Key Medicaid Financing Changes in Repeal and Replace Legislation

Medicaid and More
Alliance for Health Policy

July 7, 2017

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Overview of Better Care Reconciliation Act (BCRA) Key Changes to Medicaid

- **Like the House-passed American Health Care Act (AHCA), converts Medicaid to a per capita cap but reduces the trend rate to CPI in 2025 and beyond**
- **Offers states a block grant option for pregnant women and non-expansion parents**
- **Phases out, before entirely eliminating, enhanced federal funding for Medicaid expansion beginning in 2021**
  - 2021: 85% eFMAP; 2022: 80% eFMAP; 2023: 75% eFMAP
  - 2024+: State's regular FMAP
- **Halts the phasing in of the higher matching rate for leader states after 2017 and eliminates it entirely in 2024**
- **$2 billion annually from FY 2018 through 2022 for states that have not expanded Medicaid to increase payments to Medicaid providers (all types, not only hospitals)**
- **Maintains ACA DSH cuts for Medicaid expansion states only, even after enhanced expansion funding is eliminated**

It is unclear how many states could maintain the expansion under the phase down due to either "poison pill" legislation or a lack of state general funds to replace reduced federal funding

Source: Better Care Reconciliation Act of 2017, Discussion Draft as of June 22, 2017, available at: https://www.budget.senate.gov/imo/media/doc/SENATEHEALTHCARE.pdf; CBO score released June 26, 2017, available at: https://www.cbo.gov/publication/52849

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BCRA Would Sharply Reduce Federal Medicaid Spending and Medicaid Coverage

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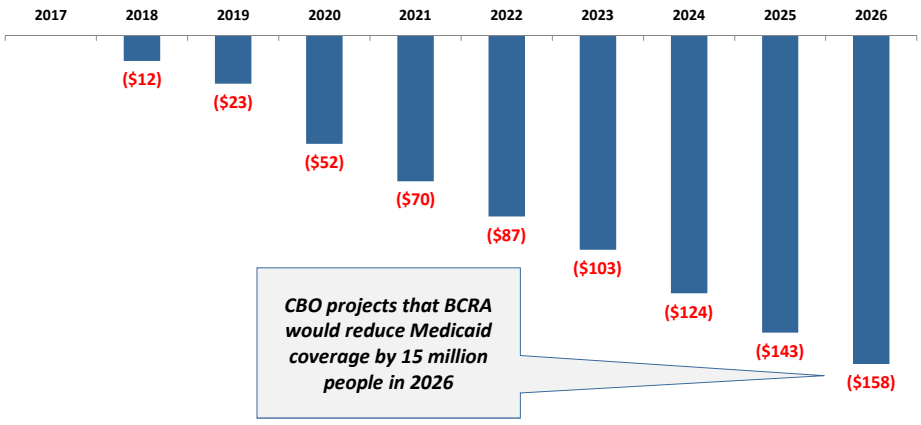
CBO projects that the BCRA would cut federal Medicaid spending by $772 billion over 10 years (2017-2026) and result in a 35% reduction in federal Medicaid funding than under current law by 2036



Source: CBO Score of BCRA, June 26, 2017, available at: https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/52849-hr1628senate.pdf

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Medicaid Per Capita Cap

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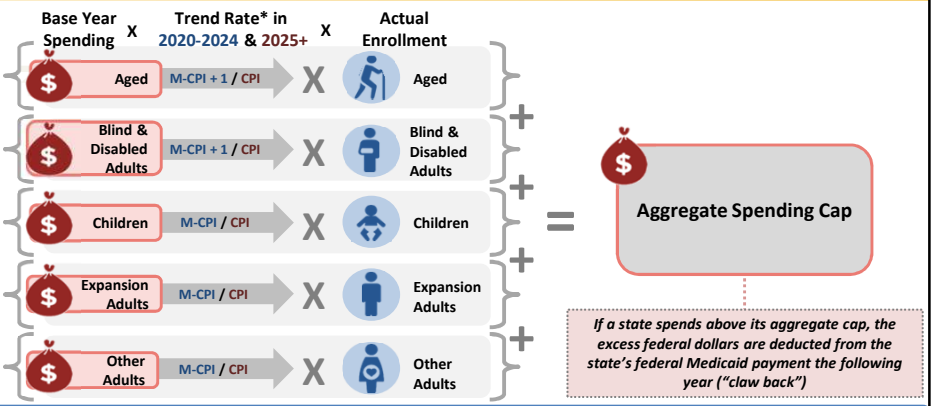
Aggregate cap on Medicaid funding is built up from ***per capita caps*** for five different eligibility groups



