Better Care Reconciliation Act

June 30, 2017

On June 22, 2017, the U.S. Senate released the discussion draft of H.R. 1628, the Better Care Reconciliation Act (BCRA), which responds to the U.S. House's American Health Care Act (AHCA) passed on May 4, 2017. The BCRA includes provisions related to repeal and replacement of the Patient Protection and Affordable Care Act (ACA), including Medicaid restructuring and insurance market changes.

While GHA continues to analyze the sweeping changes to the health care delivery system proposed in the bill, the following summary provides a high-level overview of what these changes would mean for Georgia.

Eliminating Medicaid DSH Cuts and Increasing Medicaid DSH Funding

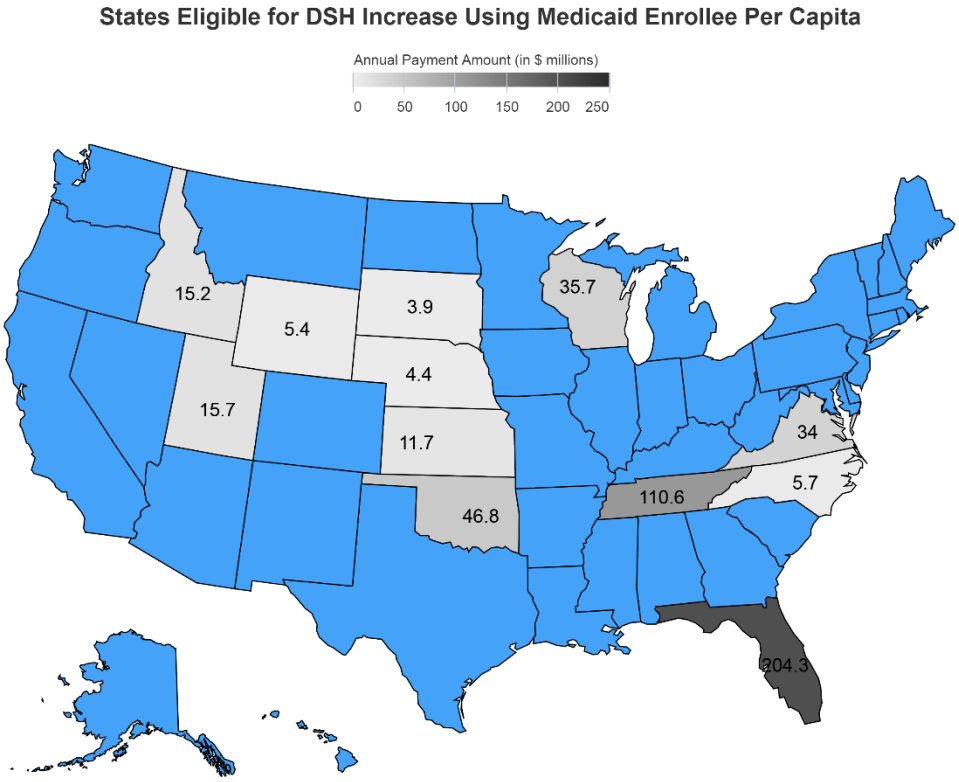
The Medicaid Disproportionate Share Hospital (DSH) program provides funding to hospitals to help offset their uncompensated costs from providing services to Medicaid and uninsured patients. The ACA included significant cuts to this program based on the assumption that Medicaid expansion and coverage gained through the state or federal health insurance marketplace would reduce hospitals' uncompensated care for these populations. Originally slated to begin in 2014, a series of subsequent federal legislation postponed these cuts until federal fiscal year (FY) 2018 (which starts on October 1, 2017). The Medicaid DSH cuts are currently scheduled to occur regardless of a state's decision to expand Medicaid. The BCRA repeals the Medicaid DSH cuts for non-expansion states beginning in FY 2018.

The BCRA also includes additional DSH funding for certain non-expansion states, beginning in FY 2020 through the first quarter of FY 2024, if the state's per capita FY 2016 DSH allotment amount is below the national average per capita FY 2016 allotment amount. The per capita DSH allotment is calculated by comparing a state's total Medicaid DSH funds to the number of Medicaid enrollees in the state. Eligible states would receive an increase to their FY 2020 Medicaid DSH allotment that would be the difference between each state's per capita FY 2016 Medicaid DSH allotment amount and the national average per capita FY 2016 Medicaid DSH allotment amount.

Georgia Impact: *As a non-expansion state, Georgia would avoid estimated cuts of $49 million in 2018 (17% reduction) and $73 million in 2019 (25% reduction). Medicaid DSH cuts under the ACA will eventually reflect a 50% reduction and for 2020-2025 are estimated to total $930 million****. It's important to note that while these cuts are avoided under the BCRA, the funding restoration should not be considered new or increased funds to the state.*** *The BCRA simply maintains the Medicaid DSH payments at the status quo. The avoidance of these cuts is critical for Georgia's hospitals that provide over $1.9 billion in uncompensated care to the Medicaid and uninsured populations annually. Georgia's current federal DSH allotment of $295 million is insufficient to cover the entire cost of uncompensated care. Escalating reductions to the amounts required under the ACA are untenable and would leave many hospitals, particularly safety net and rural hospitals, financially vulnerable.*

Georgia is <u>not</u> one of the non-expansion states projected to be eligible for the additional DSH funding beginning in FY 2020. *The map in Figure 1 reflects projections of the American Hospital Association for states eligible to receive additional DSH funding.*

