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How to Ensure that the Graham–Cassidy Bill Expands Markets and Choice in Health Care—Not Government Programs

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The Senate faces a September 30 deadline to use the budget reconciliation vehicle designated by congressional leaders for the repeal of Obamacare this year. In the wake of the Senate's recent failure to repeal and replace Obamacare, Senators Lindsey Graham (R–SC) and Bill Cassidy (R–LA) have released an updated version of their bill[1] in a renewed effort to take advantage of this expiring legislative vehicle.

While the bill, like others considered this year,[2] falls short of fully repealing Obamacare and replacing it with a new patient-centered system,[3] Graham–Cassidy includes significant improvements over current law by repealing the individual and employer mandate tax penalties, providing Medicaid reform, and empowering states to design health care subsidies and insurance rules that work for their residents. These provisions are a good first step in addressing Obamacare's damage and allowing states to pursue reforms of their insurance markets and Medicaid programs. However, Members of Congress should not be under any illusion that passing Graham–Cassidy relieves them of the burden of continuing to reform the health system in a more patient-centered, market-based direction.

Graham–Cassidy makes it easier for states to waive Obamacare insurance mandates, including several mandates most responsible for driving up health care premiums. The bill gives states access to greater regulatory relief than in the House-passed bill or the 2015 repeal bill vetoed by President Barack Obama.[4] However, due to the constraints of the budget reconciliation process, that regulatory relief is limited to health insurance coverage subsidized through the new grant program.

Graham–Cassidy helps to refocus Medicaid on those who are most in need. These changes would put federal financing of Medicaid on a sustainable path, give states stronger incentives to manage the program more effectively, and restore Medicaid's pre-Obamacare focus on the most vulnerable: the elderly, disabled, children, and pregnant women in poverty. This is major entitlement reform that has long recommended by health policy experts.[5]

However, the Senate should change the bill's grant program to fulfill the sponsors' stated intent of promoting "market-based solutions."[6] Absent change in the grant program, states could use federal funding simply to expand the number of people in government monopoly health care programs.

While reprogramming Obamacare's spending into new state block grants is designed to make Graham–Cassidy more appealing to Senators and the states that they represent, there is a cost to that approach. Specifically, because it retains the Obamacare levels of spending, the Graham–Cassidy bill also retains the major taxes in Obamacare. Indeed, it retains two that directly drive up health care costs: the health insurance premium tax and the pharmaceutical tax. (This is a change from previous attempts to repeal Obamacare.) A full repeal of Obamacare would include repealing all of its taxes.

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Structuring Block Grants to Promote Choice, Not Expand Government Health Programs

Graham–Cassidy would transfer to states additional responsibility for designing and administering subsidies to ensure access to health insurance and medical care for working Americans who are without employment-based coverage. The bill would do that by converting into a state block grant program all of the current federal Obamacare spending for subsidizing exchange coverage through tax credits and cost-sharing reductions and about 75 percent of the current Obamacare funding for expanding Medicaid to cover able-bodied adults. Under the new block grant program, states could apply to use their share of that federal money to fund their own approaches for ensuring access to affordable medical care and health insurance, particularly for lower-income individuals and those with significant medical conditions.

Graham–Cassidy appropriates state block grant funding of $146 billion starting in 2020, increasing to $190 billion in 2026—totaling $1.176 trillion over the first seven years. The bill permits states to apply the funding to one or more of the following five arrangements:

- Subsidized coverage for high-cost individuals through high-risk pools or reinsurance payments to insurers;
- Subsidy payments for premiums to purchase individual market health insurance or to reduce out-of-pocket costs;
- Paying medical providers directly for providing services to individuals;
- Contracting with managed care plans to provide coverage to specified groups of individuals; and
- Expanding Medicaid, though no more than 20 percent of a state's grant can be used for that purpose.

The Senate should ensure that the bill is changed to support the goal stated in the legislative text: creating a "market-based healthcare grant program."[7] Specifically, the Senate should delete from the enumerated options for how states could spend the new federal grant funding the provisions that would allow states to use the money to expand Medicaid, pay medical providers directly for providing services, and contract with managed-care plans to cover specified groups. Any of these options would inherently result in adding more people either to existing programs or to new programs that are effectively government-controlled monopolies without consumer choice.

