect them and their patients. And consumers and patients need time to understand how their coverage will change.

Fifth, reforms should improve affordability by eliminating taxes and fees that only serve to raise health care costs or reduce benefits for everyone. Congress delivered relief from the health insurance tax for 2017, and eliminating the tax again for next year will lower premiums by an average of \$158 per member in the individual market.¹ Not eliminating the health insurance tax will cost consumers \$267 billion over the next ten years. Similarly, not eliminating the 40

¹ Oliver Wyman, *Analysis of the Impacts of the ACA's Tax on Health Insurance in 2018 and Beyond*, August 8, 2017. <http://www.stopthehit.com/wp-content/uploads/2017/08/Oliver-Wyman-2018-HIT-Analysis%E2%80%8E-August-8-2017.pdf>

percent excise tax will ultimately affect tens of millions of Americans who receive health benefits through employer-sponsored coverage when it goes into effect in 2020.

And finally, reforms should rely on the strengths of the private market, not build a bridge to single payer systems. To best serve every American, we need both a strong private market and an effective role for and partnerships with government. Building on the choice, competition and innovation of the private sector and the strength, security and dependability of public programs is a far more effective solution than allowing states to eliminate private insurance.

Policy and Operational Concerns with the GCHJ Proposal

The GCHJ proposal fails to meet our guiding principles for health reform. The bill would have negative consequences on consumers and patients by further destabilizing the individual market; cutting Medicaid; pulling back on protections for pre-existing conditions; not ending taxes on health insurance premiums and benefits; and potentially allowing government-controlled, single payer health care to grow.

Additionally, in our analysis of the bill, we have identified a number of policy and operational issues that raise serious concerns about the GCHJ proposal and how it would affect health care coverage and costs for American families. Below we highlight several highly problematic concerns—beyond the issues we addressed in our principles above—that need to be carefully considered.

Unrealistic Expectations for States and Their Programmatic Capabilities

By March 31, 2019—just 18 months after the possible enactment of the legislation—GCHJ would require all states to establish state-specific comprehensive health coverage programs to receive federal block grant funding and prepare to transfer to a per capita cap Medicaid financing system. This extremely short timeframe for implementation would likely lead to chaos in both the individual market and Medicaid programs in all states; these challenges would be layered on top of extensive funding reductions in a majority of states.

We expect reduced choices for consumers due to the uncertainty about whether states will be successful in setting up their programs in time to enroll consumers in coverage for January 1, 2020, and their ability to attract a broad pool of enrollees into the health insurance market. Coverage that is available would have to be priced to account for this uncertainty, basically guaranteeing little if any choice for lower income consumers. This impact would be even greater in more rural locations.

Starting in 2020, it is unclear how states would reuse the existing federal infrastructure to provide tax credits to assist consumers in purchasing insurance. States would be required to establish a new administrative infrastructure to conduct eligibility determinations, deliver subsidies to health plans, facilitate enrollment and set up other programs (e.g., high risk pools or

reinsurance programs). It is unlikely that states could use the federal infrastructure to administer their programs because it was designed to administer federal tax credits.

The amount of work and resources involved in meeting the requirements to operationalize the new block grant system cannot be overstated. Not only does GCHJ fall far short on the needed timeframe to develop and implement such complex systems, it provides very few resources to do so. This means that already cash-strapped states would have to invest significant funds to even get basic functions running by January 1, 2020. It is not clear that any state has the capability of doing so under these constraints.

No Incentives for Continuous Coverage

Repeal of the individual mandate without a replacement would have an immediate destabilizing effect on the individual market. GCHJ zeros out the individual mandate penalties—retroactive to January 1, 2016—without establishing any alternative approach to promoting continuous coverage. This would have an immediate impact on the health insurance market for the remainder of 2017 and for 2018 where rates have already been approved based on the assumption that the existing mandate would remain in place.

