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Commentary: Cassidy-Graham Would Create Huge Funding Inequities Across States

By Judith Solomon

In pitching their bill to repeal the Affordable Care Act (ACA) as an effort to "equalize" treatment among states, Senators Bill Cassidy and Lindsey Graham repeatedly note that California, Maryland, Massachusetts, and New York receive a combined 37 percent of federal funding for the ACA's Medicaid expansion and marketplace subsidies.[1] They claim that that this means the ACA treats other states unfairly and that their plan, which would replace funding for the expansion and subsidies with a temporary block grant and impose a per capita cap on Medicaid as a whole, would do better. They're flatly wrong on both counts.

Those four states account for 37 percent of the *funding* for the Medicaid expansion and marketplace subsidies because they account for 32 percent of the *people* enrolled in the expansion or receiving subsidies and because they have higher-than-average health care costs.

It's Cassidy-Graham that would create huge inequities and turn federal support for health coverage into a zero-sum game. Under the ACA, states that haven't adopted the Medicaid expansion could decide at any time to do so (as Louisiana did in 2016), drawing down additional federal funds to cover more low-income people without affecting other states. Cassidy-Graham, in contrast, would raise funding for non-expansion states by imposing huge funding cuts — and thereby forcing coverage losses — on expansion states.

Cassidy-Graham's notion of equity has two big problems:

1. It Confuses Equal Dollar Funding Across States With Equitable Treatment of Vulnerable People in Different States

Equalizing funding based on the number of state residents with incomes between 50 and 138 percent of the poverty line, as Cassidy-Graham purports to do, doesn't lead to equitable outcomes. That's because states differ widely in living costs, medical care costs, competition among insurers and health care providers, extent of job-based coverage, urban or rural status, and policies over how

[1] "Graham-Cassidy-Heller-Johnson: Frequently Asked Questions," https://www.cassidy.senate.gov/imo/media/doc/GCH%20FAQs%20Final.pdf.

to provide coverage and in what amount (including the decision whether to expand Medicaid). And states hit hard by the opioid epidemic face higher health care costs as a result.

Senators Cassidy and Graham repeatedly claim their bill would allow states to respond to "the unique health care needs of the patients in each state."[2] Actually, the *current* system does just that. It allows states to respond to residents' needs by raising federal Medicaid funding and marketplace subsidies when need rises, as in a recession or natural disaster. Cassidy-Graham's block grant, with its fixed and arbitrary state allotments that would end after 2026, would not.

2. It Uses "Equity" as an Excuse for Cuts

Cassidy-Graham would cut funding by $243 billion between 2020 and 2026, compared to what states would need to maintain the Medicaid expansion and marketplace subsidies under current law. And it would distribute that money *without regard to a state's current coverage levels and spending,* deeply cutting funding to states that have expanded Medicaid and raising funding to states that haven't. States like Florida and North Carolina, which have enrolled large numbers of people in the marketplace but haven't expanded Medicaid, would also be hurt disproportionately.

Cassidy and Graham claim the block grant would give states "flexibility," allowing them either to maintain the coverage available under the ACA or try alternative approaches.[3] But for most states, any "flexibility" under Cassidy-Graham would be unwelcome flexibility to cut coverage. Every expansion state would see a cut in 2026 due to the block grant and per capita cap.[4] Meanwhile, all but four non-expansion states (Florida, Maine, North Carolina, and Wyoming) would see net increases in federal funding. *All* states would see large, net federal funding cuts starting in 2027, when the block grant disappeared entirely and the cuts under the per capita cap continued growing.[5]

States couldn't use the block grant to continue the Medicaid expansion because Cassidy-Graham repeals the statutory authority for expansion.[6] Instead, states would have to figure out how to continue coverage for the expansion population — and continue marketplace subsidies — with less money. They likely couldn't raise their own spending enough to offset the lost federal funds, so large coverage losses are likely. And by prohibiting states from using Medicaid — which is more efficient

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[2] "Read About Graham-Cassidy-Heller-Johnson," https://www.cassidy.senate.gov/read-about-graham-cassidy-heller-johnson.

[3] "Senators Introduce Graham-Cassidy-Heller-Johnson," September 13, 2017, https://www.cassidy.senate.gov/newsroom/press-releases/senators-introduce-graham-cassidy-heller-johnson.

[4] Jacob Leibenluft *et al.,* "Like Other ACA Repeal Bills, Cassidy-Graham Plan Would Add Millions to Uninsured, Destabilize Individual Market," Center on Budget and Policy Priorities, revised September 20, 2017, https://www.cbpp.org/research/health/like-other-aca-repeal-bills-cassidy-graham-plan-would-add-millions-to-uninsured.

[5] Edwin Park and Matt Broaddus, "Cassidy-Graham Plan's Damaging Cuts to Health Care Funding Would Grow Dramatically in 2027," Center on Budget and Policy Priorities, revised September 20, 2017, https://www.cbpp.org/research/health/cassidy-graham-plans-damaging-cuts-to-health-care-funding-would-grow-dramatically-in.

[6] Jessica Schubel, "Cassidy-Graham Would End Medicaid Expansion in 2020, Leave Millions of Low-Income Adults Uninsured," Center on Budget and Policy Priorities, September 19, 2017, https://www.cbpp.org/blog/cassidy-graham-would-end-medicaid-expansion-in-2020-leave-millions-of-low-income-adults.

and less expensive than private coverage — to maintain the Medicaid expansion, Cassidy-Graham would raise per beneficiary costs.

Moreover, since the block grant wouldn't grow to reflect increased need, states would likely end up capping enrollment for any coverage program they created.

Cassidy-Graham does provide a great deal of flexibility to most *non*-expansion states. They'd get more federal funding, with no strings and little accountability, and they wouldn't have to use it to provide coverage at all. Many of the states that would see big funding increases have large numbers of poor residents in a "coverage gap," with incomes too high for Medicaid but too low to qualify for marketplace subsidies, because the state didn't expand Medicaid. To the extent they now get less money per low-income individual than expansion states, it's because the state *chose* not to expand. There's no reason to believe these states would use newly available block grant funds to cover uninsured adults they *could have* covered through Medicaid under current law when they could instead use the funds to replace other state spending or for other health-related purposes. Moreover, all states would think twice before creating new programs they might not be able to sustain after 2026, when the block grant would disappear.