ACA

⊕ 1595 – 1068 Medical Assistance Trust Fund ...
Mass health < 138%
138–400% Connector purchase coverage
Commonwealth contribution
612 1.6 billion

Joint Hearing of the House & Senate Committees on Ways & Means

American Health Care Act (AHCA) Impact
Executive Office of Health & Human Services
Marylou Sudders, Secretary
March 21 2017

AHCA House Bill – summary of Massachusetts fiscal impact

- Preliminary analysis of the released bill suggests **the Commonwealth could lose $1.1-1.9 billion per year of federal revenue for MassHealth by FY22**; findings are largely consistent with CBO assumptions, which suggest ~$1.5B of reduced federal revenue in FY22
  - It transfers "downside only" risk from the federal government to the states and appears not to account for longstanding safety net payments under Massachusetts' 1115 waiver
  - It gives no additional flexibility to states to manage the program; implementation details will be set by US HHS
- Specific provisions in the AHCA bill*:
  - **Medicaid expansion population**: eliminates $500-700M+ per year of federal revenue by 2022 for MassHealth to support coverage to the ACA Medicaid expansion population
  - **Per capita caps**: transfers "downside only" risk to states through caps on per capita spending
    - By 2022, provisions could cost up to $500M of federal revenue to the Commonwealth
    - Per capita caps would grow at medical CPI-U but do not account for unpredictable high cost growth items including pharmaceutical spending
    - There are no "shared savings" if states beat the target
  - **Potentially puts ~$500-$550 million of federal revenue per year of 1115 waiver funding at risk (FY20)**
    - Safety net programs and supplemental payments through the 1115 appear to not be accounted for in how per capita caps would be set**
  - **Restructures and reduces federal subsidies for Connector enrollees by ~$200M by 2022**
    - Eliminates APTCs ($457M) and cost sharing reductions (CSRs) ($124M) and replaces them with age-based refundable tax credits
    - Value of new tax credits is likely to fall short of current APTCs and CSRs
    - Expected to impact ~195,000 individuals current obtaining subsidized coverage through the Connector
- **The bill does not enhance states' flexibility to manage within the new caps**
  - It focuses on allowing states to reduce access to care for low income people, including seniors and children, while leaving in place federal restrictions on how states pay providers and structure programs
- The bill also eliminates $19M/year in grants to DPH (e.g., family planning, sexual assault prevention)

*Estimates reflect internal analyses; page 5 compares with CBO assumptions
** *$300M of lost revenue may be addressed by technical markup*

Overview of policy and programmatic elements of AHCA (1 of 3)

Expansion population

- **Phases out enhanced match for Medicaid expansion**
  - Freezes Expansion State FMAP* at CY17 level (86% for MA vs 90% by 2019 under ACA)
  - Starting 1/1/20, enhanced match available only for specific individuals enrolled as of 12/31/19 who do not lose eligibility for more than one month
  - 50% match after 1/1/20 for new expansion population enrollees and those whose eligibility lapses for more than one month

Per Capita Cap

- **Restructures Medicaid financing as a per capita cap effective FFY20**
  - Federal funds capped in aggregate starting in FY20 based on per-enrollee spending targets multiplied by actual enrollment
  - Targets calculated by population group, using FY16 base data inflated by medical CPI and adjusted based on FY19 actuals
  - Includes elderly, blind and disabled, children, expansion adults, other adults
  - Limited exclusions (e.g., DSH, administrative costs, Medicare cost-sharing, and certain populations including CHIP, Medicare buy-in, individuals served by Indian Health Services)
  - Caps apply to both State Plan and Waiver (1115 and HCBS) expenditures
  - Aggregate cap allows for "savings" from one group to finance care for another
  - Targets do not account for high cost growth items such as pharmaceutical spending
  - States bear all downside risk if spending exceeds target, no "shared savings" if under target

DSH and Supplemental Payments

- **The bill as written does not appear to account for DSH and other 1115 Waiver Safety Net Care Pool payments in setting per capita caps** *[NOTE – $300M of lost revenue may be addressed by technical markup]*
  - State Plan supplemental payments incorporated into per capita caps, apportioned by population
  - DSH is generally outside of per capita caps, but it is unclear how MA's 1115 payments through our DSH waiver would be treated
  - Repeals DSH cuts starting in FY18 for non-expansion states and FY20 for expansion states
  - Non-DSH 1115 Waiver SNCP payments do not appear to be incorporated into per capita caps in calculating targets, but all 1115 waiver spending would be subject to the caps starting in FY20

*FMAP=Federal Medical Assistance Percentage, the federal matching rate for Medicaid

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Overview of policy and programmatic elements of AHCA (2 of 3)

Other State Funding

- **Increases funding for non expansion states while reducing funds for public health and family planning**
  - Creates new pool of $10B safety net funding for non-expansion states ($2B/year for 5 years)
  - Repeals Prevention and Public Health Fund effective 10/1/19
  - Bans federal funding for Planned Parenthood for one year upon enactment
  - Provides $422M in additional funding for Community Health Centers in FY17 only

