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Testimony Submitted
to the
Senate Finance Committee

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Good morning Chairman Hatch, Senator Wyden, and distinguished members of Committee. Thank you for the invitation to participate in this hearing on the Graham-Cassidy-Heller-Johnson legislative proposal (referred to hereafter as "Graham-Cassidy").

I am Cindy Mann, a partner at Manatt, Phelps & Phillips. At Manatt, I work with states, health care providers and provider organizations, foundations, and consumer organizations, on matters relating to health care coverage, delivery system reform, and financing, focusing primarily on publicly financed coverage and particularly, Medicaid and the Children's Health Insurance Program (CHIP). I also currently serve as an advisor to the Bipartisan Policy Center on the future of health care. Prior to joining Manatt, from June 2009 through January 2015, I served as Deputy Administrator for the Centers for Medicare & Medicaid Services (CMS) and as Director of the Center for Medicaid and CHIP Services. In that capacity, I was responsible for federal policy and oversight of Medicaid and CHIP and for supporting state implementation of those programs. While at CMS, much of my focus was working with states as they implemented provisions of the Affordable Care Act. Prior to joining CMS, I was a research professor at Georgetown University's Health Policy Institute and founded the Center for Children and Families, a research and policy organization focused on children's coverage. I also served as the Director of the Family and Children's Health Programs Group at the Health Care Financing Administration (now CMS), where I directed federal implementation of CHIP and Medicaid with respect to children, families and pregnant women from 1999 to 2001. I have over 30 years of experience in these matters both at the federal level and in states.

My testimony today highlights the impact of the legislative proposal introduced by Senators Graham, Cassidy, Heller, and Johnson to repeal and replace the Affordable Care Act, focusing particularly on the impact on Medicaid and the 74 million people served by the Medicaid program. My testimony draws, in part, on an analysis of the Graham-Cassidy proposal prepared by Manatt Health on behalf of the Robert Wood Johnson State Health & Value Strategies Project; that report is attached.

Graham-Cassidy proposal would create new and far reaching risks for people, states and the health care system.

- Through funding reductions and caps, it puts coverage at risk for virtually every group of individuals covered through "traditional" Medicaid, including one out of three children in the nation as well as millions of elderly and people with disabilities whose long term care services are covered by Medicaid.
- It will also harm—and in some cases pose life-threatening harm —to the 23 million people projected to be covered through the Medicaid expansion and the Marketplace in 2019, who, by the terms of this proposal, will lose their coverage on December 31, 2019.
- And for those purchasing coverage in the individual and small group market, Graham-Cassidy will trigger in the very short term new levels of destabilization and higher

premiums by maintaining guaranteed issue while ending the individual mandate without any replacement mechanism to promote enrollment of healthier individuals.

These and many additional issues are an unequivocal sign that we must devise a better approach, rooted in a bi-partisan process in Congress with input from states, consumers, and health care providers.

Graham-Cassidy Builds on a Deeply Flawed Bill

Graham-Cassidy builds on and incorporates most of the provisions of the Better Care Reconciliation Act (BCRA), which the Senate rejected this summer. Although some provisions have been modified, Graham-Cassidy largely adopts BCRA' s general framework and, in particular, the far-reaching changes it proposed to Medicaid – changes that go far beyond repealing and replacing the Affordable Care Act. Like BCRA, Graham-Cassidy would cut federal Medicaid funding deeply and fundamentally restructure Medicaid financing for the "traditional" (pre-expansion) Medicaid population. In addition, Graham-Cassidy takes a step beyond BCRA by terminating not only the enhanced funding for the Medicaid expansion but also the legal authority for states to cover low-income parents and other adults even with regular matching payments.[2]

More specifically, Graham-Cassidy would :

- **Impose deep cuts to Medicaid that grow over time.** While there is no score yet for the Graham-Cassidy proposal, the Congressional Budget Office (CBO) projected that the rejected BCRA bill upon which Graham-Cassidy is based would have cut Medicaid by $756 billion over ten years.[3] The cuts grow over time as the trend rates used to make the annual adjustments to the per capita caps drop beginning in 2025. Although Graham-Cassidy provides a modestly more generous trend rate than BCRA, under both proposals, the deepest cuts occur just beyond the CBO's 10-year budget scoring window.
- **Fundamentally change financing for most of the Medicaid program.** Graham-Cassidy would eliminate the federal government's guarantee to share with states the cost of all qualifying Medicaid expenditures by imposing per capita caps on federal spending for nearly all populations. Since Graham-Cassidy ends the Medicaid expansion, the consequences of this major change in financing falls solely on those enrolled in the "traditional" Medicaid program: newborns and other children, very low-income parents, pregnant women, and low-income seniors and people with disabilities.

[2] An exception is made for previously covered Native Americans under certain circumstances.
[3] Congressional Budget Office letter to the Honorable Mike Enzi re: H.R. 1628, the Better Care Reconciliation Act of 2017: An Amendment in the Nature of a Substitute [ERN17500], as Posted on the Website of the Senate Committee on the Budget on July 20, 2017, available at: https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/52941-hr1628bcra.pdf.

- **Shift all of the risk of higher costs onto states.** Under the proposal, states would bear the full risk of all costs that exceed the trend rates, which are set below expected levels of health care spending in order to achieve federal savings**.** By contrast, under current law, states and the federal government share the risk of unanticipated costs due, for example, to higher drug costs, new cancer treatments, or health emergencies like the opioid crises. States that are not able to shoulder significant new costs will need to reduce provider payment rates and benefits, increase beneficiary costs, or reduce eligibility.

Marketplace Health-Care Grants

The Graham-Cassidy proposal makes further structural changes to the health coverage landscape—beyond BCRA—by ending the tax credits and cost sharing subsidies available to people to purchase coverage in the marketplace. In place of these subsidies and the funding for Medicaid expansion, Graham-Cassidy establishes a "Market-Based Health Care Grant" block grant. Like other block grants, the total amount of federal funding for this block grant is not adjusted overt time to reflect changes in enrollment, use of services, or cost of care. In addition, the block grant would be temporary; funding is available only through 2026. States would be at full risk for any costs above the block grant funding—should they take on the massive new responsibilities that the federal government sends their way—and for all costs when the block grant ends in 2026. There is no guarantee whether and at what level federal funding would be available beginning in 2027.

Manatt Health analyzed the Graham-Cassidy proposal on behalf of the Robert Wood Johnson Foundation's State Health & Value Strategies Project.[4] While there are various analyses estimating the impact of the block grant component of the proposal, all estimates to date point in the same direction: the majority of states will lose federal funding under Graham-Cassidy, with some experiencing particularly large losses.