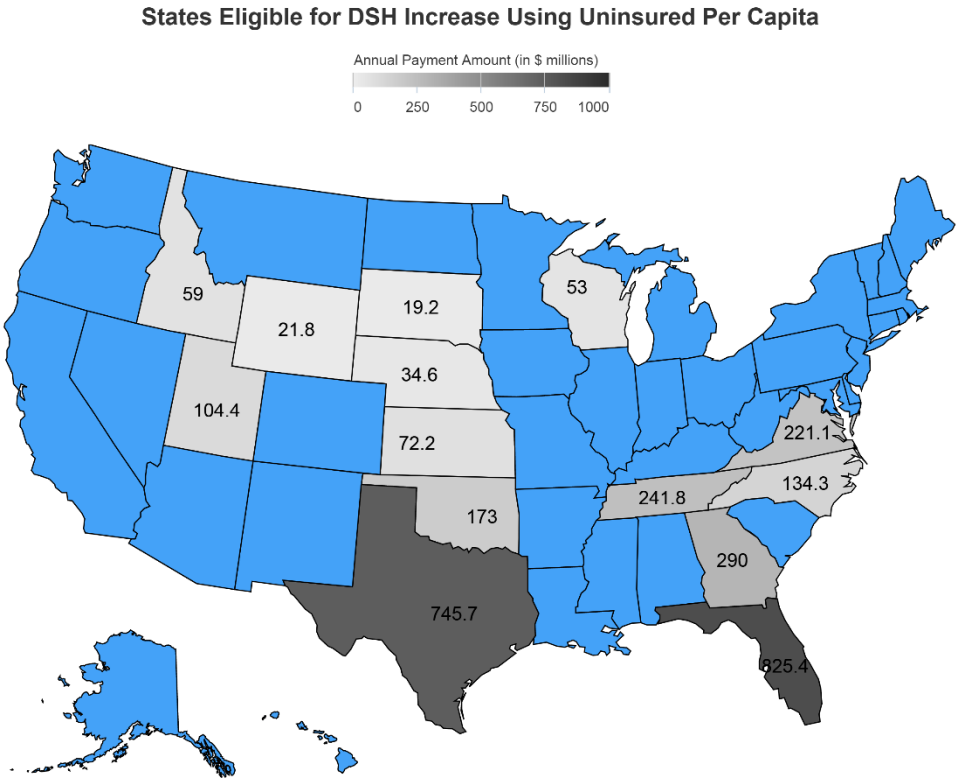
Figure 1



SUGGESTION FOR IMPROVEMENT/CHANGE TO MEDICAID DSH:

1. Additional DSH funding for non-expansion states should consider the number of uninsured (instead of the number of Medicaid enrollees) in calculating the state and national DSH per capita funding amounts. Using this methodology, Georgia would be eligible for an additional $290 million in FY 2018 (See Figure 2)**.**

Figure 2



Expansion vs. Non-Expansion

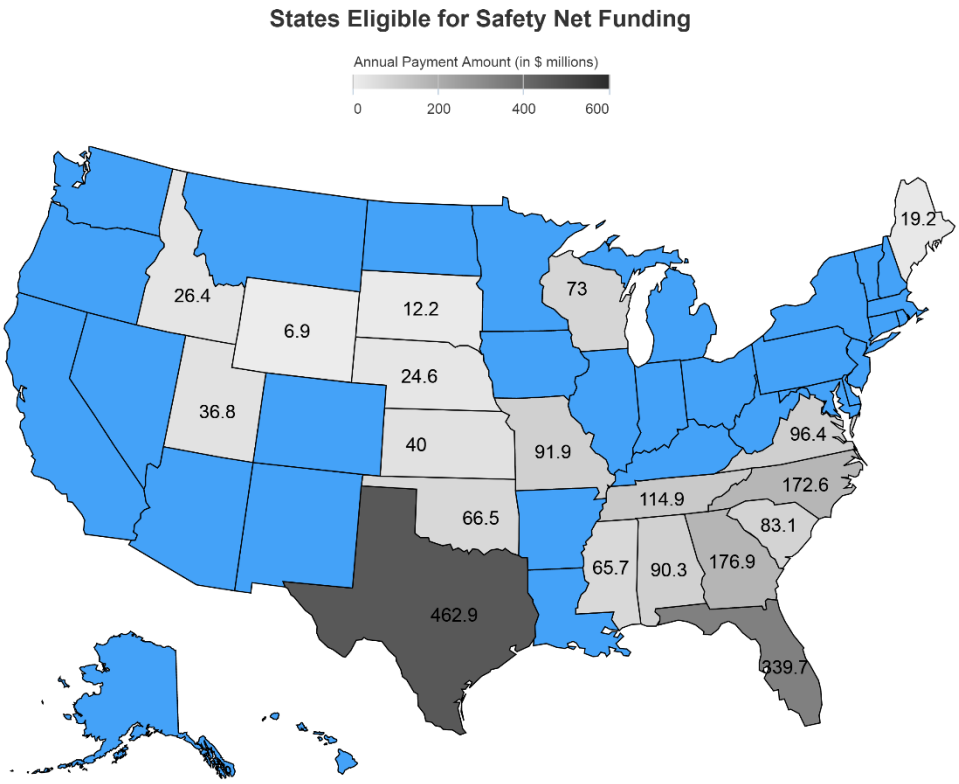
The BCRA limits the enhanced match rate for newly eligible individuals with incomes up to 133% of the federal poverty level (FPL) to only those states that expanded coverage under the ACA as of March 1, 2017. For these expansion states, the BCRA would maintain the current structure of the newly eligible matching rate for expenditures through calendar year (CY) 2020 (94% in CY 2018, 93% in CY 2019 and 90% in CY 2020). The newly eligible matching rate would then continue to phase down to 85% in CY 2021, 80% in CY 2022, and 75% in CY 2023. The newly eligible matching rate would not be available to states after CY 2023. States like Georgia that have not expanded by March 1, 2017, could still expand Medicaid to adults with income up to 133% FPL, but would only receive the state's regular federal match rate of approximately 66%.

Non-expansion states would be eligible to receive a portion of the newly created "safety net funding for non-expansion states" which is budgeted at $2 billion per year for five years. The amount awarded to each of the 19 non-expansion states would be based on each state's share of the population with income below 138% FPL, regardless of how many people are covered by the state's Medicaid program or other insurance. Any state that is currently a non-expansion state but chooses to expand will no longer be eligible for any share of the $2 billion. This safety net funding can only be used by the states

to enhance Medicaid provider reimbursement rates up to the cost of providing care to Medicaid and uninsured patients. States would draw down their share of the $2 billion as costs are incurred.