Cap calculation excludes certain enrollees (i.e., those receiving any Medicaid-funded services through an Indian Health Service or Tribal facility, children enrolled based on disability, CHIP-financed children, and partial benefit enrollees). Cap also excludes certain types of payments, including administrative funds and disproportionate share hospital (DSH) payments.

*To calculate states' starting caps in FY 2020, base year spending is trended forward by M-CPI; starting in 2020, M-CPI+1 is used to trend and calculate the aged and disabled spending caps, while M-CPI continues to apply to children, expansion adults, and other adults; beginning in FY 2025, CPI is used for all eligibility groups.

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Projected Spending Growth Relative to BCRA Caps

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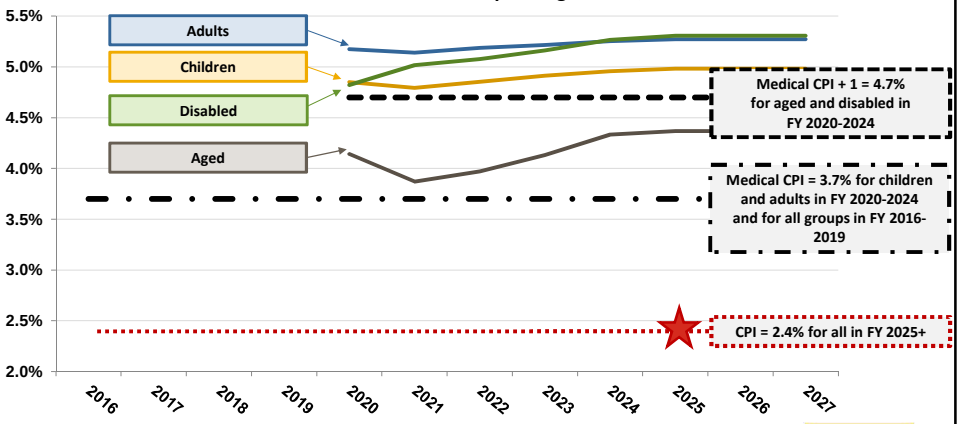
- Per enrollee spending is projected to grow more quickly than the trend rates established in the BCRA for all eligibility groups except aged through 2024
- Starting in 2025, all groups are projected to substantially exceed the trend rate

Estimated Annual Per Enrollee Spending Growth, 2017-2027



Source : Manatt Medicaid Financing Model. Note: Per enrollee growth rates projected by CMS Office of the Actuary; M-CPI projected by CBO. Spending growth for the aged and disabled groups is capped at medical CPI +1 in FY 2020-2024; the 2019 baseline amount from which 2020 caps are calculated is trended forward from 2016 by M-CPI.

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Estimated Impact of Per Capita Cap across All States

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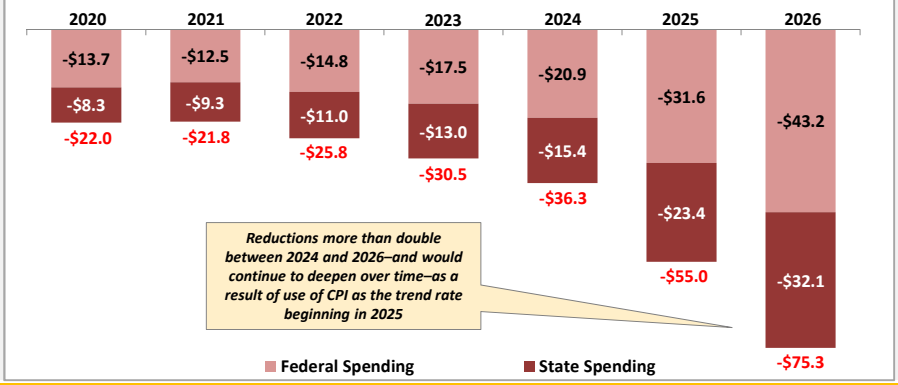
The per capita cap is projected to result in total cuts of more than $266 billion between FY 2020-2026

