SENATE FISCAL AGENCY
MEMORANDUM

DATE: June 23, 2017

TO: Members of the Michigan Senate

FROM: Steve Angelotti, Associate Director

RE: The Proposed Federal "Better Care Reconciliation Act of 2017": Estimated Fiscal Impact on Michigan's Medicaid Budget

On June 22, 2017 the leadership of the United States Senate released a draft bill that would make numerous changes to the Patient Protection and Affordable Care Act, commonly known as the ACA. The draft United States Senate bill has the title "Better Care Reconciliation Act of 2017"; for convenience the new bill will be referred to as the "BCRA".

On March 6, 2017, the United States House of Representatives released a draft bill titled the "American Healthcare Act" or AHCA. The Senate Fiscal Agency (SFA) provided an estimated fiscal impact of the proposed bill in a memorandum to the Senate on March 8, 2017. The U.S. House of Representatives passed a revised version of the AHCA on May 4, 2017.

As was the case with the AHCA, the BRCA makes many changes to the ACA, health care coverage and services, and taxes, not just changes to Medicaid. This memorandum, like the March 8 SFA memorandum on the initial version of the AHCA, is focused on the impact of the proposed BRCA on the State of Michigan's Medicaid program. This memorandum also discusses the differences in the Medicaid changes included in the BRCA and the AHCA and provides an initial estimated fiscal impact of the legislation on the State of Michigan.

Synopsis

The BRCA would lead to potential GF/GP cost increases for the State similar to those tied to the AHCA, in the range of $900.0 million GF/GP by Fiscal Year 2024-25, but the cost increases would take at least two years longer to take effect and would be more easily absorbed, although they would certainly put a strain on the State's balance sheet. These estimates assume that the trigger in Michigan's Medicaid expansion legislation, the Healthy Michigan Plan (HMP), is removed. If the trigger, which terminates the HMP once State HMP costs exceed State HMP savings, is not removed, then the HMP would effectively terminate by the end of FY 2020-21 and the net fiscal impact of the BRCA would be much smaller.

The provisions with the greatest potential fiscal impact are the changes in the Federal match rate for the HMP and the proposed per capita cap on Medicaid expenditures. The SFA estimates that the changes in Federal match for the HMP would increase costs by over $800.0 million GF/GP by FY 2023-24 if the HMP statute trigger did not exist or was removed. If the trigger is not changed then the HMP would be terminated, likely by the end of FY 2020-21. It should be noted that this termination would likely occur by FY 2020-21 even if no changes are made to the ACA.

The SFA believes the State, given the baseline options outlined in the BRCA, is not at risk to significantly exceed the per capita caps. It is possible that the State could exceed a cap for one or another eligibility grouping, but the net cost would likely be minimal compared to the BRCA proposed change in expansion match rate.

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The State would see smaller savings from the changes in retroactive eligibility and Federal match for State facility services to non-elderly adults. The State potentially could achieve savings if it opted to implement a work requirement for certain Medicaid recipients. If the State opted to receive its Medicaid funding as a block grant there could also be savings, although there would be the risk of increased costs as well.

Key Medicaid Provisions

The proposed Senate bill would make several significant changes to the Medicaid program. The most notable changes include the following:

1) The bill would reduce retroactive eligibility for Medicaid from three months to the month in which a person applied for Medicaid. Under current law, when an application for Medicaid is approved, Medicaid covered services for the person are reimbursed by Medicaid retroactive to three months before the date of application. This provision was also included in the AHCA.

2) The bill would provide 50.0% Federal match funding for Medicaid covered services provided to people between the ages of 21 and 64 who are in institutions for mental disease (IMD). At present, expenditures for such individuals in that age range being treated in IMDs (such as the State facilities in Caro, Kalamazoo, and Westland) do not receive Federal match. This provision was not included in the AHCA.