Key takeaways from Manatt' s analysis are noted here:

- **Total funding is below current law levels with much deeper cuts for some states.**

[4] We conducted two analyses. First we calculated unadjusted block grant allotments based on the basic formulas in the bill to show the state-by-state distribution of funding under the proposal. Given the amount of discretion that is included in the proposal for the Secretary of HHS to adjust the allotments, we also calculated illustrative state-by-state allotments using a Medicare price index to adjust allotments to account for differences in wages, input costs, and similar factors that impact health care spending. While our assumptions are necessarily uncertain, the analysis demonstrates that adjustments could result in significant-- and unknowable-- changes to a state's allocation. Update: State Policy and Budget Impacts of New Graham-Cassidy Repeal and Replace Proposal (September 19, 2017), available at: http://www.statenetwork.org/resource/update-state-policy-and-budget-impacts-of-new-graham-cassidy-repeal-and-replace-proposal/.

  - Over the 2020 to 2026 period, the block grant would provide 6.4% less federal funding than under current law with the gap growing over time; in 2026, national funding for the block grant is nearly 9 percent below current law spending projections.
  - The proposal radically alters the allocation of funding relative to current law, leaving many states with very deep cuts in funding. Over the 2020 to 2026 period, 29 states receive less in federal funding with an average reduction of 19 percent. Some states will see their funding cut by half.
- **No state is a "winner".**
  - The overall level of the block grant does not adjust for actual costs or enrollment; some states may receive adjustments in their allocations but at the expense of other states and all states are at risk for costs over the capped allotments.
  - Notably, these block grant allocations are in addition to other deep funding reductions in the proposal.
- **The time-limited funding creates added risks for states.** Under the proposal, the block grant ends in 2026, leaving states to take on substantial obligations with no guarantee of future funding.

States will be granted broad flexibility on how they use these funds. The funds can be used for many purposes in addition to coverage, and states will inevitably be faced with many competing pressures for how to spend these funds. Individuals who have gained coverage through Medicaid expansions and subsidized marketplace coverage have no assurance that they will receive any coverage, never mind coverage that is as affordable or comprehensive as that which is guaranteed under current law.

Implementation Challenges

Beyond the precipitous drop in funding and the sweeping programmatic changes advanced by this proposal, it is critical to consider the enormity of the responsibilities that will be shifted to states. States will have a very short time to consider how they will proceed and to then actually implement changes to launch new coverage and initiatives. It is no exaggeration to say that the Graham-Cassidy proposal will result in chaos for our health care system and most notably for the millions of people who have coverage through Medicaid and the Marketplaces today.

Attachment: *State Policy and Budget Impacts of the New Graham-Cassidy Repeal and Replace Proposal,* prepared by Manatt Health for the Robert Wood Johnson Foundation, State Health & Value Strategies, September 2017.

Update: State Policy and Budget Impacts of New Graham-Cassidy Repeal and Replace Proposal

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Authored by Manatt Health

A grantee of the Robert Wood Johnson Foundation

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IN THIS BRIEF

- ✓ After 2019, the Graham-Cassidy proposal would eliminate federal funding and authority for Medicaid expansion, as well as federal tax credit and cost-sharing reduction subsidies for Marketplace coverage.
- ✓ In 2020-2026, states instead would receive a block grant, referred to as a Market-Based Health Care allotment, which could be used for coverage, payments to providers, or other purposes.
- ✓ Over the 2020 to 2026 period, the block grant would provide 6.4 percent less federal funding than under current law. The size of the gap between current law funding and the block grant appropriation would be 8.9 percent by 2026.
- ✓ Depending on the year, between 25 and 38 states would have unadjusted allotments that provide less funding than under current law, and some of these states would see reductions of 50 percent or more in federal resources to support health coverage for low-income individuals.
- ✓ More than 23 million[2] people are projected to have subsidized coverage through Medicaid expansion or the Marketplace in 2019. Under Graham-Cassidy, Medicaid expansion coverage and the federal infrastructure for Marketplace subsidies would end, and states would have full responsibility for addressing the health care needs of low-income people without affordable coverage.
- ✓ 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.
- ✓ States would have far more flexibility to decide how to deploy federal resources, although the broad flexibility accompanying the new Market-Based Health Care allotments could leave them vulnerable to federal cuts in the future.

Introduction

This brief provides an overview of the proposal released on September 13th by Senators Lindsey Graham (R-SC) and Bill Cassidy (R-LA)—along with Senators Dean Heller (R-NV) and Ron Johnson (R-WI) and former Senator Rick Santorum (R-PA)—to "repeal and replace" the Affordable Care Act (ACA). This is an updated version of the proposal that Senators Graham and Cassidy filed on July 27th. The Graham-Cassidy ACA repeal and replace legislation would retain many features of the Better Care Reconciliation Act (BCRA) voted down by the Senate on July 25th, including per capita caps on Medicaid spending[1] and elimination of the individual and employer mandates. However, it also goes beyond that proposal by converting Marketplace and Medicaid expansion federal funding into a block grant.

OVERVIEW OF PROPOSAL

Graham-Cassidy would eliminate federal funding for Marketplace and Medicaid expansion coverage after 2019 and replace it with a capped allotment distributed to states in the form of "Market-Based Health Care" block grants. The national amounts available for state allotments would not vary based on actual costs or enrollment, and would be less than estimated current law federal spending on Marketplace and Medicaid expansion coverage. States would have significant flexibility to use their block grant funds for coverage, payments to providers or other health care-related purposes. As explained in the appendix and as illustrated by the state-by-state estimates provided in Tables 1A, 1B and 2 of this analysis, the proposal also alters the distribution of federal funds among states, sending dollars from expansion states and other states that receive a relatively significant share of current law federal subsidies for Marketplace coverage to non-expansion states and those with lower Marketplace participation and/or costs. No state match would be required. The block grant would end after 2026.

For coverage funded with block grant dollars, states would be granted waivers, upon request, of various federal rules governing coverage; these include restrictions on premium variation, rating rules based on health status, essential health benefit requirements, and minimum medical loss ratios. While these provisions apply only to insurance coverage funded under the allotment, by financing even a small coverage program with allotment dollars, it appears a state could make the new rules apply to the entire individual and small group markets.

Following is a summary of key issues and implications of the Graham-Cassidy proposal for states, consumers, and other stakeholders.

Market-Based Health Care Grant Program - The Market-Based Health Care Grant Program is the block grant that replaces federal funding for Marketplace subsidies and Medicaid expansion coverage after 2019. States would have significant flexibility to use their block grant funds for coverage, payments to providers, or other health care-related purposes. In 2020, the available block grant funds are distributed among states based on their historic spending patterns for Marketplace, Basic Health Program (BHP), and Medicaid

expansion coverage. Over time, however, the block grant formula increasingly distributes federal dollars based on each state's share of low-income (between 45 percent and 133 percent of the federal poverty level (FPL)) individuals nationwide, adjusted to reflect the risk profile of the state's low-income population, the actuarial value of coverage funded by the state with block grant dollars, and a discretionary state-specific adjustment by the Secretary of Health and Human Services (HHS). These adjustments do not add any new dollars to the block grant, but can result in changes in the distribution of block grant funds among states. In the case of the Secretary's state-specific adjustment, the size of and specifications for the adjustment are open-ended. In 2020 and 2021, an additional contingency fund appropriation is available to increase allotments for states with low population densities (Alaska, Montana, North Dakota, South Dakota, and Wyoming) and those that did not expand Medicaid under the ACA.