Eligibility and Benefits

- **Changes certain Medicaid eligibility and benefits requirements**
  - Requires eligibility redeterminations every 6 months for expansion population beginning 10/1/17
  - Repeals Essential Health Benefits requirement for expansion population beginning in 1/1/20 (e.g., does not require addiction services)
  - Repeals hospital presumptive eligibility and limits presumptive eligibility
  - Reduces mandatory eligibility for kids ages 6-18 from 138% FPL to 100% FPL effective 1/1/20 (though states may cover children 100-138% through CHIP)
  - Ends the requirement that otherwise eligible applicants who report they are citizens or have a qualifying immigration status be covered for up to 90 days while they produce citizenship or immigration documents, effective six months after enactment
  - Requires states to use federal minimum for home equity in asset test (for elders, individuals living in nursing facilities and HCBS waiver participants)
  - Reduces retroactive eligibility from 3 months to the month in which an individual applies (Note: MA currently has a waiver to provide 10 days retroactive eligibility for most members under age 65)
  - Changes treatment of lottery winnings and inheritances in income calculation for eligibility

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Overview of policy and programmatic elements of AHCA (3 of 3)

Reduced Subsidies on Exchange

- **Net reduction in federal funding to support health coverage for subsidized populations via Connector**
  - Bill would repeal advance premium tax credits (APTCs) and cost sharing reductions (CSRs). These changes would affect ~195,000 individuals currently in subsidized coverage through the Connector.
  - Though the bill would replace a portion of the lost premium tax credits and potentially offer a pool of funds to reduce enrollee costs, these measures appear to fall far short of current funding levels

Regressive Replacement Subsidies

- **New Premium Tax Credits are likely to have regressive impacts**
  - Structure of new premium tax credits – linked to age rather than income or cost of insurance - is likely to disproportionately increase premium costs to older and poorer Massachusetts residents currently enrolled in the Health Connector
  - Consumer confusion and market disruption are likely, given bill would require annual changes to tax credit rules until 2020

Ripple Effects from Medicaid Changes

- **Risks to Medicaid expansion funding would have cascading effects into Health Connector, HIX platform, and commercial market**
  - Given the Health Connector and MassHealth's close policy & programmatic partnership and shared eligibility and enrollment platforms, the bill's substantial changes to Medicaid, including per capita caps in 2020, could pose impacts to the Health Connector's enrollment, finances, policy and operations as well as the broader commercial market (of which the Health Connector's enrollees – both subsidized and unsubsidized – are a part)

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ACHA will result in $1.1 – $1.9 billion+ annual reduction in federal revenue

	Actual FY16 Spending		Federal revenue at risk under AHCA by FY22	
	FFY16 gross spending	FFY16 federal revenue	Internal estimates	Applying CBO assumptions
Expansion population	$2.1B	**$1.8B**	▪ **~$500-700M**	▪ **~$830M**
Other population (eg, FFS/ MCO, state plan supps)	$16.2B	**$8.3B**	▪ **$0-500M:** *Historical growth suggests caps could be managed*	▪ **~$490M**
1115 waiver payments	$1.2B	**$0.6B**	▪ **~$425-475M*** ▪ *$300M could be offset by technical markup*	▪ **Not addressed**
Total MassHealth impact	$19.6B	**$10.7B**	▪ **~$0.9-1.7B**	▪ **~$1.3B**
Connector impact**	$0.6B	**$0.6B**	▪ **~$0.2B**	▪ **~$0.2B**
DPH impact	N/A	**$19M**	▪ $19M in grants (e.g., family planning, sexual assault prevention)	
Total combined impact	$20.2B	**$11.3B**	▪ **~$1.1-1.9B**	▪ **~$1.5B**

*Assumes MA can resume making regular DSH payments if the per capita cap structure would limit current 1115 waiver payments funded by DSH allotment. Another $330M of federal revenue would be at risk if the Secretary of HHS does not allow MA to make such a change.

** Excludes ConnectorCare wrap, captured in MassHealth 1115 waiver impact above

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Preliminary estimate: ACHA revenue losses would increase from 2020 to 2022

	CBO-extrapolated estimates ($M)			Internal estimates ($M)		
	2020	2021	2022	2020	2021	2022
Expansion population	460	690	830	250-350	375-550	500-700
Other population (eg, FFS/ MCO, state plan supps)	300	390	490	0-300	0-400	0-500
				Historical PMPMs suggest caps could be managed		
1115 waiver payments	*Not addressed*			500-550*	475-525*	425-475*
				$300M could be offset by technical markup		
Total MassHealth impact	760	1,080	1,330	750-1,200	850-1,475	925-1,675
Connector impact**	200	200	200	200	200	200
DPH impact	19	19	19	19	19	19
	Grants (e.g., family planning, sexual assault prevention)					
Total combined impact ($B, rounded)	**1.0**	**1.3**	**1.5**	**1.0-1.4**	**1.1-1.7**	**1.1-1.9**

*Assumes MA can resume making regular DSH payments if the per capita cap structure would limit current 1115 waiver payments funded by DSH allotment. Another $330M of federal revenue would be at risk if the Secretary of HHS does not allow MA to make such a change.
** Excludes ConnectorCare wrap, captured in MassHealth 1115 waiver impact above

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