3) The bill would reduce the cap on Medicaid provider taxes (known in Michigan as Quality Assurance Assessment Programs, or QAAPs) from 6.0% in FY 2019-20 down to 5.0% in FY 2024-25, with a decrease of 0.2% per year in the cap. This provision was not included in the AHCA.

4) The bill would allow states to implement a work requirement for certain Medicaid recipients, basically non-disabled, non-elderly, non-pregnant adults who are not caretakers of children under 6 or disabled children. This provision was not in the version of AHCA analyzed in the SFA's March 8 memorandum but was included in the version of the AHCA adopted by the U.S. House.

5) The bill would, effectively, eliminate funding for Planned Parenthood for one year following enactment (the legislation specifies entities that provide abortions that received more than $350.0 million in Medicaid revenue, which appears to only describe Planned Parenthood). A similar provision was in the AHCA.

6) The bill would make no changes to the reductions in disproportionate share hospital (DSH) payments included in the ACA for states that, like Michigan, expanded Medicaid (reductions for non-expansion states would be restored). The original version of the AHCA restored these reductions for all states.

7) The bill would change the Federal match rate for expansion Medicaid, reducing it down to the traditional Medicaid match rate over a period of four years. The ACA set the Federal match rate for expansion Medicaid (known as the Healthy Michigan Plan or HMP in Michigan) at 100.0% in calendar years 2014-16, then slowly reduced it to a permanent 90.0% in calendar year 2020 and beyond. The BRCA would reduce the match rate from 90.0% to 85.0% in calendar year 2021, 80.0% in calendar year 2022, 75.0% in calendar year 2023, and to the regular Medicaid match rate in calendar year 2024 and beyond (Michigan's regular Medicaid match rate has hovered around 65.0% for several years).

The AHCA took a different approach, maintaining the enhanced 90.0% Federal match rate for expansion Medicaid for ongoing cases beyond January 1, 2020, but reimbursing new expansion Medicaid cases at the state's regular match rate.

8) The bill would implement expenditure caps on various Medicaid eligibility categories (elderly, blind or disabled, children, expansion Medicaid, and all other eligibles). The base period for the cap would be a state-chosen eight consecutive calendar quarters between January 1, 2014 and September 30, 2017. The spending for each category in that base period would be inflated by various consumer price index (CPI) measures to create a cap in each fiscal year starting in FY 2019-20 (Medicaid CPI +1.0% for elderly, blind, and disabled and medical CPI for other categories up until FY 2024-25, when the inflation measure would be urban CPI). If a state exceeded its cap its Federal Medicaid match funding would be reduced by ¼ of the excess in each quarter of the next fiscal year. A similar provision, with differences in the inflation measures used and the base period, was included in the AHCA.

9) The bill would give the State the option of receiving its Medicaid funding as a block grant. The block grant would be based on the base period expenditure cap trended forward based on the urban CPI (not the medical CPI) and statewide population growth. States would still be required to cover most basic medical services and the actuarial value of the coverage would have to be at least 95.0% of the aggregate benchmark coverage set under the ACA. States would have to meet maintenance of effort requirements as well. Cost sharing could not exceed 5.0% of family income. A similar provision was included in the AHCA.

Initial Estimated Fiscal Impact of BRCA Medicaid Provisions

Retroactive Eligibility Change

The change in retroactive eligibility from three months prior to application to the current month of application would lead to a reduction in Medicaid expenditures. While there are no data specific to current expenditures, there was a proposal in the FY 2005-06 Department of Community Health budget to seek a waiver to eliminate the three month retroactive eligibility provision. The projected savings, in an era with a lower Federal match rate, was $28.3 million Gross and $12.3 million GF/GP. It would appear that GF/GP savings from this provision, which would appear to take effect in FY 2017-18, would be in a similar range.

Match Funding for Medicaid Covered Services for non-Elderly Adults in State Facilities

The bill would provide Federal match, at a 50.0% match rate, for Medicaid covered services for individuals between the ages of 21 and 64 served in IMDs such as Michigan's State hospitals and centers. The reimbursement would be limited to services not to exceed 30 consecutive days in a month nor 90 days in a calendar year, so the reimbursement would not apply to all individuals served in these facilities.