Manatt's estimates indicate the block grant program would provide a lower level of funding at the national level relative to current law and result in a substantial redistribution of the remaining resources among states.[3]

- Over 2020 to 2026, the block grant would provide states with $81.6 billion less in federal funding than would be available under current law, a reduction of 6.4 percent. In 2026, national funding for the block grant is 8.9 percent below current law spending projections.
- Most states would receive less funding under the block grant than under current law. As shown in Table 1A, 32 states would receive less federal funding in 2020 under the unadjusted amount of the block grant. By 2026, some states fare better, but the majority (27 states) continue to face a loss of federal funding. Over the 2020 to 2026 period, 29 states receive less in federal funding with an average reduction of 19 percent.
- In some states, the loss of federal funding is significantly higher, reflecting the disparate impact of the Graham-Cassidy proposal on states that have expanded Medicaid and/or generally have higher-cost care. States such as Alaska, Connecticut, Delaware, New Hampshire, New Mexico, New York, Oregon, Vermont, and Washington would see reductions of 25 percent or more over the 2020 to 2026 period under the Graham-Cassidy unadjusted allotments relative to current law.
- Over 2020 to 2026, 22 states would receive more federal funding under their unadjusted block grant amount than under current law, although they still would face cuts as a result of the Medicaid per capita cap included in the Graham-Cassidy proposal.[4] This group of states is dominated by non-expansion states, but also includes some expansion states with relatively low Medicaid and/or Marketplace expenditures per person.
- Allowable adjustments to the block grant amounts could result in significant changes in the distribution of federal resources among states. For example, if the Secretary elects to take the geographic cost of providing services into account using a Medicare price index, 33 states see a decrease in their 2020 to 2026 federal funding from the adjustment while the remaining states see an increase. This is because the Secretary can only increase funding for higher cost states by reducing the federal funding available for lower cost states. With the price adjustment, the number of states receiving less 2020 to 2026 federal funding relative to current law increases from 29 to 31.

See Table 1A for estimates of state-by-state federal funding for unadjusted allotments under the Market-Based Health Care Grant Program. To illustrate the potential impact of the adjustments, Table 1B provides illustrative estimates that assume the Secretary of HHS adjusts each state's allotment to reflect a state-specific measure of the cost of providing care. Table 2 provides additional detail on current law federal expenditures for Marketplace, BHP, and Medicaid expansion coverage.

State Responsibility for Coverage - More than 23 million[5] people are projected to have subsidized coverage through the Medicaid expansion or Marketplace in 2019. Under Graham-Cassidy, Medicaid expansion coverage and the federal infrastructure for Marketplace subsidies would end, and as of January 1, 2020, states would assume full responsibility for addressing health care needs for low-income individuals who do not have affordable insurance. The block grant, however, provides states with less funding to do so as compared to current law funding levels.

- Graham-Cassidy would provide new state flexibility, including to repurpose federal dollars away from coverage to payments to providers or other health care-related initiatives. However, the lack of a clear connection to coverage and minimal federal requirements may put the funding at greater risk for reductions in the future.
- In addition to determining how best to use block grant funds to address lack of coverage, stabilize the market and reduce premiums and other out-of-pocket costs, state policymakers may face pressure to use some of these funds to address state budget issues, heightened by other components of the bill, including the per capita cap on federal Medicaid payments[6] and the bill's restriction on states' use of provider taxes and assessments.[7]
- 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.

Waiver Authority and Effects on Individuals with Pre-Existing Conditions - The proposal gives states broad latitude to obtain waivers (under new authority) of the ACA's consumer protection and insurance regulation provisions for individual or small group coverage funded through the Market-Based Health Care Grant Program. States would have the flexibility to eliminate the essential health benefit or any other benefit rule; allow insurers to vary premiums based on health, age, or any factor other than sex or membership in a protected class; and eliminate requirements for a minimum medical loss ratio. In states that obtain waivers, individuals with pre-existing conditions could face substantially higher premiums in the individual and small group markets, or find their policies do not cover essential services. While coverage must be available on a guaranteed-issue basis, states could obtain waivers to permit insurers to increase premiums or contributions based on health status, or carve out or limit coverage for the specific treatments they need. Unlike under the ACA's Section 1332 waivers, there are no coverage "guardrails" limiting the waivers. Instead, states must describe in their waiver applications how individuals with pre-existing conditions will have "adequate" and "affordable" coverage.

Implications for Individual Market/Marketplace Coverage - The proposal eliminates the individual and employer mandates, the premium tax credit and cost-sharing subsidies, and permits a broader range of individuals to purchase catastrophic coverage, but leaves many of the other current law (ACA) requirements for individual market and Marketplace plans in place unless a state seeks a waiver. Without state action, premiums in this market would likely increase substantially, potentially destabilizing the market.

Other Key Medicaid Provisions - As noted, Graham-Cassidy not only establishes the Market-Based Health Care allotments, but also permanently terminates the state option to expand Medicaid; beginning in 2020, states would no longer have the option to cover expansion populations, even at the regular match (with the exception of grandfathered Native American populations, under certain circumstances). In addition, it converts Medicaid funding to a per capita cap (although the current draft includes a more favorable trend rate for elderly and disabled populations than earlier versions of Senate repeal and replace legislation and for frontier states with low Market-Based Health Care allotments, the proposed legislation delays implementation of the per capita cap). States with allotments that grow, relative to a base year, by less than the medical component of the Consumer Price Index (CPI) would be eligible for a proportionate reduction in their otherwise applicable Medicaid disproportionate share hospital (DSH) cuts, but would need to provide the non-federal share to draw down these dollars. However, Graham-Cassidy no longer delays pending Medicaid DSH reductions for non-expansion states (or states that drop their expansion), meaning that all states will experience DSH reductions in federal fiscal year (FFY) 2018. Both hospitals and states also will see an impact from the bill's provision that restricts states' abilities to rely on provider taxes, phasing down the allowable tax safe harbor from 6 percent to 4 percent in FFY 2025 and beyond. Graham-Cassidy also modifies longstanding Medicaid retroactive eligibility authority for most Medicaid beneficiaries to provide only two (not three) months of coverage; three months of retroactive coverage would continue to be available for recipients who are 65 or older and who are eligible for Medicaid on the basis of being blind or disabled at the time the application is made. Finally, the legislation no longer includes an earlier BCRA provision that appropriated $45 billion for substance use disorder treatment and recovery services, plus $252 million for research.

CONCLUSION

The Graham-Cassidy proposal would have major implications for states and their residents given the smaller pool of federal funding that would be available for coverage as compared to funding under current law, the redistribution of the reduced federal funds among states, the major restructuring of federal financing for state Medicaid programs overall, and the ability for states to waive key consumer protections of the ACA. Particularly in the long term, given that national amounts for the new block grants would be indexed at a rate below general inflation and then terminated after 2026, coupled with the establishment of per capita caps for all non-expansion populations in the Medicaid program, the legislation could create significant fiscal and political pressure on state policymakers. Finally, the proposal provides states with significant flexibility to determine how to use their federal block grant dollars, but it also provides the Secretary of HHS with substantial flexibility to decide how to distribute federal block grant funds among states.