Impact of Per Capita Cap, FY 2020-2026 (billions)



Source: Manatt Medicaid Finance Model.
Note: Impact of per capita cap if states maintain expansion only through 2020 and reduce their state spending to remain below per capita cap allotment. If it were instead assumed that states maintain expansion indefinitely, the estimated size of the cut is $322.8 billion between FY 2020-2026 ($189.2 billion in federal reductions and $133.5 billion in state reductions).

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Actual Trend Rates May Vary from Projections

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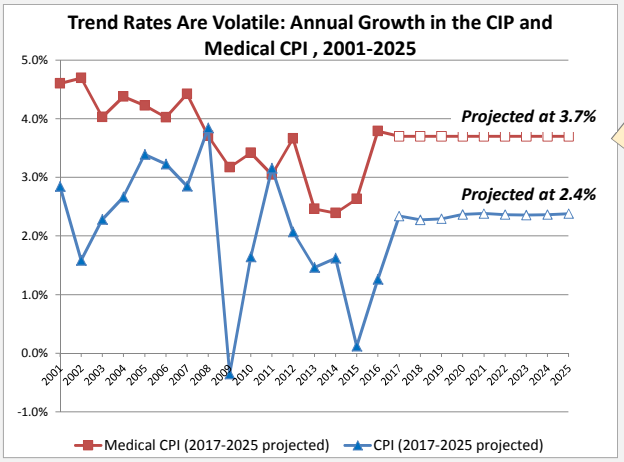

- Under the BCRA, if Medical CPI turns out to be 3.2%, rather than 3.7% as projected by CBO, between 2020 and 2026 total Medicaid cuts would increase from $266.8 billion to $399.9 billion.
- Under the AHCA, if Medical CPI comes in at 3.2% rather than 3.7% during the same time period, total Medicaid cuts would jump from $295 billion to $466 billion.
- In both cases, if the trend rates comes in higher than 3.7%, the reductions would be lower.

Source: Manatt analysis of Bureau of Labor Statistics, CPI Databases, https://www.bls.gov/cpi/data.htm; Congressional Budget Office, https://www.cbo.gov/publication/52486; https://www.cbo.gov/sites/default/files/recurringdata/51135-2017-01-economicprojections.xlsx; Manatt Medicaid Financing Model; Commonwealth Fund, http://www.commonwealthfund.org/publications/blog/2017/jun/impact-of-medicaid-caps

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States and the Medicaid Program Bear the Risks of All Costs Above the Caps

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Medicaid reductions under a cap could be higher *if…*

National trend rate is lower than projected

A state faces higher costs due to:

- New drug costs
- New treatments
- New epidemic
- Natural disaster
- Aging population

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Thank You

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Data is available at State Network:
http://www.statenetwork.org/resource/understanding-the-senates-better-care-reconciliation-act-of-2017-bcra-key-implications-for-medicaid

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Appendix

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Redistribution among "High" and "Low" Spend States

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- **An additional adjustment is made to state's aggregate cap if per capita spending is significantly above or below the mean for all states**
  - States ***above*** mean by 25% or more: Cap will be decreased the following year by .5% to 2%
  - States ***below*** mean by 25% or more: Cap will be increased the following year by .5% to 2%
- **Redistribution excludes states with low population density (i.e., AK, MT, ND, SD, and WY)**
- **In FY 2020 and FY 2021, adjustment will be based on state's average per capita spending across all eligibility groups**
- **In FY 2022+, the adjustments will be made for each eligibility group; as a result, some states may receive a downward adjustment for one eligibility group and an upward adjustment for another**
- **This new feature of per capita caps could create incentives for states to attempt to cut per capita expenditures more than other states to avoid an additional penalty**

HHS Secretary determines adjustment level between .5% and 2%; overall impact must be budget neutral

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"High" and "Low" Spend States Potentially Affected by BCRA Redistribution: FY 2020 and FY 2021