***Georgia Impact**: GHA's modeling shows that as a non-expansion state, Georgia would be allocated about $177 million per year (the third largest amount) of the $2 billion set aside for non-expansion states. (See Figure 3 for allocations by state.) Funding is not based on how many people are uninsured but on the size of the state's low-income population. The larger the state, the more funding the state would receive.*

Figure 3



*These funds appear to be an attempt to create "equity" between expansion and non-expansion states since the bill allows expansion states to receive significantly higher base funding compared to non-expansion states. However, **this funding falls far short of what Georgia would receive if Georgia had expanded Medicaid up to 133% FPL under the ACA.** Based on an analysis conducted by the Georgia Chamber of Commerce, increased coverage funded by enhanced federal matching Medicaid funds would bring an additional $4.3 billion in federal funds to Georgia in 2018 and up to $6 billion annually by 2023.*

The enhanced federal match rate of 90% would be worth $1.4 billion annually for Georgia's expansion population (as compared to federal funds available to Georgia under their regular federal match rate of around 69%[1].) Since Georgia did not expand coverage by March 1, 2017, the BCRA reduces the amount of federal funds available to the state should it make a future decision to expand coverage for low-income Georgians. This provision of the bill is inherently inequitable to states that took a more fiscally conservative approach to health care policy.

SUGGESTIONS FOR IMPROVEMENT/CHANGE TO THE SAFETY NET POOL:

1. Fund distribution should be based on the number of uninsured under 138% instead of the total population. States with disproportionate numbers of uninsured should get a bigger allotment. For Georgia, this would increase the state's annual allocation by $24 million.
2. Because hospitals are, by far, the main safety net providers for the uninsured population and have been hurt the most by reimbursement cuts under the ACA, any funding received by non-expansion states from the safety net funding pool should be used exclusively for uncompensated costs incurred by hospitals.
3. If expansion states can continue their expansion programs even if only for a transition period, non-expansion states should receive the same amount of federal dollars to cover the cost of the uninsured. This would equalize funding for non-expansion states to stabilize hospitals and other providers for treating the uninsured. Georgia hospitals' provide $1.7 billion annually in uncompensated indigent and charity care and bad debt write-offs.

Per Capita Allotments

The BCRA drastically changes the current financing arrangement for the Medicaid program by capping future federal funding beginning in FY 2020. A state-specific cap would be established based on each state's annual per capita expenditures for Medicaid (derived from expenditures and enrollees during an eight-quarter period selected by the state from quarters between October 2013 and June 2017.) Once established, the annual per capita amount increases over time based on a set growth rate. From FY 2020 to FY 2024, the growth rate is defined as the medical component of the Consumer Price Index (CPI-M) for most Medicaid populations and CPI-M plus one percent for the elderly and disabled populations. After FY 2024, the growth rate is the Consumer Price Index for all urban consumers (CPI-U) for all enrollee categories. Historically, CPI-M has been 1.6 percentage points higher than the CPI-U[2], meaning that the change to using CPI-U as the growth rate in FY 2025 would be a significant cut to the Medicaid program.

The total federal cap is calculated based on separate expenditures for various Medicaid population groups. The population groups include children (excluding blind and disabled children and children funded through the Children's Health Insurance Program or CHIP); elderly; adult blind and disabled; expansion enrollees (defined as those enrollees for whom some states are receiving an enhanced match under the ACA); and other nonelderly, nondisabled, non-expansion adults. Some other Medicaid expenditures, such as administrative expenses, are exempt from the cap.

[1] Based on the Georgia Chamber of Commerce's analysis of estimated 2023 expenditures.

[2] Based on the average annual change in the medical component of the CPI for all urban consumers versus the CPI for all urban consumers between 2007 and 2016.

Additionally, Medicaid supplemental payments (not including Medicaid DSH payments) would be included in the caps. In Georgia, these payments would include Upper Payment Limit (UPL) payments made to hospitals, teaching physicians and nursing homes as well as payments made to private hospitals under the Hospital Medicaid Financing Program.

Beginning in FY 2020, a state's per capita cap could be adjusted by 0.5% to 2.0% if the state's per capita expenditures either exceed 25% of the national average per capita or are 25% below the national average per capita. In the case where a state exceeds the national average by 25% or more, its per capita cap would be reduced; conversely, states that are below the national average by 25% or more would see an increase in its per capita caps. In FY 2020 and FY 2021, a state's eligibility for the adjustment would be based on the averages of all population groups. After FY 2021, the eligibility is determined separately for each population group. These adjustments must be budget neutral on a national level.

Georgia Impact: *While Medicaid funding has historically been a federal/state partnership, the BCRA spending caps create a national standard and move all the financial risk to the states. Additionally, federal-spending caps limit a state's ability to modernize or enhance its Medicaid program. Demand for Medicaid is driven by social and economic factors that are often beyond the control of an individual, a state or a health system. And there are components of Medicaid, including coverage for the elderly and disabled, advances in medicine (e.g., specialty pharmaceutical-based treatments for Hepatitis C), and outbreaks of infectious diseases that will continue to be expensive and often unpredictable. Unlike the federal government, Georgia is constitutionally mandated to balance its budget every year.* ***An inflexible federal expenditure cap could force Georgia to reduce payments to hospitals and other safety net providers, eliminate valuable services, and/or cut needy populations from its Medicaid program.***