Table 1A. Estimated Federal Spending for Marketplace and Medicaid Expansion Under Current Law Versus Unadjusted Allotments Under Graham-Cassidy, 2020-2026 (millions)

State	Marketplace, BHP, and Medicaid expansion under current law[1]				Graham-Cassidy unadjusted allotment[2]							
					Amount				Change relative to current law			
	2020	2021	2026	2020-2026	2020	2021	2026	2020-2026	2020	2021	2026	2020-2026
United States	$155,932	$164,363	$208,636	$1,268,550	$152,000	$151,000	$190,000	$1,187,000	$(3,932)	$(13,363)	$(18,636)	$(81,550)
Alabama	$1,481	$1,550	$1,802	$11,493	$1,284	$1,601	$3,564	$16,842	$(197)	$51	$1,762	$5,349
Alaska	$579	$610	$767	$4,694	$928	$772	$281	$3,534	$349	$162	$(486)	$(1,160)
Arizona	$4,201	$4,469	$5,972	$35,315	$4,106	$4,041	$4,936	$31,619	$(95)	$(428)	$(1,036)	$(3,696)
Arkansas	$1,709	$1,803	$2,337	$14,060	$1,737	$1,734	$2,246	$13,938	$28	$(69)	$(91)	$(122)
California	$26,390	$27,812	$35,486	$215,291	$25,688	$24,233	$24,263	$174,185	$(702)	$(3,579)	$(11,223)	$(41,106)
Colorado	$2,454	$2,589	$3,328	$20,117	$2,437	$2,317	$2,418	$16,939	$(17)	$(272)	$(910)	$(3,178)
Connecticut	$2,085	$2,198	$2,806	$17,025	$2,026	$1,844	$1,486	$12,213	$(59)	$(354)	$(1,320)	$(4,812)
Delaware	$777	$820	$1,058	$6,381	$780	$696	$483	$4,383	$3	$(124)	$(575)	$(1,998)
District of Columbia	$380	$402	$530	$3,159	$406	$385	$395	$2,792	$26	$(17)	$(135)	$(367)
Florida	$10,211	$10,660	$12,357	$78,868	$8,902	$9,258	$14,188	$79,040	$(1,309)	$(1,402)	$1,831	$172
Georgia	$2,730	$2,850	$3,302	$21,082	$2,380	$3,047	$7,056	$32,834	$(350)	$197	$3,754	$11,752
Hawaii	$654	$690	$897	$5,387	$670	$627	$604	$4,441	$16	$(63)	$(293)	$(946)
Idaho	$549	$573	$663	$4,237	$479	$544	$1,024	$5,187	$(70)	$(29)	$361	$950
Illinois	$4,580	$4,824	$6,086	$37,154	$4,328	$4,440	$6,334	$37,368	$(252)	$(384)	$248	$214
Indiana	$2,703	$2,848	$3,665	$22,136	$2,707	$2,834	$4,324	$24,662	$4	$(14)	$659	$2,526
Iowa	$872	$919	$1,164	$7,091	$828	$892	$1,482	$8,111	$(44)	$(27)	$318	$1,020
Kansas	$553	$579	$671	$4,289	$479	$688	$1,851	$8,153	$(74)	$109	$1,180	$3,864
Kentucky	$4,023	$4,247	$5,564	$33,293	$4,200	$3,897	$3,560	$27,025	$177	$(350)	$(2,004)	$(6,268)
Louisiana	$2,624	$2,763	$3,493	$21,296	$2,500	$2,543	$3,526	$21,111	$(124)	$(220)	$33	$(185)
Maine	$489	$512	$594	$3,793	$423	$468	$835	$4,333	$(66)	$(44)	$241	$540
Maryland	$2,228	$2,347	$2,992	$18,156	$2,174	$2,132	$2,565	$16,568	$(54)	$(215)	$(427)	$(1,588)
Massachusetts	$2,935	$3,087	$3,948	$23,908	$2,906	$2,820	$3,241	$21,474	$(29)	$(267)	$(707)	$(2,434)
Michigan	$5,629	$5,934	$7,640	$46,134	$5,623	$5,289	$5,214	$37,779	$(6)	$(645)	$(2,426)	$(8,355)
Minnesota	$2,533	$2,674	$3,462	$20,855	$2,588	$2,416	$2,284	$16,975	$55	$(258)	$(1,178)	$(3,880)
Mississippi	$507	$529	$614	$3,916	$442	$803	$2,661	$10,942	$(65)	$274	$2,047	$7,026
Missouri	$1,501	$1,571	$1,824	$11,640	$1,301	$1,473	$2,758	$14,007	$(200)	$(98)	$934	$2,367
Montana	$1,022	$1,077	$1,362	$8,303	$1,669	$1,416	$613	$6,747	$647	$339	$(749)	$(1,556)
Nebraska	$679	$712	$829	$5,288	$586	$621	$999	$5,435	$(93)	$(91)	$170	$147

Table 1A. Continued

State	Marketplace, BHP, and Medicaid expansion under current law[1]				Graham-Cassidy unadjusted allotment[2]							
					Amount				Change relative to current law			
	2020	2021	2026	2020-2026	2020	2021	2026	2020-2026	2020	2021	2026	2020-2026
Nevada	$1,526	$1,623	$2,171	$12,834	$1,515	$1,498	$1,864	$11,820	$(11)	$(125)	$(307)	$(1,014)
New Hampshire	$541	$570	$730	$4,421	$530	$491	$441	$3,381	$(11)	$(79)	$(289)	$(1,040)
New Jersey	$5,020	$5,290	$6,768	$41,002	$4,937	$4,654	$4,643	$33,405	$(83)	$(636)	$(2,125)	$(7,597)
New Mexico	$2,109	$2,227	$2,918	$17,460	$2,199	$1,986	$1,520	$12,920	$90	$(241)	$(1,398)	$(4,540)
New York	$17,024	$18,194	$25,537	$147,102	$17,151	$15,487	$11,833	$100,712	$127	$(2,707)	$(13,704)	$(46,390)
North Carolina	$4,917	$5,148	$5,986	$38,183	$4,256	$4,403	$6,653	$37,323	$(661)	$(745)	$667	$(860)
North Dakota	$280	$296	$374	$2,280	$460	$445	$382	$2,641	$180	$149	$8	$361
Ohio	$5,054	$5,331	$6,913	$41,587	$5,140	$5,135	$6,658	$41,290	$86	$(196)	$(255)	$(297)
Oklahoma	$1,252	$1,312	$1,527	$9,739	$1,081	$1,315	$2,812	$13,506	$(171)	$3	$1,285	$3,767
Oregon	$4,317	$4,562	$6,011	$35,824	$4,403	$3,834	$2,145	$22,668	$86	$(728)	$(3,866)	$(13,156)
Pennsylvania	$6,067	$6,389	$8,043	$49,157	$5,699	$5,527	$6,330	$42,028	$(368)	$(862)	$(1,713)	$(7,129)
Rhode Island	$520	$548	$703	$4,250	$519	$499	$546	$3,718	$(1)	$(49)	$(157)	$(532)
South Carolina	$1,434	$1,499	$1,743	$11,112	$1,245	$1,468	$2,972	$14,597	$(189)	$(31)	$1,229	$3,485
South Dakota	$216	$226	$264	$1,680	$302	$362	$508	$2,658	$86	$136	$244	$978
Tennessee	$1,825	$1,912	$2,224	$14,189	$1,576	$1,976	$4,433	$20,883	$(249)	$64	$2,209	$6,694
Texas	$5,688	$5,944	$6,898	$44,016	$4,946	$6,835	$17,530	$78,513	$(742)	$891	$10,632	$34,497
Utah	$739	$772	$895	$5,714	$642	$757	$1,536	$7,539	$(97)	$(15)	$641	$1,825
Vermont	$526	$555	$709	$4,297	$518	$462	$319	$2,905	$(8)	$(93)	$(390)	$(1,392)
Virginia	$1,982	$2,071	$2,402	$15,329	$1,725	$2,022	$4,051	$19,983	$(257)	$(49)	$1,649	$4,654
Washington	$4,861	$5,140	$6,822	$40,481	$5,010	$4,527	$3,476	$29,486	$149	$(613)	$(3,346)	$(10,995)
West Virginia	$1,326	$1,399	$1,806	$10,893	$1,331	$1,265	$1,318	$9,244	$5	$(134)	$(488)	$(1,649)
Wisconsin	$1,427	$1,494	$1,734	$11,071	$1,956	$1,942	$2,590	$15,475	$529	$448	$856	$4,404
Wyoming	$203	$212	$245	$1,568	$284	$279	$252	$1,668	$81	$67	$7	$100