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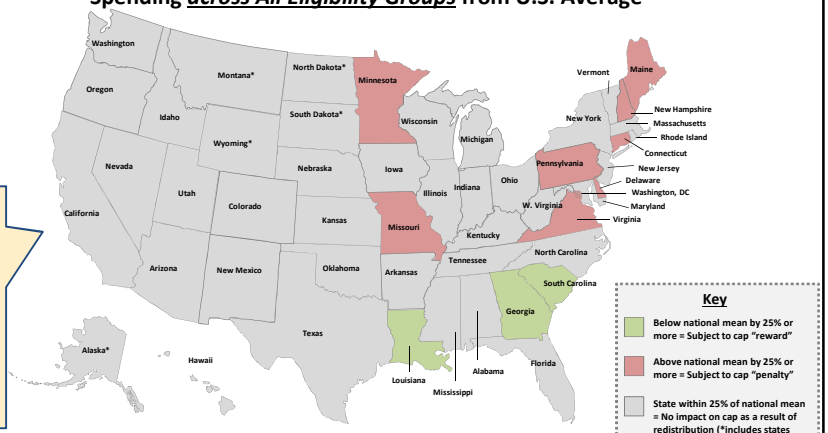
Difference in State's Average Per Member Per Year (PMPY) Spending *across All Eligibility Groups* from U.S. Average



Under the redistribution model, 3 states are projected to receive an increase in their per capita cap ("reward"), while 9 may be subject to a downward adjustment ("penalty") for FY 2020 and FY 2021

: Per member per year (PMPY) spending amounts for full-benefit enrollees as estimated in Manatt's Medicaid Financing Model. Excludes Medicaid expenditures for disproportionate share hospital payments, Medicare premiums, and administrative costs.

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"High" and "Low" Spend States Potentially Affected by BCRA Redistribution: FY 2022 and Beyond

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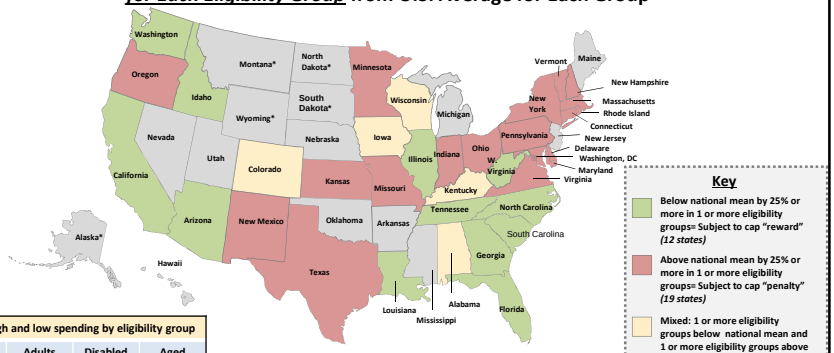
Difference in State's Average Per Member Per Year (PMPY) Spending *for Each Eligibility Group* from U.S. Average for Each Group



Key

- Below national mean by 25% or more in 1 or more eligibility groups= Subject to cap "reward" *(12 states)*
- Above national mean by 25% or more in 1 or more eligibility groups= Subject to cap "penalty" *(19 states)*
- Mixed: 1 or more eligibility groups below national mean and 1 or more eligibility groups above national mean = Unclear whether state will reap "reward" or face "penalty" *(5 states)*
- All eligibility groups within 25% of national mean = No impact on cap as a result of redistribution (*includes states exempted from model due to low population density) *(15 states)*

States with "mixed" high and low spending by eligibility group

State	Children	Adults	Disabled	Aged
AL	-29.9%	-8.3%	-52.1%	41.8%
CO	-14.7%	-26.4%	25.1%	16.7%
IA	8.0%	-39.1%	32.7%	57.0%
KY	15.6%	35.2%	-26.0%	-1.7%
WI	-40.1%	-30.4%	-23.8%	33.5%

: Per member per year (PMPY) spending amounts for full-benefit enrollees as estimated in Manatt's Medicaid Financing Model. Note: es Medicaid expenditures for disproportionate share hospital payments, Medicare premiums, and administrative costs.

