NACHSA National Association of County Human Services Administrators

An Affiliate Organization of NACo ★ National Association of Counties

NACHSA Summary
GOP Affordable Care Act Replacement Plan
February 17, 2017

An outline of a Republican Affordable Care Act replacement plan was released on February 16, 2017. It is similar to House Speaker Paul Ryan's plan from last year. The financial specifics (amounts, baselines) are lacking, as well as estimates on how the plan affects the uninsured rate.

Congress has recessed for a week. Given the contentious town hall meetings in the past few weeks, GOP members wanted to be able to return home with a 'plan.'

Actual Congressional action on a repeal and replacement bill remains uncertain. As currently drafted, the concepts appear to be drafted such that the Senate's expedited reconciliation process (no filibuster, simple majority vote) could be employed. However, significant details remain to be fleshed out, including but not limited to: the federal costs of the replacement; impact on insurance coverage; and whether states will accept a fixed amount of Medicaid funding.

Immediately below are a few observations about the provisions. Key replacement provisions follow.

- The tax credits and health savings accounts outlined below raise the question whether low- to moderate income individuals would be able to take advantage of these mechanisms, given other stresses on their budgets.
- The Medicaid block grant and per capita cap proposals will lock each state into a fixed amount of funding. Those states that chose to expand their Medicaid programs under the ACA would slowly lose the enhanced match over an unspecified time period. Non-expansion states would be receive a Medicaid funding boost during the time the expansion dollars are phased out to provide 'equity' among the states.
- Disproportionate Share Hospital payments and other federal funding (unspecified) would not be in the per-capita or block grant base.

Key replacement provisions include:

Tax Credits (page 10)

- It is advance-able and refundable and would be available to all individuals purchasing in the individual market and is not based on income.
- No specifics on the size of the credit which would indicate the cost to the Treasury of this tax expenditure and whether low-income individuals would benefit from it.
- The size of the credit would be age rated.
- Families with young adults (to age 26) could claim the credit.
- Plans covering abortion would not be eligible for the credit.
- Not available to undocumented individuals or those in jail.
- Could buy a catastrophic illness plan with the credit.

Health Savings Accounts (page 12)

- The proposal expands the dollar limits and provides more flexibility for health savings accounts.
- Would nearly double the amount families could set aside from $3,400 to $6,750 for an individual and $6,550 to $13,100 for family coverage.

Medicaid (page 14)

- Enhanced rate for Medicaid expansion would be repealed and states given an unspecified transition period after which the Medicaid match would be the traditional 50/50 split.
- To provide 'equity,' states that did not expand ACA Medicaid coverage would get a temporary financial boost in their program.
- States would have the option to have a block grant of Medicaid funding, based on an amount provided to the state during an unspecified base year.
- States would have flexibility in how they spend Medicaid funds but 'would be required to provide required services to the most vulnerable elderly and disabled individuals.'
- States would have the option to choose a per capita allotment, based on their average spending in an unspecified base year, with an unspecified inflationary increase, locking each state into their historic spending pattern. Some federal payments would NOT be included in the base, including DSH payments, administrative costs and 'others.'
- Scheduled cuts to DSH would be repealed.

State Innovation Grants (page 16)

- Amounts and source of funding are not identified.
- States could use the grants to:
    - Reduce out-of-pocket costs.
    - Lower costs to providers caring for high utilizers of care.
    - Stabilize individual and group markets.
    - Access preventative care.
    - Promote private plan participation.

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