Source: Manatt Health analysis.

Notes: Amounts assume that the entire 2020 allotment amount of $146 billion is distributed to states, including the $10 billion reserve fund. In addition, amounts shown here include $6 billion in 2020 and $5 billion in 2021 to increase allotments for low-density (AK, MT, ND, SD, WY) and non-expansion states.

1. Amounts are for federal fiscal years. See Table 2 for additional detail.

2. Estimates assume that states will choose 2017 as their base year for use in allotment calculations. As a result, amounts differ from those provided on Senator Cassidy's website (https://www.cassidy.senate.gov/read-about-graham-cassidy-heller-johnson), which use 2016 as the base year.

Table 1B. Estimated Federal Spending for Marketplace and Medicaid Expansion Under Current Law Versus Adjusted Allotments Under Graham-Cassidy, 2020-2026 (millions)

State	Marketplace, BHP, and Medicaid expansion under current law[1]				Graham-Cassidy allotment with illustrative price adjustment[2]							
					Amount				Change relative to current law			
	2020	2021	2026	2020-2026	2020	2021	2026	2020-2026	2020	2021	2026	2020-2026
United States	$155,932	$164,363	$208,636	$1,268,550	$152,000	$151,000	$190,000	$1,187,000	$(3,932)	$(13,363)	$(18,636)	$(81,550)
Alabama	$1,481	$1,550	$1,802	$11,493	$1,284	$1,361	$3,059	$14,523	$(197)	$(189)	$1,257	$3,030
Alaska	$579	$610	$767	$4,694	$928	$863	$345	$4,013	$349	$253	$(422)	$(681)
Arizona	$4,201	$4,469	$5,972	$35,315	$4,106	$3,901	$4,902	$31,092	$(95)	$(568)	$(1,070)	$(4,223)
Arkansas	$1,709	$1,803	$2,337	$14,060	$1,737	$1,486	$1,979	$12,359	$28	$(317)	$(358)	$(1,701)
California	$26,390	$27,812	$35,486	$215,291	$25,688	$27,581	$28,409	$197,306	$(702)	$(231)	$(7,077)	$(17,985)
Colorado	$2,454	$2,589	$3,328	$20,117	$2,437	$2,223	$2,386	$16,563	$(17)	$(366)	$(942)	$(3,554)
Connecticut	$2,085	$2,198	$2,806	$17,025	$2,026	$2,007	$1,664	$13,276	$(59)	$(191)	$(1,142)	$(3,749)
Delaware	$777	$820	$1,058	$6,381	$780	$689	$492	$4,400	$3	$(131)	$(566)	$(1,981)
District of Columbia	$380	$402	$530	$3,159	$406	$417	$440	$3,032	$26	$15	$(90)	$(127)
Florida	$10,211	$10,660	$12,357	$78,868	$8,902	$8,526	$13,322	$74,073	$(1,309)	$(2,134)	$965	$(4,795)
Georgia	$2,730	$2,850	$3,302	$21,082	$2,380	$2,748	$6,472	$30,054	$(350)	$(102)	$3,170	$8,972
Hawaii	$654	$690	$897	$5,387	$670	$696	$690	$4,917	$16	$6	$(207)	$(470)
Idaho	$549	$573	$663	$4,237	$479	$505	$972	$4,901	$(70)	$(68)	$309	$664
Illinois	$4,580	$4,824	$6,086	$37,154	$4,328	$4,246	$6,232	$36,448	$(252)	$(578)	$146	$(706)
Indiana	$2,703	$2,848	$3,665	$22,136	$2,707	$2,594	$4,071	$23,140	$4	$(254)	$406	$1,004
Iowa	$872	$919	$1,164	$7,091	$828	$831	$1,421	$7,732	$(44)	$(88)	$257	$641
Kansas	$553	$579	$671	$4,289	$479	$619	$1,692	$7,432	$(74)	$40	$1,021	$3,143
Kentucky	$4,023	$4,247	$5,564	$33,293	$4,200	$3,447	$3,239	$24,690	$177	$(800)	$(2,325)	$(8,603)
Louisiana	$2,624	$2,763	$3,493	$21,296	$2,500	$2,206	$3,146	$18,905	$(124)	$(557)	$(347)	$(2,391)
Maine	$489	$512	$594	$3,793	$423	$451	$824	$4,240	$(66)	$(61)	$230	$447
Maryland	$2,228	$2,347	$2,992	$18,156	$2,174	$2,376	$2,940	$18,471	$(54)	$29	$(52)	$315
Massachusetts	$2,935	$3,087	$3,948	$23,908	$2,906	$3,100	$3,665	$23,641	$(29)	$13	$(283)	$(267)
Michigan	$5,629	$5,934	$7,640	$46,134	$5,623	$5,044	$5,116	$36,765	$(6)	$(890)	$(2,524)	$(9,369)
Minnesota	$2,533	$2,674	$3,462	$20,855	$2,588	$2,428	$2,361	$17,268	$55	$(246)	$(1,101)	$(3,587)
Mississippi	$507	$529	$614	$3,916	$442	$695	$2,331	$9,563	$(65)	$166	$1,717	$5,647
Missouri	$1,501	$1,571	$1,824	$11,640	$1,301	$1,339	$2,552	$12,943	$(200)	$(232)	$728	$1,303
Montana	$1,022	$1,077	$1,362	$8,303	$1,669	$1,382	$605	$6,629	$647	$305	$(757)	$(1,674)
Nebraska	$679	$712	$829	$5,288	$586	$585	$963	$5,208	$(93)	$(127)	$134	$(80)

