Graham-Cassidy-Heller-Johnson Amendment

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I am Dennis G. Smith, Senior Advisor for Medicaid and Health Care Reform for the Arkansas Department of Human Services (DHS). It is a privilege to be with you today to convey Governor Asa Hutchinson's support for the Graham-Cassidy-Heller-Johnson proposed amendment to H.R. 1628, the "Better Care Reconciliation Act of 2017," (BCRA) under consideration by the U.S. Senate. My remarks will focus on federal funding for private insurance subsidies, the use of the Children's Health Insurance Program (CHIP) as the model for re-establishing the relationship between states and the federal government, Medicaid per capita caps, and work requirements.

Federal Funding for Subsidies

The Graham-Cassidy-Heller-Johnson proposed amendment would provide states with nearly $1.2 trillion in federal funding between 2020 and 2026 to provide health insurance coverage and pay for direct medical care for our citizens who are in poverty or who are at lower income levels and cannot afford the full cost of their health insurance coverage. Earlier this month, the Congressional Budget Office (CBO) released its most comprehensive look at health insurance coverage and spending since its March 2016 baseline.[1] This report is useful in understanding the context of the Graham-Cassidy-Heller-Johnson proposal and the populations it would impact most significantly.

Graham-Cassidy-Heller-Johnson would replace the private insurance subsidies and Medicaid expansion funding provided under the Affordable Care Act (ACA) with state block grants. CBO reports that 9 million individuals are receiving subsidies to purchase individual

[1] The Congressional Budget Office (CBO). Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2017 to 2027 (September 2017). Available at: https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53091-fshic.pdf.

coverage through the marketplaces and coverage through the Basic Health Program (BHP) in 2017. By comparison, that is about the same number of people the CHIP program has covered in the past several years and is less than three percent of the total population in the United States under age 65. The second population group included in the block grant proposal is the 13 million adults who are now covered through Medicaid at a state option. Thus, coverage for this population is already administered by states.

In scoring H.R. 3590, the "Patient Protection and Affordable Care Act (PPACA)"[2] CBO estimated that under "current law" there would be 35 million nonelderly people enrolled in Medicaid and CHIP in 2017, five million *fewer* than the number of people enrolled in 2010 (CBO Director Douglas Elmendorf letter to Majority Leader Harry Reid, March 11, 2010).[3] Conversely, CBO projected that under PPACA (which would have *required* all states to expand Medicaid), there would be 15 million more people covered by Medicaid and CHIP in 2017 than under its current law baseline. Today, there are 69 million nonelderly people enrolled in Medicaid and CHIP, 13 million of whom are "newly eligible" adults. Excluding the Medicaid expansion population, CBO projected there would be 35 million people enrolled in Medicaid and CHIP in 2017. Instead, there are 56 million people enrolled in Medicaid and CHIP (excluding the Medicaid expansion) – 21 million more people than CBO expected if all states had expanded the program. That difference alone is twice the size of the population receiving premium subsidies this year.

[2] PPACA was passed by the Senate on December 24, 2009. The Health Care and Education Reconciliation Act of 2010 made additional changes to PPACA. Together, the two Acts are commonly referred to as the Affordable Care Act (ACA).

[3] https://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/113xx/doc11307/reid_letter_hr3590.pdf Table 3.

Experience now tells us what CBO could not accurately model back in 2010, that there is very different distribution in the sources of coverage for individuals with income at lower income levels than expected. As Congress searches for answers for how to stabilize premiums for those in the individual market, it should consider where people actually went for coverage. Millions of people CBO expected to enroll in the individual market are in Medicaid instead. Combining funding for these two groups into state block grants is consistent with the basic concepts of insurance pools. Adding younger, healthier lives and spreading the risk among a larger pool of people will help stabilize premiums for everyone in the individual market, both those who are subsidized and those who are not.

Creating a new program to cover 22 million people beginning in 2020 will be a challenge for states, but is not unrealistic. States are already serving more than half of these individuals through Medicaid; and there are 50 million more people under age 65 covered through traditional Medicaid. States administer the Supplemental Nutrition Assistance Program (SNAP) on behalf of the federal government. Enrollment in SNAP has ranged from 47.4 million people in October 2013 to 41.3 million people in June 2017.[4] So as you consider this new grant program to be administered by the states, it would be a program of relatively modest size. Additionally, using the Modified Adjusted Gross Income (MAGI) methodology to determine eligibility is much easier to administer than the old Medicaid income standards and methodologies. There should be no question as to whether states have the ability to administer such a program.