GCHJ fails to take any steps to ensure that state programs broaden the risk pool as much as possible, ensuring that individuals of all ages and health status are insured, not just those who are higher-risk or costlier to insure. In fact, GCHJ maintains the existing requirement that health plans offer coverage to everyone that applies (i.e., “guaranteed availability” and “guaranteed issue”), thus creating more incentives for people to delay purchasing health care coverage until they have an immediate health care need. This approach would drive up costs for everyone. It creates a regulatory environment in which fewer younger, healthier individuals will be incentivized to get coverage and the overall pool of people purchasing health insurance will be weighted more heavily with older and less healthy people. This will lead to further market instability, higher costs, fewer choices, and the loss of coverage for millions of Americans.

Constantly Shifting Budgets and Uncertainty for States

The block grant formula proposed by GCHJ would undergo several changes between 2020 and 2026, and the funding would be completely eliminated after six years unless Congress reauthorizes the funding. This would result in constantly shifting budgets which, in turn, would create a high level of uncertainty for states as they try to plan for the future. Moreover, states would be faced with difficult choices about which populations to serve, especially since the proposed funding methodology excludes the working poor—those with incomes under 50% of the federal poverty level (FPL)—and those with moderate incomes (between 138-400% FPL).

Starting in 2023, the Secretary of Health and Human Services (HHS) would be required to use a risk adjustment formula to significantly adjust block grant funding. It is unclear how HHS could develop a risk adjustment system across states that would each implement their programs

differently. This would create even more challenges for plans as they develop and price products.

Even with the required investment for programmatic operations to account for the new block grant system, the entire program is set to expire in only six years. It is difficult to imagine states, health plans, and health systems devoting significant resources for a program whose long-term viability and funding levels are so uncertain.

Uncertainty for Existing ACA Programs That Are Not Modified

The existing ACA risk adjustment program for health plans would remain in place under GCHJ, but it would become impossible to implement. To work effectively, risk adjustment requires a uniform set of benefits and consistent rating approaches to manage against adverse selection. The very core of GCHJ seeks to remove uniformity in these areas, making a federal risk adjustment program unfeasible.

Uncertainty for Health Plan Business Planning

Insurers plan several years in advance before making decisions about their participation in new markets. Under GCHJ, the implementation of major reforms in 2020 would leave little to no opportunity for health plans to determine the potential market or rules of operation before they make decisions about the products they offer. Moreover, states would have broad flexibility in deciding how to use their block grant funding. Some of the potential options, including direct payments to providers and a single-payer structure, would remove any role for private coverage, thereby taking away valuable coverage options from consumers.

In addition, since states submit their applications for how they will use their portion of the market based grants on March 31st of the preceding year, it is unclear how insurers will know how this affects the pricing for both individual market products and Medicaid managed care for the following year given that states and insurers will not know the grant amount until much later in the year.

Negative Impact on Employer-Sponsored Coverage

While employer-sponsored coverage is not the primary focus of the GCHJ proposal, it likely would have a negative impact on the 177 million Americans who get their health insurance coverage through work.

Several factors would cause employees to either lose coverage, face higher costs, or see a reduction in benefits:

- Because states can waive essential health benefits, self-insured employers would be able to reinstate annual and life-time benefit limits that were common before the ACA. This would

severely impact employees who have an ongoing need for expensive health care services and treatments such as chemotherapy.

- GCHJ maintains taxes that directly increase consumer costs and limit benefits, including the ACA health insurance tax and the Cadillac tax—both of which raise out-of-pocket costs for Americans who get coverage through work.
- Under GCHJ, health care providers would be likely to see more uninsured patients and would be likely to receive lower reimbursement rates under the new systems implemented by states. This, in turn, would cause provider payment rates to increase in other markets—including the market for employer-sponsored health coverage. This type of cost-shifting, from public programs to private payers, would increase under GCHJ since there would be more uninsured patients who are unable to pay their medical bills and there would be more providers receiving reimbursement rates that fail to cover their actual costs of delivering medical care.

Effects on Low-Income and Vulnerable Populations Covered Through Medicaid

The GCHJ proposal would significantly reduce the federal government’s role in financing health benefits for Medicaid beneficiaries, while also limiting the funds available to support private coverage options for individuals with modest incomes who are not eligible for Medicaid.