Table 1B. Continued

State	Marketplace, BHP, and Medicaid expansion under current law[1]				Graham-Cassidy allotment with illustrative price adjustment[2]							
					Amount				Change relative to current law			
	2020	2021	2026	2020-2026	2020	2021	2026	2020-2026	2020	2021	2026	2020-2026
Nevada	$1,526	$1,623	$2,171	$12,834	$1,515	$1,512	$1,935	$12,080	$(11)	$(111)	$(236)	$(754)
New Hampshire	$541	$570	$730	$4,421	$530	$498	$460	$3,466	$(11)	$(72)	$(270)	$(955)
New Jersey	$5,020	$5,290	$6,768	$41,002	$4,937	$4,939	$5,068	$35,610	$(83)	$(351)	$(1,700)	$(5,392)
New Mexico	$2,109	$2,227	$2,918	$17,460	$2,199	$1,911	$1,505	$12,667	$90	$(316)	$(1,413)	$(4,793)
New York	$17,024	$18,194	$25,537	$147,102	$17,151	$17,080	$13,426	$110,645	$127	$(1,114)	$(12,111)	$(36,457)
North Carolina	$4,917	$5,148	$5,986	$38,183	$4,256	$4,070	$6,272	$35,101	$(661)	$(1,078)	$286	$(3,082)
North Dakota	$280	$296	$374	$2,280	$460	$427	$367	$2,538	$180	$131	$(7)	$258
Ohio	$5,054	$5,331	$6,913	$41,587	$5,140	$4,706	$6,277	$38,809	$86	$(625)	$(636)	$(2,778)
Oklahoma	$1,252	$1,312	$1,527	$9,739	$1,081	$1,164	$2,525	$12,136	$(171)	$(148)	$998	$2,397
Oregon	$4,317	$4,562	$6,011	$35,824	$4,403	$3,926	$2,260	$23,358	$86	$(636)	$(3,751)	$(12,466)
Pennsylvania	$6,067	$6,389	$8,043	$49,157	$5,699	$5,313	$6,260	$41,177	$(368)	$(1,076)	$(1,783)	$(7,980)
Rhode Island	$520	$548	$703	$4,250	$519	$521	$586	$3,913	$(1)	$(27)	$(117)	$(337)
South Carolina	$1,434	$1,499	$1,743	$11,112	$1,245	$1,324	$2,727	$13,381	$(189)	$(175)	$984	$2,269
South Dakota	$216	$226	$264	$1,680	$302	$352	$497	$2,590	$86	$126	$233	$910
Tennessee	$1,825	$1,912	$2,224	$14,189	$1,576	$1,716	$3,897	$18,400	$(249)	$(196)	$1,673	$4,211
Texas	$5,688	$5,944	$6,898	$44,016	$4,946	$6,255	$16,346	$72,913	$(742)	$311	$9,448	$28,897
Utah	$739	$772	$895	$5,714	$642	$701	$1,451	$7,092	$(97)	$(71)	$556	$1,378
Vermont	$526	$555	$709	$4,297	$518	$482	$343	$3,045	$(8)	$(73)	$(366)	$(1,252)
Virginia	$1,982	$2,071	$2,402	$15,329	$1,725	$1,884	$3,853	$18,920	$(257)	$(187)	$1,451	$3,591
Washington	$4,861	$5,140	$6,822	$40,481	$5,010	$4,600	$3,634	$30,246	$149	$(540)	$(3,188)	$(10,235)
West Virginia	$1,326	$1,399	$1,806	$10,893	$1,331	$1,134	$1,215	$8,532	$5	$(265)	$(591)	$(2,361)
Wisconsin	$1,427	$1,494	$1,734	$11,071	$1,956	$1,862	$2,544	$15,084	$529	$368	$810	$4,013
Wyoming	$203	$212	$245	$1,568	$284	$282	$264	$1,714	$81	$70	$19	$146

Source: Manatt Health analysis.

Notes: Amounts assume that the entire 2020 allotment amount of $146 billion is distributed to states, including the $10 billion reserve fund. In addition, amounts shown here include $6 billion in 2020 and $5 billion in 2021 to increase allotments for low-density (AK, MT, ND, SD, WY) and non-expansion states.

1. Amounts are for federal fiscal years. See Table 2 for additional detail.

2. The Graham-Cassidy proposal includes state-level allotment adjustments for population risk, actuarial value of coverage, and, at the Secretary of HHS's discretion, state-specific factors (e.g., wage rates). For illustrative purposes, amounts shown here include a state-specific adjustment based on a price index constructed using actual and standardized Medicare costs per capita for 2015 (https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Geographic-Variation/GV_PUF.html).

Table 2. Detail on Estimated Federal Spending for Marketplace and Medicaid Expansion Coverage Under Current Law, 2020-2026 (millions)

