Why Graham-Cassidy Is a Disaster for Families and Health Care Consumers

The Graham-Cassidy plan, in a nutshell: radical repeal of the ACA and massive Medicaid cuts would take away health care from millions of Americans

By Stan Dorn

Medicaid expansion and financial help with private insurance would end in 2020, replaced by an underfunded block grant devoid of essential safeguards

Huge health care cuts in 2020-2026. Starting in 2020, the Graham-Cassidy proposal ends all funding for Medicaid expansion and Marketplace financial assistance. The non-partisan Congressional Budget Office (CBO) estimates that, under current law, these two funding streams will total more than $1.4 billion and cover 28 to 29 million people. Over 7 years, the block grant would cut $231 billion from currently projected funding. Cuts would grow larger over time, reaching 21% of total funding by 2026, with much higher cuts in many states.

The block grant terminates less than 10 years from today. Unless Congress finds a new source of funding, the block grant will not serve anyone in 2027 or beyond.

Each state's block grant amount is set in stone. Not one additional penny goes to a state experiencing unexpected cost increases due to recession, expensive new prescription drugs, substance use disorders like opioid addiction, infectious disease epidemics, or public health crises resulting from extreme weather events. If any of these things happen, states will face a grim choice precisely when residents most need help: ration care and deny health coverage; raise taxes; or cut other state services.

Nothing requires states to use block grant dollars to provide health coverage to low- and moderate-income residents. Much of the money can substitute for past state Medicaid spending or pay state administrative costs—effectively diverting federal health care dollars into new state spending on roads, football stadiums, or other non-health purposes. To the extent allowed by the Trump Administration, block grants can pay health care providers, rather than furnish health coverage. Nothing prevents states from serving higher-income residents, at the expense of those with greater needs.

Major new state systems to determine eligibility and provide coverage must be operational by January 2020. The ACA's system for eligibility determination and enrollment ends after 2019. Except for Medicaid and CHIP, state health programs will no longer receive federal data about income, citizenship, or immigration status. After the Administration publishes regulations and guidelines, each state must figure out who qualifies for block grant help, what happens if the money runs out, which benefits are covered, what premiums and deductibles can be charged, and what rules will govern the private insurance market. States must then develop administrative policies and

procedures, arrange for insurers to offer coverage, set up enrollment systems, and educate the public about what to do—all in roughly two years. By contrast, when the ACA passed in 2010, the major coverage provisions did not go into effect until 2014. Even so, many states and the federal government had difficulty even setting up functional websites. Graham-Cassidy is likely to trigger administrative chaos in many states.

Graham-Cassidy's politicized funding formula redistributes money from states that covered many people to those that covered few under the ACA, shifting overall financial control from states to the federal government. States with Medicaid expansions or significant Marketplace enrollment will have federal resources taken away and given to states that have not covered many of their residents. States will lose their current flexibility to claim more federal funds by covering more people, as Louisiana did in expanding Medicaid in 2016. Instead, state funding will be set in federal statutory formulas that grant HHS enormous power to increase or reduce state funding based on "State demographics, wage rates, income levels, and other factors as determined by the Secretary."[1]

Private insurance markets would immediately fall apart

Graham Cassidy would immediately end the current requirement for individuals to purchase health insurance, which CBO previously reported would raise premiums by 20 percent and cause 16 million people to become uninsured. The latter group includes not just healthy people who decide to remain uninsured until they get sick and need health care; it also includes people for whom the resulting premium increase makes coverage unaffordable.

Waivers would end insurance safeguards for people who need health care

Graham-Cassidy authorizes state waivers that permit insurance companies to raise premiums by unlimited amounts for older adults and people with preexisting conditions. The resulting "age tax" goes far beyond previous Senate and House bills, since these new, radical waivers allow unlimited premium increases based on age. Moreover, premium spikes are not limited to initial enrollment. When insured consumers or their children obtain care, waivers can let insurance companies jack up premiums by any desired amount before renewing coverage. People will use insurance at their peril.

Waivers can eliminate essential health benefits, including maternity care, treatment of mental health and substance use disorders, and prescription drugs—services often unavailable before the ACA.

Waivers can let insurers divert any amount of premium dollars away from health care and towards insurance company administration and profits, by ending all "Medical Loss Ratio" safeguards.

HHS must grant waivers that last until 2026 to any state that says the "magic words." Once a state describes how it "intends to maintain access to adequate and affordable health insurance coverage for individuals with pre-existing conditions"—an extremely lenient and open-ended test that provides no substitute for the ACA's specific statutory insurance requirements—Graham-Cassidy provides that HHS "shall" grant the waiver,[2] which must remain approved through the end of 2026.[3]

Waivers create bifurcated insurance markets that trigger death spirals. Waivers are limited to people and health insurance funded through the block grant. However, the rest of the individual market remains protected by all of ACA's insurance rules. Without an individual coverage requirement, markets will immediately be destabilized, as healthy people delay enrollment until they get sick and know they need care. Premiums will skyrocket for comprehensive coverage protected by ACA safeguards, triggering a classic death spiral that quickly makes such coverage unavailable.

Unlike the waivers allowed under ACA Section 1332, no guardrails would limit these new Graham-Cassidy waivers. Waivers could cut comprehensiveness of benefits, raise consumer costs, reduce the number of people with insurance, or worsen the federal budget deficit.

Graham-Cassidy incorporates previously rejected partisan cuts to the entire Medicaid program

As with previous Senate bills rejected by bipartisan majorities, Graham-Cassidy makes cuts and radical changes to the basic Medicaid program by imposing rigid, uniform, per-capita caps on federal dollars. By cutting a part of Medicaid that has nothing to do with the ACA, the bill endangers essential health coverage for roughly 70 million seniors, children, pregnant women, people with disabilities, and low-income parents.

From 2020 through 2026, these caps would cut federal funding for the basic Medicaid program by approximately $175 billion, based on CBO estimates of prior legislation. This is in addition to the above-described block-grant cuts.

If health care costs per person rise beyond allotted levels, states unable to replace missing federal dollars would have no choice but to ration essential care. By rigidly limiting per capita costs based on general inflation or overall health care costs, Graham-Cassidy ignores any new prescription drug costs, increased use of long-term services and supports, or public health problems that disproportionately affect Medicaid seniors, people with disabilities, pregnant women, children, or low-income parents.

Radical cuts to women's reproductive health care

Graham-Cassidy would end Medicaid funding of Planned Parenthood clinics for 12 months.

Starting in January 2018, no individual or small-group plan purchased with tax credits could cover abortions other than for rape, incest, or where needed to prevent a pregnant woman's death. Women could no longer use their own money to buy supplemental abortion coverage from these insurers.

Graham-Cassidy gives HHS Secretary Tom Price vast new powers to enforce federal abortion restrictions if he finds that a state has failed to provide adequate enforcement. Any private insurer or employer offering insurance that HHS believes violates federal abortion rules could be fined $100 per enrollee per day. Effective the moment the bill is signed, this radical, new federal enforcement power is buried in multiple cross-references set out in the final two pages of the Graham-Cassidy bill.[4]

Endnotes

[1]Social Security Act Section 2105 (i)(5)(F), added by Graham-Cassidy Section 106(b).

[2]Section 106(b) adding new subsections (i)(1)(B)(i) and (i)(1)(A)(iv) to Social Security Act Section 2105.

[3]Section 106(b) adding subsection (i)(3) to Social Security Act Section 2105.

[4]Section 204.

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