CBO estimates that, in 2020 under current law, the federal government will spend a total of $147 billion to subsidize the cost of coverage:

[4] https://fns-prod.azureedge.net/sites/default/files/pd/34SNAPmonthly.pdf

- $82 billion for the newly eligible Medicaid population;
- $49 billion for premium tax credits;
- $10 billion for cost sharing reduction outlays; and
- $6 billion for the Basic Health Program (which provides coverage to 1 million people).

Graham-Cassidy-Heller-Johnson appropriates an amount nearly equal to the CBO projections ($146 billion in 2020) for the states and gives states three years to spend their annual allotments. It also allows states to use 15 percent of their funds (20 percent with a waiver) to provide services to Medicaid populations. There is an additional appropriation of $15 billion in 2020 that the Administrator of the Centers for Medicare & Medicaid Services (CMS) can use to provide short-term assistance to carriers or states to help stabilize the markets.

In 2017, the federal government will spend about $111 billion on the Medicaid expansion population and private insurance subsidies, according to the September 2017 CBO report. Under the Graham-Cassidy-Heller-Johnson proposal, federal spending for these populations will increase to $190 billion in 2026, an increase of more than 70 percent. Slowing the rate of growth should not be considered a "loss" to the states or to individuals. For example, in its March 2015 Medicaid baseline, CBO projected that the average federal spending on benefit payments per elderly enrollee would be $10,620 in 2017. In January 2017, CBO revised its estimate that the average federal spending on benefit payments per elderly enrollee would be $8,000 in 2017. CBO also reduced its average per enrollee spending estimate for the Medicaid blind and disabled population for 2017 from $14,310 to $12,150. I am not aware of an argument among policymakers that the elderly Medicaid population "lost" $2,620 in benefits or that people with disabilities "lost" more than $2,000 in benefits. Growth in average spending has simply been slower than previously projected.

CHIP as the Model and Platform

Twenty years ago, Chairman Hatch provided the leadership necessary to create the State Children's Health Insurance Program under Title XXI of the Social Security Act. Senator Grassley was also a member of the Senate Finance Committee at that time and helped shape this new program, which serves about eight million children today at a cost of approximately $16 billion this year. The original features of the CHIP program included:

- Capped allotments to states;
- Great flexibility given to states to determine eligibility, benefits, and cost sharing;
- A mandatory appropriation for a limited number of years; and
- No individual entitlement.

One of the stated goals of the ACA was to lower the cost of health care, but the law has fallen far short in achieving this aim. The Graham-Cassidy-Heller-Johnson proposal provides a mechanism for the federal government to incentivize the states to succeed where current law has not. States will react to the new budget caps in the same manner as they did to CHIP – by designing the program in a manner than spreads the dollars in the most effective and economical manner possible while staying within the constraints of a fixed budget.

Adopting CHIP as the model and platform should be viewed as a very positive advantage for the Graham-Cassidy-Heller-Johnson proposal. There are already policies and procedures in place to handle financial transactions between the federal government and states. States have an existing accountability system to modify rather than build from the bottom up. Over the 20-year history of CHIP, Congress has consistently reauthorized the program, and periodically increased

funding for it. Indeed, Chairman Hatch and Ranking Member Wyden have recently announced their agreement to reauthorize CHIP for another five years.

Allotment Formula Under Graham-Cassidy-Heller-Johnson

When CHIP was created, nothing like it existed on a national level. Only three states had started their own programs to serve low-income children. Congress constructed a funding formula out of necessity based on several variables, including the number of low-income children without health insurance. Congress also tried to create greater equity among the states through the enhanced match rates it would pay them.

Today's situation is quite different. The Graham-Cassidy-Heller-Johnson formula starts with the current distribution of funding among the states. Because not all states expanded Medicaid eligibility under PPACA, the distribution of funds varies greatly. Over time, this proposal seeks to distribute funds on a more equitable basis so that, by 2026, per capita federal funding is spread evenly among the states.

There is no perfect funding formula that can accommodate all the variations among states and that includes the match rate formula for determining the Federal Medical Assistance Percentage (FMAP) used in the Medicaid program. Every state can give a multitude of reasons as to how it is disadvantaged. The goal of achieving financial parity is laudable. The proposal makes those adjustments gradually, over a period of eight years from now.

Medicaid Per Capita Caps

While the Graham-Cassidy-Heller-Johnson proposal offers an entirely new approach to providing coverage for the newly eligible Medicaid adults and subsidized private insurance

enrollees, the proposed per capita cap concept for the traditional Medicaid population is familiar. The discussion on per capita caps is even older than CHIP.

The legislative language on per capita caps is complex, as there are exclusions from the caps, a formula for setting the base rates by population group, and different growth rates among the population groups. The caps apply only to per capita federal funding of benefits, not to enrollment growth.