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Additional Medicaid Provisions New to BCRA

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- Reduces allowable provider tax threshold from 6% to 5% in FY 2025 and beyond; phase down begins in FY 2021
- Offers states option to cover mental health and SUD services provided to Medicaid beneficiaries ages 21 to 65 in Institutes of Mental Disease (IMDs) under certain conditions; match rate will be 50%
- Establishes new bonus pool to reward states that spend below their aggregate caps and meet quality metrics in a given FY (available from FY 2023-FY 2026)
- Permits 6-month redetermination of expansion adults at state option
- Permits states to continue "grandfathered managed care waivers" in perpetuity through state plan authority, subject to meeting certain conditions
- Maintains ACA DSH cuts for Medicaid expansion states only, even after enhanced expansion funding is eliminated; from FY 2020 to FY 2023, increases DSH allotment for non-expansion states with below average DSH allotments in FY 2016
- Requires HHS Secretary to solicit advice from state Medicaid agencies and Medicaid Directors before promulgating proposed rules with impacts to Medicaid program operations/financing

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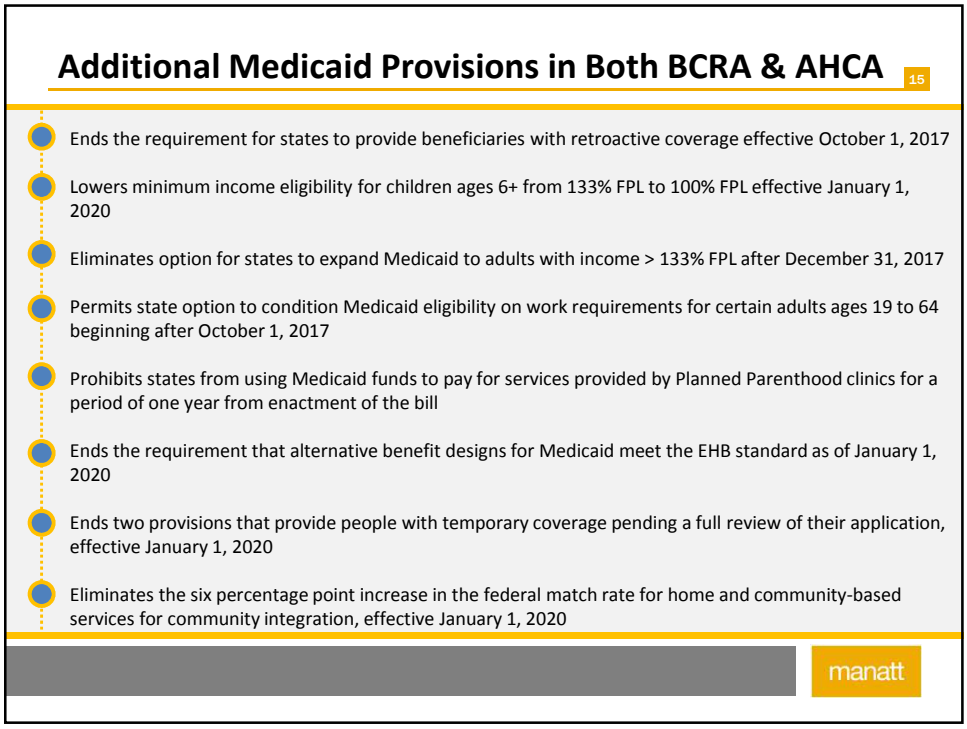
Additional Medicaid Provisions in Both BCRA & AHCA
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Ends the requirement for states to provide beneficiaries with retroactive coverage effective October 1, 2017
Lowers minimum income eligibility for children ages 6+ from 133% FPL to 100% FPL effective January 1, 2020
Eliminates option for states to expand Medicaid to adults with income > 133% FPL after December 31, 2017
Permits state option to condition Medicaid eligibility on work requirements for certain adults ages 19 to 64 beginning after October 1, 2017
Prohibits states from using Medicaid funds to pay for services provided by Planned Parenthood clinics for a period of one year from enactment of the bill
Ends the requirement that alternative benefit designs for Medicaid meet the EHB standard as of January 1, 2020
Ends two provisions that provide people with temporary coverage pending a full review of their application, effective January 1, 2020
Eliminates the six percentage point increase in the federal match rate for home and community-based services for community integration, effective January 1, 2020
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