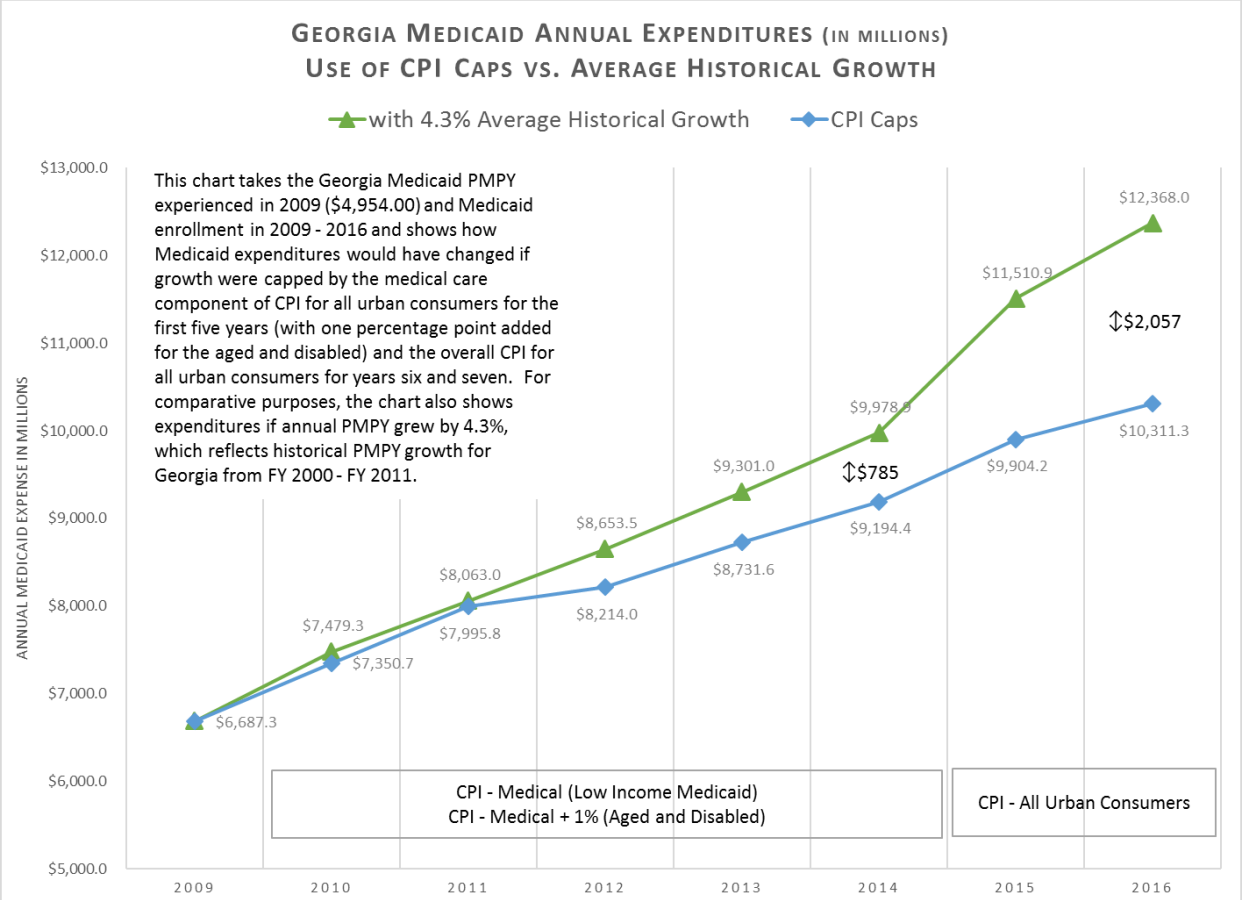
GHA has concerns that non-DSH supplemental payments will be included in the per capita amounts. There would be no prohibition for the state to use the related federal funds in other areas of Medicaid spending. As such, the provider groups that have relied on these payments to subsidize uncompensated care provided to Medicaid patients will experience cuts to their Medicaid revenue. For example, supplemental payments to Georgia hospitals totaled $171 million in FY 2016. These payments are used to support graduate medical education, hospital-based public health services and to offset uncompensated care provided to Medicaid patients.

Establishing separate amounts based on Medicaid population categories as proposed in the bill is an important step for recognizing the costs associated with various population groups, and most notably the elderly and disabled. A state's opportunity to select the base period to calculate the per capita caps will help states like Georgia, that were slow to recover from the Great Recession and who are just now restoring Medicaid cuts or funding more reasonable provider payment levels.

It is also positive that the growth rate is initially based on the CPI-M through FY 2024; however, GHA is concerned that the growth rate may not fully account for program costs and ***the application of the CPI-U after FY 2024 will shift additional financial burden to states.*** *An application of the proposed methodology to historical Georgia Medicaid enrollment and per capita expense shows what would have been a significant and escalating reduction in federally shared Medicaid expenditures over time. Based*

on a historical four percent annual growth rate in the Georgia Medicaid per capita expense[3], the amount of annual expense shifted to Georgia using the BCRA-required CPI-related caps would have been $785 million after five years and $2.1 billion after seven years. (See Figure 4).

Figure 4

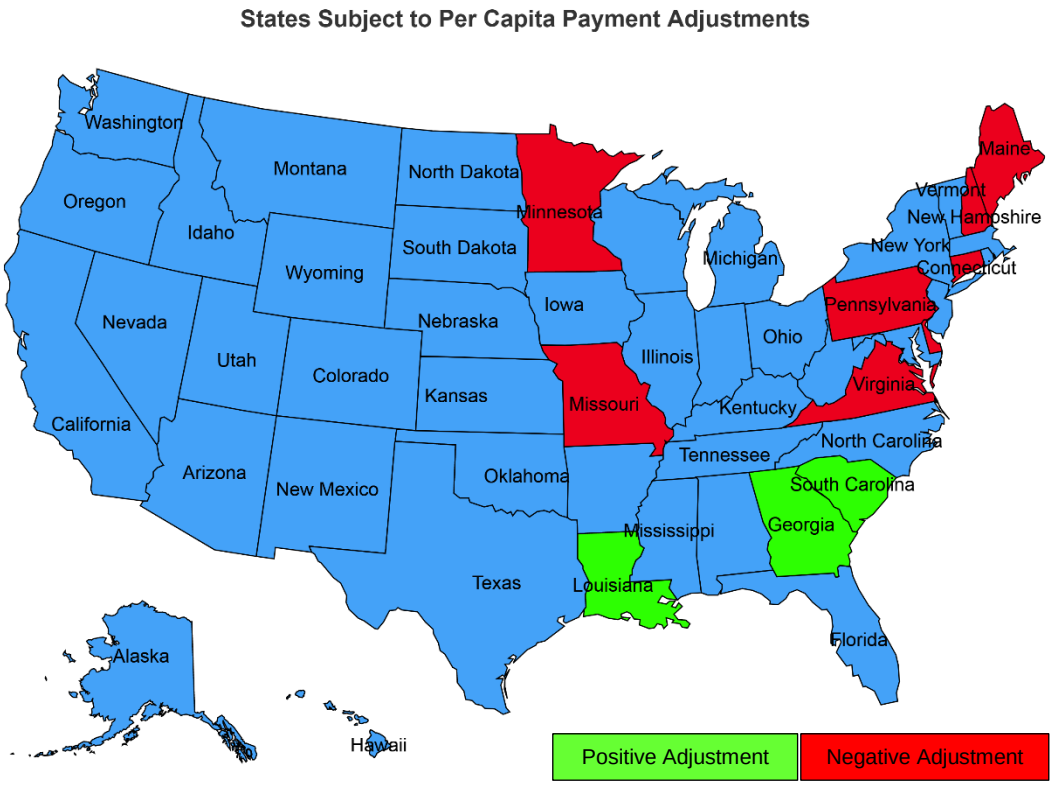


Based on a Manatt Health study of Medicaid per capita spending differences by state, Georgia is likely to initially see a positive adjustment between 0.5% and 2.0% as the state's overall per capita spending is estimated to be 25% lower than the national average. This adjustment is estimated to range from $38 million to $154 million in federal funds annually[4] but would require state matching funds of $21 million to $83 million, depending on the adjustment amount. See Figure 5 for those states subject to the proposed per capita spending adjustments.