Per capita caps are not new to Medicaid. States, including Arkansas, have accepted per capita spending caps in their various Section 1115 Demonstration Projects. States are at full risk for any cost greater than these caps. These caps typically have some inflation protection, which Graham-Cassidy-Heller-Johnson also includes.

The success of per capita caps in controlling growth rates through Section 1115 Demonstration Projects is ample evidence to apply them to the traditional Medicaid program. However, per capita caps have been an option for states. And few states have accepted per capita caps for their most expensive populations – the elderly and people with disabilities. This is the area in which CMS must be willing to give states ample authority to use new approaches to service delivery reform. Risk is only acceptable when states have the authority to control how services are delivered.

States learn and borrow from each other. No doubt there will be an accelerated learning curve for some. The good news is many states, including Arkansas, are ahead of the curve with new models of organized care.

Per capita caps, without a doubt, are a means of imposing fiscal discipline, and there is no escaping that fact. We also know that Medicaid is unsustainable for both the states and the federal government, and the hard work needs to be done.

Work Requirements

Graham-Cassidy-Heller-Johnson includes an option for the states to adopt a work requirement for able-bodied adults on Medicaid. Work requirements are consistent with the original purpose of Medicaid expressed in Section 1901, which includes, "… to help such families and individuals attain or retain capability for independence …" Medicaid can help working aged adults, on a temporary basis, to improve their health and get back on their feet. But the safety net should not be a restraint that deters someone from fully participating in the labor force and improving their economic standing.

Last month, Arkansas Works paid $524.32 in premiums, cost sharing, and additional services for each of the 257,579 enrollees in a qualified health plan (QHP), which equals nearly $6,300 per year per individual. Approximately 60,000 of these adults had income above the poverty level ($12,060 for a single adult) and were required to pay about $13 a month for their health insurance premiums, plus up to $3 for each drug prescription. The able-bodied adults with income below 100 percent of poverty paid nothing for their coverage.

We have asked CMS for approval to impose mandatory work requirements on certain able-bodied adults that would be enforced by loss of coverage if the adult does not comply for more than three months in a calendar year. On a bipartisan basis, our state legislators agreed that expecting able-bodied adults to work in exchange for $6,300 in health insurance coverage benefits is fair. Legislators across the political spectrum supported the Governor in a special

legislative session earlier this year to reinforce the message that the pathway to independence is through work.

If our waiver request is approved, beginning January 1, 2018, those with income below 100 percent of poverty will be required to either work or engage in one of several activities, such as going to school, participating in job training, or volunteering. Achieving that objective will help lift people in our state out of poverty. Our design also exempts about half of the Arkansas Works population for a variety of reasons, including those who already work at least part time or are caring for a child or disabled family member. Additionally, the requirement will apply only to individuals less than 50 years of age.

Work requirements present opportunities to learn new skills, broaden horizons, overcome new challenges, experience the intrinsic dignity of work, build for the future, and give back to the community. The benefits of work are far greater than earning a paycheck. Work leads to independence, which is among the core objectives of the Medicaid program. Thus, our focus on promoting work goes beyond the Arkansas Works program. For instance, we recently re-designed our home and community-based services waiver for people with developmental and intellectual disabilities to emphasize community-supported employment because of this population's ardent aspirations for the experience of work.

Work requirements are a fair bargain in the social contract between individuals on public assistance and the taxpayers who foot the bill. It is important to examine the relationship in a new light in which the cost of coverage to the taxpayer is recognized as a true value by the person covered. The able-bodied adults have an obligation to their neighbors meet the requirements of the program. Rights cannot be separated from responsibilities. The Department of Human Services (DHS), the Department of Workforce Services (DWS), health insurance

carriers, state and local educational agencies, and private sector partners will assist individuals in meeting their work requirement. The message to these individuals is that there are people willing to help, but you must also be willing to help yourself.

Creating the expectation of work has already demonstrated some success. Since January 1, 2017, Arkansas Works recipients have been referred to DWS. More than 15,000 Arkansas Work recipients started new jobs without accessing any DWS services. Over 8,600 individuals accessed at least one DWS service and, of these, 1,361 have started new jobs. With the new waiver, Medicaid coverage for adults will become more than just access to medical services. It will present new hope as a pathway out of poverty and to greater prosperity for individuals, their families, their communities, and our state. The new work requirements are not only about today, they are about the future.

Conclusion

Governor Hutchinson has joined more than a dozen other Governors in lending their strong support to the Graham-Cassidy-Heller-Johnson solution. Working with the Arkansas Delegation, other Governors, Administration officials, and Senators Graham, Cassidy, and Santorum, changes have been made to improve this approach over the past several weeks. It is my pleasure to convey his strong support to the Committee.