As we discuss in the next section below, a new analysis from Avalere estimates that GCHJ would reduce federal Medicaid funding by \$713 billion over 2020-2026 and by more than \$3.5 trillion over 2020-2036 if the bill’s block grant funding is not reauthorized. The authors conclude: “Funding cuts of this magnitude will force states to re-evaluate their Medicaid programs, including the number of individuals covered and the generosity of the provided benefits.”

In examining the impact of these cuts, it is important for policymakers to recognize that the individual market and Medicaid are closely related with respect to the partial overlap in the populations they serve. For example, many low-wage employees do not have access to employer-sponsored coverage and need help accessing affordable coverage; if their incomes fall due to loss of employment or other reasons, Medicaid becomes an important safety net.

Conversely, individuals with Medicaid who move up the economic ladder may lose eligibility and need affordable coverage in the individual market. Reducing subsidies for their coverage—as GCHJ proposes—would create incentives for people to remain at an income level that qualifies for Medicaid coverage and, as a result, have the perverse effect of discouraging people from lifting themselves up out of poverty.

Given how the two markets interact with respect to a diverse and often vulnerable population, Congress should ensure that federal policies are designed to ensure both the long-term stability

and affordability of the individual market and continued strength and long-term sustainability of the Medicaid program. The GCHJ proposal fails to meet these objectives.

Initial Research Findings on the Impact of the GCHJ Proposal

We believe the extensive reforms in the GCHJ proposal should not be fast-tracked for passage by September 30. Instead, additional time should be allowed for the Congressional Budget Office (CBO) to produce a comprehensive analysis of the bill and for states to fully understand the proposed financial and structural impact to their individual health insurance markets and Medicaid programs.

Research findings by several organizations raise important issues and questions that should be examined more closely before the Senate votes on the GCHJ bill. Below we highlight a number of these findings, which are based on legislative language released on September 13. An updated bill, released on September 24, appears to be even more problematic, proposing to create two separate systems of health coverage—one for healthy people and another for sick people. This approach is unworkable in any form and would undermine protections for those with pre-existing medical conditions, increase premiums, and lead to widespread terminations of coverage for people currently enrolled in the individual market.

A new study by Avalere estimates that GCHJ would reduce, relative to current law, federal Medicaid funding by \$713 billion over 2020-2026 and by more than \$3.5 trillion over 2020-2036, if the bill's block grant funding is not reauthorized.² For the 2020-2026 time period, this includes \$593 billion in cuts that are attributed to the proposed block grants and \$120 billion that are attributed to the proposed Medicaid per capita cap system. Avalere estimates that 34 states and the District of Columbia would experience Medicaid funding reductions through 2026, and all states would see a reduction in their federal Medicaid funding by 2036.

While discussing the Medicaid funding cuts that 34 states would experience in 2020-2026, the Avalere study explains: "These states include all expansion states and three states (AR, IA, and ME) that see large reductions in their traditional Medicaid spending due to per capita caps. As expansion states are only permitted to use 15% of their block grant allotments in Medicaid, their total Medicaid funding would be substantially reduced."

Another study, released by Manatt Health, outlines the following findings:³

² Avalere, *Graham-Cassidy-Heller-Johnson Bill Would Reduce Medicaid Funds to States by \$713B Over the Next 10 Years*, Chris Sloan, Richard Kane, September 22, 2017. <http://avalere.com/expertise/managed-care/insights/graham-cassidy-heller-johnson-bill-would-reduce-medicaid-funds-to-states-by>

³ Manatt Health, *Update: State Policy and Budget Impacts of New Graham-Cassidy Repeal and Replace Proposal*, September 2017. http://www.statenetwork.org/wp-content/uploads/2017/09/SHVS_Graham-Cassidy-Sept-2017_Final.pdf

- Over 2020-2026, the block grant proposed by the GCHJ bill would provide 6.4 percent less federal funding than under current law. By 2026, the gap between current law funding and the proposed block grant funding would be 8.9 percent. Over 2020-2026, 29 states would experience, relative to current law, a reduction in federal funding (with an average reduction of 19 percent) and nine of these states – Alaska, Connecticut, Delaware, New Hampshire, New Mexico, New York, Oregon, Vermont, and Washington – would see reductions of 25 percent or more.
- Looking beyond 2026, the Manatt study explains: “States will be at full financial risk for funding coverage programs and services developed under the block grant when the grant ends in 2026; there is no guarantee of whether and at what level federal funding would be available beginning in 2027.”
- Finally, this analysis comments: “States would have broad latitude to obtain waivers of ACA provisions, including waivers of ACA benefit and rating requirements. In states that obtain waivers, individuals with pre-existing conditions could face substantially higher premiums or find their policies do not cover essential services.”