State	2020			2021			2026			2020-2026		
	Marketplace[1] and BHP[2]	Medicaid expansion[3]	Total	Marketplace[1] and BHP[2]	Medicaid expansion[3]	Total	Marketplace[1] and BHP[2]	Medicaid expansion[3]	Total	Marketplace[1] and BHP[2]	Medicaid expansion[3]	Total
United States	$69,910	$86,022	$155,932	$73,396	$90,967	$164,363	$87,672	$120,964	$208,636	$550,477	$718,073	$1,268,550
Alabama	$1,481	$-	$1,481	$1,550	$-	$1,550	$1,802	$-	$1,802	$11,493	$-	$11,493
Alaska	$242	$337	$579	$254	$356	$610	$296	$471	$767	$1,888	$2,806	$4,694
Arizona	$1,201	$3,000	$4,201	$1,262	$3,207	$4,469	$1,471	$4,501	$5,972	$9,382	$25,933	$35,315
Arkansas	$293	$1,416	$1,709	$306	$1,497	$1,803	$356	$1,981	$2,337	$2,269	$11,791	$14,060
California	$7,990	$18,400	$26,390	$8,369	$19,443	$27,812	$9,739	$25,747	$35,486	$62,104	$153,187	$215,291
Colorado	$585	$1,869	$2,454	$614	$1,975	$2,589	$714	$2,614	$3,328	$4,559	$15,558	$20,117
Connecticut	$636	$1,449	$2,085	$667	$1,531	$2,198	$779	$2,027	$2,806	$4,960	$12,065	$17,025
Delaware	$162	$615	$777	$170	$650	$820	$197	$861	$1,058	$1,259	$5,122	$6,381
District of Columbia	$4	$376	$380	$4	$398	$402	$4	$526	$530	$28	$3,131	$3,159
Florida	$10,211	$-	$10,211	$10,660	$-	$10,660	$12,357	$-	$12,357	$78,868	$-	$78,868
Georgia	$2,730	$-	$2,730	$2,850	$-	$2,850	$3,302	$-	$3,302	$21,082	$-	$21,082
Hawaii	$98	$556	$654	$102	$588	$690	$119	$778	$897	$757	$4,630	$5,387
Idaho	$549	$-	$549	$573	$-	$573	$663	$-	$663	$4,237	$-	$4,237
Illinois	$1,785	$2,795	$4,580	$1,871	$2,953	$4,824	$2,177	$3,909	$6,086	$13,887	$23,267	$37,154
Indiana	$593	$2,110	$2,703	$619	$2,229	$2,848	$715	$2,950	$3,665	$4,573	$17,563	$22,136
Iowa	$328	$544	$872	$344	$575	$919	$403	$761	$1,164	$2,561	$4,530	$7,091
Kansas	$553	$-	$553	$579	$-	$579	$671	$-	$671	$4,289	$-	$4,289
Kentucky	$335	$3,688	$4,023	$350	$3,897	$4,247	$406	$5,158	$5,564	$2,591	$30,702	$33,293
Louisiana	$970	$1,654	$2,624	$1,015	$1,748	$2,763	$1,180	$2,313	$3,493	$7,525	$13,771	$21,296
Maine	$489	$-	$489	$512	$-	$512	$594	$-	$594	$3,793	$-	$3,793
Maryland	$668	$1,560	$2,228	$698	$1,649	$2,347	$810	$2,182	$2,992	$5,168	$12,988	$18,156
Massachusetts	$776	$2,159	$2,935	$806	$2,281	$3,087	$929	$3,019	$3,948	$5,935	$17,973	$23,908
Michigan	$1,269	$4,360	$5,629	$1,327	$4,607	$5,934	$1,542	$6,098	$7,640	$9,836	$36,298	$46,134
Minnesota	$915	$1,618	$2,533	$965	$1,709	$2,674	$1,200	$2,262	$3,462	$7,389	$13,466	$20,855
Mississippi	$507	$-	$507	$529	$-	$529	$614	$-	$614	$3,916	$-	$3,916
Missouri	$1,501	$-	$1,501	$1,571	$-	$1,571	$1,824	$-	$1,824	$11,640	$-	$11,640
Montana	$375	$647	$1,022	$393	$684	$1,077	$457	$905	$1,362	$2,917	$5,386	$8,303
Nebraska	$679	$-	$679	$712	$-	$712	$829	$-	$829	$5,288	$-	$5,288

Table 2. Continued

State	2020			2021			2026			2020-2026		
	Marketplace[1] and BHP[2]	Medicaid expansion[3]	Total	Marketplace[1] and BHP[2]	Medicaid expansion[3]	Total	Marketplace[1] and BHP[2]	Medicaid expansion[3]	Total	Marketplace[1] and BHP[2]	Medicaid expansion[3]	Total
Nevada	$372	$1,154	$1,526	$389	$1,234	$1,623	$450	$1,721	$2,171	$2,877	$9,957	$12,834
New Hampshire	$155	$386	$541	$162	$408	$570	$190	$540	$730	$1,205	$3,216	$4,421
New Jersey	$1,373	$3,647	$5,020	$1,436	$3,854	$5,290	$1,668	$5,100	$6,768	$10,641	$30,361	$41,002
New Mexico	$185	$1,924	$2,109	$194	$2,033	$2,227	$227	$2,691	$2,918	$1,442	$16,018	$17,460
New York	$4,978	$12,046	$17,024	$5,466	$12,728	$18,194	$8,691	$16,846	$25,537	$46,825	$100,277	$147,102
North Carolina	$4,917	$-	$4,917	$5,148	$-	$5,148	$5,986	$-	$5,986	$38,183	$-	$38,183
North Dakota	$99	$181	$280	$104	$192	$296	$120	$254	$374	$769	$1,511	$2,280
Ohio	$847	$4,207	$5,054	$886	$4,445	$5,331	$1,030	$5,883	$6,913	$6,567	$35,020	$41,587
Oklahoma	$1,252	$-	$1,252	$1,312	$-	$1,312	$1,527	$-	$1,527	$9,739	$-	$9,739
Oregon	$674	$3,643	$4,317	$707	$3,855	$4,562	$824	$5,187	$6,011	$5,253	$30,571	$35,824
Pennsylvania	$2,472	$3,595	$6,067	$2,591	$3,798	$6,389	$3,016	$5,027	$8,043	$19,233	$29,924	$49,157
Rhode Island	$120	$400	$520	$125	$423	$548	$143	$560	$703	$918	$3,332	$4,250
South Carolina	$1,434	$-	$1,434	$1,499	$-	$1,499	$1,743	$-	$1,743	$11,112	$-	$11,112
South Dakota	$216	$-	$216	$226	$-	$226	$264	$-	$264	$1,680	$-	$1,680
Tennessee	$1,825	$-	$1,825	$1,912	$-	$1,912	$2,224	$-	$2,224	$14,189	$-	$14,189
Texas	$5,688	$-	$5,688	$5,944	$-	$5,944	$6,898	$-	$6,898	$44,016	$-	$44,016
Utah	$739	$-	$739	$772	$-	$772	$895	$-	$895	$5,714	$-	$5,714
Vermont	$140	$386	$526	$147	$408	$555	$169	$540	$709	$1,084	$3,213	$4,297
Virginia	$1,982	$-	$1,982	$2,071	$-	$2,071	$2,402	$-	$2,402	$15,329	$-	$15,329
Washington	$613	$4,248	$4,861	$640	$4,500	$5,140	$741	$6,081	$6,822	$4,734	$35,747	$40,481
West Virginia	$274	$1,052	$1,326	$287	$1,112	$1,399	$335	$1,471	$1,806	$2,134	$8,759	$10,893
Wisconsin	$1,427	$-	$1,427	$1,494	$-	$1,494	$1,734	$-	$1,734	$11,071	$-	$11,071
Wyoming	$203	$-	$203	$212	$-	$212	$245	$-	$245	$1,568	$-	$1,568

Source: Manatt Health analysis.
Notes: Amounts are for federal fiscal years.

1. Reflects national growth as projected by CBO, applied to state-level amounts. Estimate based on:
   - 2017 tax credit data for all states (https://downloads.cms.gov/files/effectuated-enrollment-snapshot-report-06-12-17.pdf);
   - 2016 cost-sharing reduction (CSR) data for 38 healthcare.gov states (https://aspe.hhs.gov/health-insurance-marketplace-cost-sharing-reduction-subsidies-zip-code-and-county-2016), with national average applied to CSR enrollees in remaining states (https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/Effectuated_Quarterly_Snapshots.html);
   - September 2017 CBO projections for national totals (https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53091-fshic.pdf). Because CBO recently revised its projections, current law estimates shown here differ from a previous publication describing an earlier version of the Graham-Cassidy proposal (http://www.statenetwork.org/wp-content/uploads/2017/08/SHVS_Repeal-and-Replace_Final.pdf).
2. MN and NY provide BHP coverage for certain individuals who would otherwise be eligible for subsidies through the Marketplace. Estimates of federal funding reflect projections in state budget documents, with amounts extended out to 2026 using 2021 growth rate (https://mn.gov/dhs/general-public/publications-forms-resources/reports/financial-reports-and-forecasts.jsp; https://www.budget.ny.gov/pubs/archive/fy18archive/enactedfy18/FY2018EnactedFP.pdf).
3. Estimate based on Manatt Medicaid Financing Model (for background, see http://www.statenetwork.org/resource/understanding-the-senates-better-care-reconciliation-act-of-2017-bcra-key-implications-for-medicaid/). Note that the national figure differs from CBO baseline for ACA subsidies (https://www.cbo.gov/sites/default/files/recurringdata/51298-2017-01-healthinsurance.pdf) in part because CBO: (1) only breaks out federal spending on Medicaid expansion for individuals who were made eligible by the ACA; (2) assumes that additional states have expanded by 2020. Spending from the Manatt Medicaid Financing Model includes newly eligible individuals in the expansion adult group but also those who were eligible under pre-ACA rules, for whom states may receive enhanced federal match (AZ, DE, HI, MA, MN, NY, VT, WA) and/or regular federal match (AR, CO, CT, IL, IN, IA, MI, NH, NY, ND, OH, OR, PA; in all but IN, NY, and OR the estimated share of expansion group enrollees at regular match is less than 10 percent).