Without such changes, states are likely to spend the funding in ways that expand the number of people in government health care programs rather than providing subsidies to help recipients purchase the coverage of their choice in a competitive private market with a variety of different plan options. The pattern of the Obamacare Medicaid expansion and the CHIP program before it shows that, with very few exceptions, states historically have used federal funding for health insurance coverage simply to expand one-size-fits-all government programs.[8]

1. H.R. 1628, 115th Cong., 1st Sess., https://www.cassidy.senate.gov/imo/media/doc/Legislative%20Text.pdf (accessed September 20, 2017).
2. Edmund F. Haislmaier, Robert E. Moffit, Robert E. Rector, and Marie Fishpaw, "Better than the Status Quo, Senate Health Care Bill Still Misses Major Opportunities," Heritage Foundation *Issue Brief* No. 4723, June 26, 2017, http://www.heritage.org/health-care-reform/report/better-the-status-quo-senate-health-care-bill-still-misses-major.
3. Constraints of the congressional budget reconciliation process have limited the range of policies that can be pursued using this vehicle.
4. Restoring Americans' Healthcare Freedom Reconciliation Act of 2015, H.R. 3762, 114th Congress, https://www.congress.gov/bill/114th-congress/house-bill/3762 (accessed July 8, 2017).
5. See, for instance, the recommendation for reforming federal Medicaid financing in The Heritage Foundation's *Blueprint for Reform: A Comprehensive Policy Agenda for a New Administration in 2017*, Mandate for Leadership Series, 2016, p. 55, http://www.heritage.org/budget-and-spending/report/blueprint-reform-comprehensive-policy-agenda-new-administration-2017.
6. Section 106, p. 8.
7. Ibid.
8. On Medicaid: From 2014 to 2016, private and public health insurance enrollment increased by 15.7 million individuals, of which 89 percent (14 million individuals) were in Medicaid. See Edmund F. Haislmaier and Drew Gonshorowski "2016 Health Insurance Enrollment: Private Coverage Declined, Medicaid Growth Slowed," Heritage Foundation *Issue Brief* No. 4743, July 26, 2017 accessed September 19, 2017, http://www.heritage.org/sites/default/files/2017-07/IB4743_0.pdf. On CHIP: In only a few states does the general, non-Medicaid CHIP population have access to the open health care market.

With recent liberal calls for government control of health care through single-payer programs with no consumer choice,[9] it is key that policymakers promote access to mainstream private insurance for more Americans rather than opening the door to additional government program expansions.

Conclusion

If the Senate makes the recommended changes in the block grant program, Graham–Cassidy would provide an improvement over the status quo. However, without these changes, nothing would prevent states from simply expanding government health programs, which could result in transferring up to 8 million people (half of the people in the individual market)[10] from private coverage into government-run programs with no consumer choice.

Further, even with the changes recommended here, it is important to remember that this bill would be only a first step in the long-term effort necessary to achieve a truly patient-centered health care system. While it would create a foundation for state leaders to develop more patient-centered, market-based health care policies, doing so will be neither a quick nor an easy task. At the same time, federal policymakers will still face a great deal more work at the federal level to restore free-market principles in the remaining areas of health reform, including the tax treatment of health insurance, Medicare, and many other areas.

In short, Members of Congress should not be under any illusion that passing Graham–Cassidy relieves them of the burden of continuing to reform the health care system in a more patient-centered, market-based direction.

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9. David Weigel, "Sanders Introduces Universal Health Care, Backed by 15 Democrats," *The Washington Post* PowerPost blog, September 13, 2017, https://www.washingtonpost.com/powerpost/sanders-will-introduce-universal-health-care-backed-by-15-democrats/2017/09/12/d590ef26-97b7-11e7-87fc-c3f7ee4035c9_story.html?utm_term=.61969e1e0a42 (accessed September 20, 2017).
10. Haislmaier and Gonshorowski, "2016 Health Insurance Enrollment: Private Coverage Declined, Medicaid Growth Slowed."