[3] Derived from the Manatt Health Analysis of Kaiser Family Foundation, Average Growth in Annual Medicaid Spending from FY 2000 to FY 2011. February 2017

[4] Based on Manatt's estimated PMPY for Georgia for FY 2020/2021 ($6,340) and most recent Medicaid enrollment figures from CMS for October 2015 – March 2016 (~1.9 million).

Figure 5



Block Grant Option

The BCRA creates a new option for states to receive a flexible block grant of funds for a period of five years, rather than a per capita allotment, for the traditional adult populations. The "Medicaid Flexibility Program" would be available beginning in FY 2020. Funding for the block grant amount is based on the same calculation used for the per capita allocation for the eligible population, multiplied by the number of enrollees in the year prior to adopting the block grant. Funding will increase by growth in the CPI-U but will not be adjusted for changes in the Medicaid eligible population. States would be able to roll over any unused funds at the end of the fiscal year, and such funds will remain available during the five-year program period.

Georgia Impact*: This option creates the same issues for Georgia as previously discussed under "Per Capita Allotments." If Georgia were to choose this Medicaid funding option, it would allow for greater flexibility in the design of its Medicaid program; however,* ***it would also add significant financial risk to the state because the block grant would not take into account increases or other changes in the covered population.*** *The cost of any unusual growth in enrollment (e.g., increased enrollment due to an economic recession) as well any unanticipated increase in the cost of care would be borne solely by the state.*

SUGGESTIONS FOR IMPROVEMENT/CHANGE TO MEDICAID FINANCING:

1. Exclude non-DSH supplemental payments from the per capita base period and allow states to continue existing supplemental payments as currently structured.
2. Maintain the use of the CPI-M (and in the case of the elderly and disabled populations, CPI-M plus one percentage point) for the annual per capita growth rate after FY 2024.
3. Align the current state requirements in establishing rates for Medicaid managed care organizations with the provisions used to set state Medicaid per capita caps.

Implementation

1. Phase-in populations for per capita cap funding. Start with low-income Medicaid first, and then bring in sub-populations of the aged, blind and disabled over time.
2. Phase-in the blending of the regular match rate funding and per capita cap funding application to allow a gradual shift in 100% of risk to the states (e.g., year 1 – federal funds = 75% FMAP based and 25% per capita based; year 2 – federal funds = 50% FMAP based and 50% per capita based).

Alternate Approaches

1. For low-income, able-bodied adults under 100% FPL, provide states with per capita cap funding based on the enhanced match rate, but require program design components that mandate employment activities and promote consumerism and healthy behaviors.
2. States expanding coverage up to 100% of the federal poverty level should continue to receive the enhanced matching rate past 2020 for this population. It is unlikely this population will ever be able to afford private market health care insurance without significant subsidies.

Medicaid Provider Taxes

The bill includes provisions that would phase down the Medicaid provider tax threshold. Medicaid provider taxes are currently used by almost all states to help finance a portion of the state's share of Medicaid expenditures, often for payment increases for the provider group being taxed. The current threshold is at 6% of provider revenue. Under the bill, the level would drop to 5.8% in FY 2021, 5.6% in FY 2022, 5.4% in FY 2023, 5.2% in FY 2024, and 5.0% in FY 2025 and subsequent fiscal years.

Georgia Impact: *Georgia's current Hospital Provider Payment Program and Hospital Medicaid Financing Program would not be impacted by the provision as the tax level is at 1.45% and 0.06%, respectively. However,* ***the Nursing Home Provider Fee (NHPF) program would be impacted as the current tax rate is 6.0%.*** *The current NHPF program generates $171 million[5] annually, which, together with matching federal funds of $373 million, is used to support payments to nursing homes serving Medicaid patients.*

There are two possible impacts to the NHPF program:

1. *The state replaces the reduced provider fees with state funds, in which case this becomes a state cost.*

[5] The amount reflected in the state FY 2018 Appropriations Act.

2. *The state does not replace the reduced provider fees with state funds, in which case the participating nursing homes lose the federal funds drawn down by the amount being reduced.*

Here are the fiscal scenarios by year:

Fiscal Year	*State Replaces Funds (State Cost)*	*State Does Not Replace Funds (Provider Cut)*
2021	*$5.7 million*	*$12.4 million*
2022	*$11.4 million*	*$24.9 million*
2023	*$17.1 million*	*$37.3 million*
2024	*$22.9 million*	*$49.7 million*
2025	*$28.6 million*	*$62.1 million*

Inpatient Psychiatric Services

BCRA provides states with an additional option to provide Medicaid coverage for inpatient psychiatric services to individuals over the age of 21 and under the age of 65. With few exceptions, states cannot currently receive federal matching funds for enrollees in these age groups who receive inpatient psychiatric services in a freestanding psychiatric hospital of more than 16 beds (referred to in the law as an Institute for Mental Disease or IMD). As a condition of providing this new coverage, states would be required to maintain the number of licensed beds at psychiatric hospitals owned, operated, or contracted for by the state on the date of enactment. States would also have to maintain the level of annual state spending for inpatient services at a psychiatric hospital and active psychiatric care and treatment provided on an outpatient basis. States would receive a 50% federal matching rate for providing this coverage effective October 1, 2018.