Appendix: Additional Details on the Market-based Health Care Grant Program

National Funding Levels

- 2020: $146 billion (with $10 billion out of 2020 appropriation reserved for an increase in 2020 allotments of up to 5 percent for each state, with any unspent amount added to 2026 allotments)
- 2021: $146 billion
- 2022: $157 billion
- 2023: $168 billion
- 2024: $179 billion
- 2025: $190 billion
- 2026: $190 billion
- 2027 and beyond: No allocation

In addition, in 2020 and 2021, a "contingency fund" of $6 billion and $5 billion, respectively, is available for states with fewer than 15 residents per square mile (25 percent) and non-expansion states (75 percent).

Uses of Funds

- Allowable uses of funds include:
  - Stabilizing premiums and promoting issuer participation in the individual market;
  - Paying providers directly for health care services;
  - Funding assistance to reduce out-of-pocket costs for people in the individual market;
  - Helping people buy coverage, including by paying individual market premiums; and
  - Providing health insurance coverage for Medicaid-eligible individuals by establishing and maintaining relationships with health insurance issuers, but limited to 15 percent of the state's allotments.
- Funds can be used for up to two years after the year for which they were appropriated (e.g., 2020 funds could be used in 2020, 2021, and 2022).
- No state matching requirement.
- State-specific allotments are prorated as needed to match the national allotments.

Distribution Formula

The formula for distributing funds among states changes over time. In 2020 it is based on a state's historic spending on Medicaid expansion, Marketplace coverage, and the BHP, indexed forward from a base period. Over time, allotments increasingly are based on a state's share of low-income individuals between 45 percent and 133 percent of the FPL. Beginning in 2021, state allotments also may be adjusted based on the risk profile of the state's low-income population, the actuarial value of coverage funded by the state with block grant dollars, and a discretionary state-specific adjustment by the Secretary of HHS that accounts for additional factors (e.g., wage rates) that impact health care expenditures in a state.

2020 Allotment

- Based on the following sum of federal expenditures in a state during a base period (selected by a state from four consecutive quarters between first quarter of fiscal year 2014 and first quarter of 2018):
  - Medicaid expansion, indexed by MACPAC projections through November 2019;
  - BHP, indexed by medical CPI;
  - Advanced premium tax credits, indexed by medical CPI; and
  - Cost-sharing reductions, indexed by medical CPI.
- In 2020, states may request a share of up to $10 billion that is reserved for an advance payment to increase their 2020 allotments.

2021 to 2025 Allotments

- During this period, each state's allotment is based on its prior year allotment taking into account special adjustments (see below) plus or minus one-sixth of the difference between the state's prior year allotment and its projected 2026 allotment. (As described below, the 2026 allotment is based on each state's share of low-income people.)
- The following adjustments may be applied to a state's allotment, depending on the year and state circumstances:
  - Population risk adjustment
    - A risk adjustment factor based on the clinical risk categories into which the low-income individuals in each state are classified in accordance with a methodology to be developed by the Secretary
    - Applies to 2021 to 2026, but phased in between 2021 (25 percent), 2022 (50 percent), 2023 (75 percent)
    - In all years, limited to increasing/decreasing a state's allotment by no more than 10 percent
  - Coverage value adjustment
    - Applies to 2024, 2025, and 2026, but phased in at 25 percent in 2024, 50 percent in 2025, and 75 percent in 2026
    - Reduces a state's allotment in proportion to the extent to which it offers coverage valued at less than the amount required for targeted low-income children in the Children's Health Insurance Program (CHIP)
    - The proposal provides specific rules for how to "value" the coverage of selected individuals (e.g., individuals served by the block grant who are not receiving any coverage must be assigned an actuarial value of 0 percent)
  - State-specific population adjustment
    - Secretary's discretion to adjust allotments according to a "population adjustment factor"
    - Must take into account "legitimate factors" that impact health expenditures beyond clinical characteristics of low-income individuals
    - May include demographics, wage rates, income levels, and other factors

2026 Allotment

- In 2026, each state receives a share of the available national allotment ($190 billion) based on its share of low-income individuals between 45 percent and 133 percent of FPL.
- The adjustments described above under the formula for 2021 to 2025 continue to apply in 2026.

Endnotes

1. The new legislation changes the growth rate for elderly and disabled in 2025 and beyond as compared to BCRA, and includes a delay of the per capita cap for certain rural states meeting specified conditions.
2. Table 1, page 4 - https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53091-fshic.pdf.
3. Unless otherwise noted, the estimates presented here do not reflect potential adjustments to the allotments of individual states since it is unclear how they would be deployed by the Secretary of HHS and cannot be used to increase the national funding level available for state allotments.
4. Although not shown here, our earlier analysis indicated that the per capita cap included in BCRA, the earlier Senate legislation to repeal and replace the Affordable Care Act that was voted down by the Senate on July 25th, would result in an $189.2 billion reduction in federal Medicaid expenditures between fiscal year 2020 and fiscal year 2026. We will be updating these estimates to reflect interactions between Graham-Cassidy's modified version of the BCRA per capita cap in the near future.
5. https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53091-fshic.pdf.
6. As noted, the Graham/Cassidy proposal would impose per person caps on federal funding for almost all Medicaid populations, including children, seniors, and people with disabilities and on virtually all services, including acute care, preventive care, and nursing home and other long-term care services. The trend rates for the caps tighten considerably in 2025; they are set at the medical CPI for the elderly and disabled populations and at CPI for all other beneficiaries. While the trend rate for elderly and disabled enrollees is more generous than was provided under BCRA, these trend rates are below CBO projections for the growth of health care and long-term care costs.
7. Graham/Cassidy tightens the proposal first advanced in BCRA to reduce states' ability to rely on provider taxes and assessments to finance Medicaid or other State priorities. The constraints begin in 2021 and by 2025, the current 6 percent limit that guides CMS in determining what is and is not an acceptable tax is reduced to 4 percent. See HR1628, section 123.

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