An analysis from Fitch Ratings cautions that “over time even non-expansion states will face budgetary challenges given the proposed changes to Medicaid, which will likely accelerate for all states over time.”⁴ Fitch states that Medicaid changes in the GCHJ proposal “could have implications for states’ credit quality and for the credit quality of related public finance entities that depend on state funding.”

While discussing the potential for other state-funded activities to be affected by Medicaid funding cuts, Fitch states: “Medicaid changes that significantly reduce federal funding to states will cause states to consider a broad mix of spending cuts or revenue increases to maintain long-term fiscal balance. In a time of already muted revenue growth, spending cuts could affect K-12 and higher education the most, as those are the other largest areas of state spending outside of Medicaid.”

An issue brief released by the Kaiser Family Foundation (KFF) provides estimates—including state-by-state data—on how federal funding for health benefits would be affected by the GCHJ bill’s proposals for a new block grant program and a Medicaid per capita cap financing system.⁵ KFF explains that the deepest cuts would be imposed in states that implemented the ACA’s Medicaid eligibility expansion. The issue brief states: “There would be a significant redistribution in federal funding across states under the block grant. Overall expansion states would lose \$180 billion for ACA coverage and non-expansion states would gain \$73 billion over

⁴ Fitch Ratings, *Latest ACA Bill Includes Medicaid Repeal and Replace Provisions for States*, September 15, 2017. <https://www.fitchratings.com/site/pr/1029238>

⁵ Kaiser Family Foundation, *State-by-State Estimates of Changes in Federal Spending on Health Care Under the Graham-Cassidy Bill*, September 2017. <http://files.kff.org/attachment/Issue-Brief-State-by-State-Estimates-of-Changes-in-Federal-Spending-on-Health-Care-Under-the-Graham-Cassidy-Bill>

the 2020-2026 period. A typical Medicaid expansion state would see an 11% reduction in federal funds for coverage compared to an increase of 12% in a typical non-expansion state.”

Most recently, the Brookings Institution issued a report that analyzed the impact on the number of Americans with health insurance coverage under the GCHJ proposal.⁶ The authors estimate that, in 2018 and 2019, the number of insured Americans would fall by 15 million. With the transition to the Market-Based Health Care Grant program starting in 2020 where federal funding for the exchange marketplaces through APTC, CSR, and BHPs along with a portion of the Medicaid expansion funding are converted into a block grant, they estimate that the number of uninsured individuals would rise to around 21 million per year over the 2021-2026 period. Looking out at the effects on insurance coverage in 2027 and beyond after the expiration of the block grant funding program, upwards of 32 million fewer individuals would have coverage. The authors caution that this estimate may be conservative because it does not include all of the provisions in the GCHJ proposal, including the effects of the per capita caps on Medicaid.

All of these findings raise serious questions and concerns about the likely impact of the GCHJ proposal on health care costs and choices for consumers who buy coverage in the individual health insurance market and the continued role of Medicaid as a health care safety net for low-income Americans. To answer these questions, we believe it is critically important for the Senate to allow time for CBO to conduct a comprehensive analysis of this new legislation before voting on its approval.

Conclusion

While our organizations cannot support the GCHJ proposal given the lack of alignment with our principles, we will keep working to find the right solutions that reflect the commitment we all share: affordable coverage and high-quality care for every American. By working together, we can improve health care and deliver the coverage and care that every American deserves.

⁶ How will the Graham-Cassidy proposal affect the number of people with health insurance coverage? September 22, 2017. <https://www.brookings.edu/research/how-will-the-graham-cassidy-proposal-affect-the-number-of-people-with-health-insurance-coverage/>