Georgia Impact: *This provision could supplement the state's cost if they chose to increase the amount of inpatient psychiatric services available to the non-elderly adult Medicaid eligibility population. Due to the maintenance of effort requirements, the state could not supplant existing state expenditures with new federal funds, so the use of this provision would require new state outlays.* ***The overall impact on access to inpatient behavioral health services is likely to be limited since, as a non-expansion state, Georgia provides very little Medicaid coverage to this population.***

Other Medicaid Eligibility Changes

The bill makes a number of changes regarding how states determine Medicaid eligibility, including:

- the repeal of the expanded authority given to states and hospitals under the ACA to make presumptive eligibility determinations;
- new limitations on the ability for states to make eligibility retroactive;
- incentivizing states to require enrollees with incomes above 133% FPL to renew eligibility every six months instead of annually; and
- reverting the mandatory Medicaid income eligibility level for poverty-related children back to 100% FPL (states could cover the population above 100% FPL under their State Children's Health Insurance Program.)

States would have the option of instituting a work requirement in Medicaid for non-disabled, non-elderly, non-pregnant adults as a condition of receiving coverage under Medicaid. Work requirements are modeled after the requirements and exemptions that exist in the current Temporary Aid to Needy Families (TANF) program. Any state that chooses to institute a Medicaid work requirement will receive a 5% increase in its match rate for its administrative expenses.

Georgia Impact: *As a provider organization, GHA is concerned about the change in some of the eligibility provisions. For example, GHA partnered with the state to promote a presumptive eligibility program so that hospitals can help get people signed up for Medicaid at the point of service. Otherwise, people without coverage simply become indigent or charity care for the hospital.* ***Elimination of the presumptive eligibility program will likely increase the amount of uncompensated care provided by hospitals.***

Assuming the federal matching rate for the State Children's Health Insurance Program would ultimately revert back to the non-ACA enhanced federal medical assistance percentage (eFMAP) Georgia's current program, PeachCare for Kids, would require $94 million in state matching funds as the eFMAP would move from 100% to 78% for this population.[6]

Changes to Insurance Subsidies

The BCRA maintains the ACA's health insurance premium subsidies provided via tax credits, but reduces the value of the credits. Beginning in tax year 2020, tax credits would be available to individuals with incomes up to 350%. Currently, tax credits are available to individuals with incomes between 100%-400% FPL. It would also prohibit individuals with access to any employer-sponsored coverage from becoming eligible for the credit.

With respect to the formula for calculating each individual's required premium contribution, the BCRA would specify age and income-adjusted applicable percentages beginning in tax year 2020. The contributions would range from 2% of an individual's income for those in the lowest income band, regardless of their applicable age band, to 16.2% for those in the highest income band and the oldest age band. Individuals in the same income bracket below 150% FPL would contribute the same percentage of income regardless of age. However, within each income bracket above 150% FPL, older individuals would be required to contribute more than younger individuals.

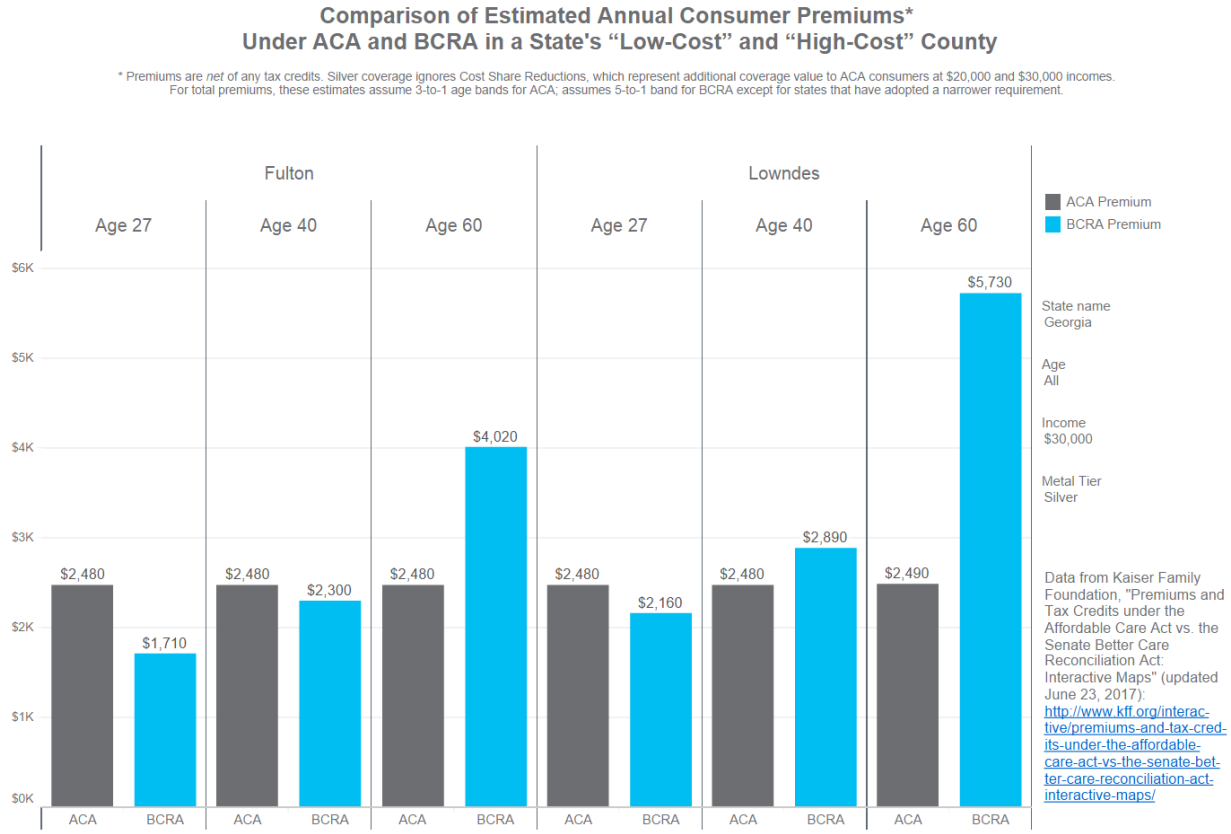
Under the ACA, insurers are required to offer plans with lower cost-sharing, which are funded through subsidies paid to the insurer. The BCRA eliminates the current cost-sharing subsidies for individuals with incomes below 250% FPL effective for plan years beginning in 2020. Until then, the bill would appropriate necessary amounts to the HHS Secretary to provide cost-sharing subsidies from the date of enactment through December 31, 2019.

Georgia Impact*: GHA supports the use of premium and cost-sharing subsidies to help low-income individuals purchase coverage through the federal Health Insurance Marketplace.* ***For non-expansion states like Georgia, expanding the eligibility for premium subsidies to individuals with incomes below 100% FPL is an important step to help decrease the uninsured rate and increase access to health care services. However, these subsidies must be large enough to make insurance coverage truly affordable to this population.*** *The current premium subsidy averages around $4,300 per year per person in*

[6] Based on AFY 2017 Total Fund Appropriations for PeachCare for Kids and the FFY 2018 eFMAP of 77.95%.

Georgia.[7] *The provisions of the BCRA are likely to increase premiums for older Georgians significantly without a corresponding increase in the available subsidies (see Figure 6).* ***Providers are put at additional risk without cost-sharing subsidies that help offset deductibles and copayment requirements for low-income individuals.*** *Under the ACA, hospitals have seen an increasing amount of bad debt from patients who have insurance, but cannot afford their high deductibles or other cost-sharing amounts.*

Figure 6



Insurance Market Stabilization

The bill appropriates short-term funding to CMS to provide financial support to health insurers to address disruptions in coverage and access and to respond to urgent health care needs within states. Annual funding available is $15 billion for each of CY 2018 and CY 2019 and $10 billion for each of CY 2020 and CY 2021.

The BCRA also establishes the "Long-Term State Stability and Innovation Program," which would make funding available to states to:

[7] Addendum to the Health Insurance Marketplaces 2017 Open Enrollment Period: January Enrollment Report. For the period: November 1, 2016 – December 24, 2016. January 10, 2017. Department of Health & Human Services, Centers for Medicare & Medicaid Services.

1. Establish or maintain a program or mechanism that provides financial assistance (e.g., by reducing premium costs) for enrolling in the individual market to high-risk individuals who have or are projected to have high health care utilization (as measured by cost) and who do not have access to employer-sponsored insurance;
2. Establish or maintain a program to enter into arrangements with health insurers for the purpose of stabilizing premiums as well as promoting market participation and plan choice in the individual market;
3. Provide payments for health care providers for the provision of services specified by the CMS Administrator; and
4. Provide assistance to reduce out-of-pocket costs (such as copayments, coinsurance, and deductibles) for individuals with health insurance purchased on the individual market.

The allocation of funds to individual states will be based on a formula to be determined by the HHS Secretary. See Table 1 for the annual allotments from CY 2019 through CY 2026 as well as the state matching fund requirements. During CY 2019 through CY 2021, at least $5 billion would be required to be used for arrangements with health insurers for the purposes of stabilizing premiums and promoting participation in the individual market.

Table 1

Long-Term State Stability and Innovation Program		
Calendar Year	**National Amount**	**State Matching Requirement**
2019	$8 billion	None
2020	$14 billion	None
2021	$14 billion	None
2022	$6 billion	7%
2023	$6 billion	14%
2024	$4 billion	21%
2025	$4 billion	28%
2026	$4 billion	35%

Georgia Impact: *As the allocation will subsequently be determined by the HHS Secretary,* ***there is no current way to determine the impact to Georgia.*** *Regardless of the allocation amount, new state outlays would be required to access these funds beginning in 2022.*

Additional Provisions Intended to Stabilize the Insurance Markets

The BCRA sets the penalty for not complying with individual and employer mandates at zero and makes several changes to insurance market coverage:

- Requires insurers to impose a six-month waiting period before coverage can start for people who enroll in the individual market if they have been uninsured for more than 63 days within the past year. This provision is intended to replace the individual mandate with an incentive to individuals to maintain continuous coverage.

- Allows premiums in the individual market to vary by age from a ratio of 5:1. This means premiums for younger individuals would be set five times lower than for the highest age bracket.
- Shifts the responsibility to states to set their own medical loss ratios (MLRs) for group and individual coverage effective for plan years beginning on or after January 1, 2019.

***Georgia Impact**: **GHA is concerned about the use of a waiting period to create an incentive for individuals to maintain continuous coverage. The uninsured will continue to seek care, typically through the emergency room, creating additional uncompensated care for hospitals.** This issue is exacerbated if available premium subsidies are too low and insurance premiums are not truly affordable for low-income individuals.*

Waivers for State Innovation

The BCRA makes modifications to the Section 1332 waiver process established under the ACA to encourage states to take advantage of the waiver program. Section 1332 allows states to receive a waiver to alter requirements related to insurance exchanges, premium and/or cost-sharing subsidies, and qualified health plans.[8] The bill eliminates the 1332 waiver requirements related to coverage, affordability and comprehensiveness, and instead, requires the HHS Secretary to grant a waiver as long as the state's plan would not increase the federal deficit. The bill also appropriates $2 billion in funding beginning in FY 2017 and remaining available through FY 2019 to provide grants to states to help with the cost of preparing a waiver application and implementing the state plan upon waiver approval. Funding from the Long-Term State Stability and Innovation Program (discussed above) could also be used to help implement a state's plan under a 1332 waiver as long as the use of the funds is consistent with the requirements of the program.

***Georgia Impact**: GHA appreciates the new flexibility provided to states to more closely tailor the health insurance market to the particular needs of their state. However, **we are concerned that the waivers requirements do not provide enough protections to ensure that Section 1332 waivers do not result in an decrease in health insurance coverage, particularly for vulnerable populations like individuals with pre-existing conditions.** For example, a waiver that results in a significant increase in premiums or cost sharing for individuals with pre-existing conditions will likely lead to a higher number of uninsured seeking care in hospital emergency rooms. **Any waiver of the essential health benefit requirements for qualified health plans offered on the insurance exchanges also poses a concern for hospitals.** While limiting the services covered under a health plan may make the plan more affordable, it also increases the likelihood that patients will forego necessary treatment because it is not covered. Without the appropriate protections, it is typically those important, but expensive, services (e.g., behavioral health and substance abuse services) that are excluded from health plans.*

Repeal of Taxes

The BCRA eliminates most of the health care related taxes that were included in the ACA. These include the tax on health insurance premiums; the medical device tax; the tax on over-the-counter medications;

[8] Section 1332 also allows for waiver of the individual and employer mandate, but these are eliminated under the BCRA.

the 0.9% Medicare surtax on taxpayer income over $200,000 for individuals/$250,000 for couples; and the excise tax on indoor tanning.

In addition, the BCRA delays the effective date of the "Cadillac tax" on high-value health insurance plans until 2026.

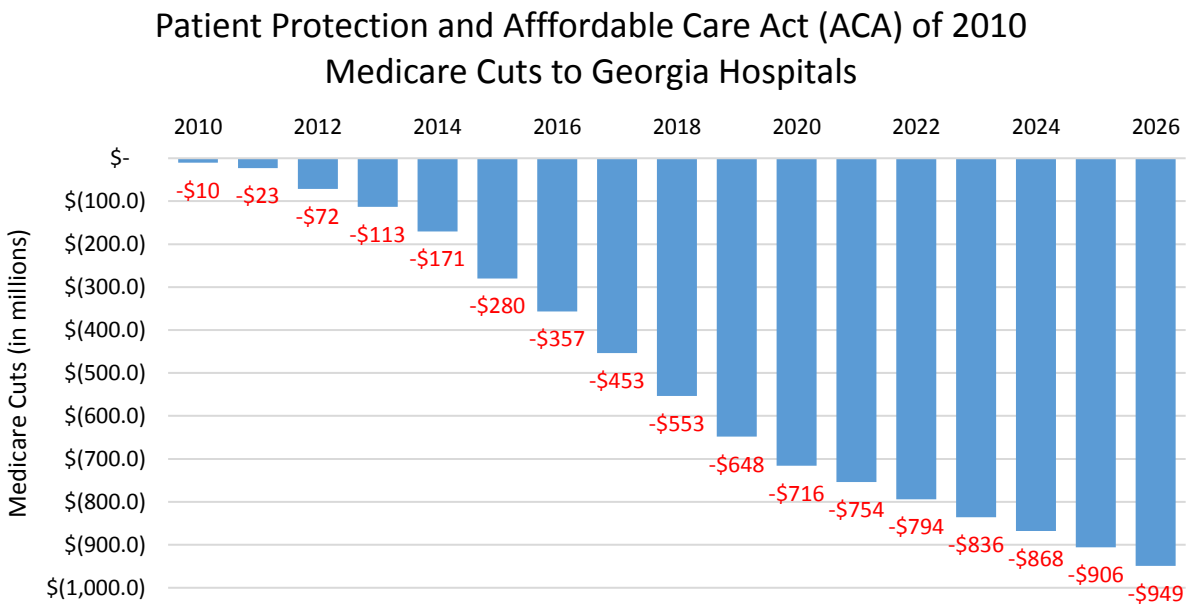
***Georgia Impact*: The elimination of the tax on health insurance premiums would benefit Georgia's Medicaid program.** *During the one-year moratorium, the Medicaid program saved $32 million in state funds because it did not have to pay higher capitation payments to the Medicaid managed care plans to cover the cost of the tax.*

Medicare Cuts

The BCRA does not repeal the Medicare cuts for hospitals that were instituted under the ACA.

Georgia Impact: *GHA is concerned that the bill does not repeal the Medicare cuts for hospitals. These Medicare reductions have already amounted to just over $1 billion from 2010 to 2016 and are expected to escalate to almost $1 billion annually by 2026 (see Figure 7). These cuts were intended to fund the coverage expansions incurred under the ACA.* ***If the Medicare cuts remain and the BCRA Medicaid funding provisions and changes to the premium subsidies move forward, Georgia will be at an even greater disadvantage.***

Figure 7



Reduction in Insurance Coverage Affecting Medicare DSH

Because the insurance coverage provisions of the legislation would increase the number of uninsured people and decrease the number of people with Medicaid coverage relative to the numbers under current law, the Congressional Budget Office (CBO) estimates that Medicare spending would increase by $42 billion over the 2018-2026 period.

Medicare makes additional DSH payments to facilities that serve a higher percentage of uninsured patients. Those payments have two components: an increase to the payment rate for each inpatient case and a lump-sum allocation of a pool of funds based on each qualifying hospital's share of the days of care provided to beneficiaries of Supplemental Security Income and Medicaid.

Under the BCRA, the decreased enrollment in Medicaid (in expansion states) would slightly reduce the amounts paid to hospitals, per CBO estimates. However, the increase in the number of uninsured people would substantially boost the amounts distributed on a lump-sum basis.[9]

Georgia Impact: *Medicare DSH payments in Georgia annually total $185 million for the lump-sum allocation and are variable for the increase for each inpatient case.* ***We cannot currently estimate the amount of additional payments Georgia would receive from Medicare DSH payments as we don't know how Georgia's share of the lump-sum allocation would change based on the loss of insurance coverage in Georgia relative to other states.***

Public Health Funding

The ACA established the Prevention and Public Health Fund to provide expanded and sustained national investments in prevention and public health, to improve health outcomes, and to enhance health care quality. To date, the Fund has invested in a broad range of evidence-based activities including community and clinical prevention initiatives; research, surveillance and tracking; public health infrastructure; immunizations and screenings; tobacco prevention; and public health workforce and training.

Under the BCRA, Prevention and Public Health Fund appropriations from FY 2018 and on will be repealed.

Georgia Impact*: Various Georgia entities have received $155 million from this fund since 2012.* ***The biggest benefactor has been the Georgia Department of Public Health, which has received $47 million to date. These funds are supporting a wide range of public health activities in Georgia, including immunization, preventive health block grants and breastfeeding promotion and support.***[10]

Funding to Support State Response to Opioid Crisis

BCRA would appropriate $2 billion for FY 2018 to the HHS Secretary to provide grants to states to "support substance use disorder treatment and recovery support services for individuals with mental or substance use disorders." Such funds would remain available until expended.

Georgia Impact: *As the allocation will subsequently be determined by the HHS Secretary,* ***there is no current way to determine the impact to Georgia; however, any support to address this issue is positive.*** *According to the Centers for Disease Control, the abuse of opioids costs the U.S. economy $78.5 billion a year. Nearly 25% of the economic burden is shouldered by public sources, including Medicaid, Medicare and other public insurance as well as government-funded treatment programs.*[11]

[9] Courtesy of Congressional Budget Office Cost Estimate. Better Care Reconciliation Act. March 13, 2017.
[10] SOURCE: https://pphf.hhs.gov
[11] *Opioid Epidemic Costs U.S. $78.5 Billion Annually: CDC*. HealthDay News. September 21, 2016.