The total appropriation for the three adult facilities in Caro, Kalamazoo, and Westland is about $190.0 million Gross. It is not clear to what extent services at the Center for Forensic Psychiatry in Ypsilanti would be eligible for reimbursement so the roughly $76.0 million spent there was not included in this estimate.

Of the $190.0 million about $23.0 million Gross is already Medicaid reimbursement for people outside the 21-64 age range. If one assumes that half of the remaining expenditures ($167.0

million Gross) meet the criteria of no more than 30 consecutive days in a month nor 90 days in a calendar year, then about $83.5 million in expenditures would be eligible for reimbursement at a 50% match, leading to increased Federal reimbursement of $41.8 million and a reduction in GF/GP costs of $41.8 million. This provision would take effect immediately, so, if the legislation was enacted at the Federal level, the State would realize these savings in FY 2017-18.

Reduction in the Maximum Provider Tax

At present the maximum allowable state medical provider tax (for purposes of Medicaid reimbursement) is 6.0%. The BRCA would reduce that maximum to 5.8% in FY 2020-21, 5.6% in FY 2021-22, 5.4% in FY 2022-23, 5.2% in FY 2023-24, and 5.0% in FY 2024-25 and beyond.

The State currently has two provider taxes (QAAPs) in place, on hospital services and long-term care services. The hospital tax is actually well below 5.0% and would not be affected by this provision. The long-term care provider tax, with the expansion of the QAAP included in the budget on its way to the Governor, would be at 6.0% in FY 2017-18. This tax would collect about $259.5 million in FY 2017-18.

The State retains a gainshare on these taxes that offsets GF/GP spending. In the FY 2017-18 Department of Health and Human Services (DHHS) budget the gainshare is about $89.7 million. The non-gainshare QAAP revenue, about $169.7 million, is used along with $315.2 million in Federal Medicaid match revenue, to increase long-term care reimbursement by $485.0 million Gross.

Assuming a 2.0% QAAP growth rate and no change in the 6.0% cap, by FY 2024-25 long-term care QAAP revenue would be $298.0 million, with a gainshare of $99.2 million. Long-term care reimbursement would be increased by $568.2 million Gross.

Under the 5.0% cap, by FY 2024-25 long-term care QAAP revenue would be $248.4 million, with a gainshare of $87.0 million. The long-term care reimbursement increase from the QAAP would be reduced to $461.0 million. If the State chose to continue providing full reimbursement for long-term care services, the State would have to use GF/GP to make up the gap between $568.2 million and $461.0 million.

At a continued 65.0% Federal match rate this $107.2 million Gross gap would cost $37.5 million GF/GP to eliminate. The reduction in gainshare revenue from $99.2 million to $87.0 million would increase costs by an additional $12.2 million GF/GP. The 5.0% cap would increase GF/GP costs in FY 2024-25 by up to $49.7 million. In previous years, as the cap decreases stepwise from 6.0% to 5.0%, the GF/GP cost increase would be proportionally less.

Work Requirement

States would be permitted to implement a work requirement for non-disabled, non-elderly, non-pregnant adults. Parents and caretakers of children under 6 or disabled children would be exempt, as would those under 20 who are enrolled in educational programs. This provision would be optional for states. If Michigan chose to implement such a proposal, the potential savings would be based on the number of Medicaid enrollees who violated the work requirement and were cut off from eligibility. That number cannot be estimated, but there would be potential cost savings.

Planned Parenthood Funding

The provision effectively eliminating, for one year, Medicaid reimbursement to Planned Parenthood would likely not have a direct fiscal impact as other providers presumably would be eligible for Medicaid reimbursement for services currently provided by Planned Parenthood.

Disproportionate Share Hospital (DSH) Funding

The BRCA would make no change to Michigan's DSH allotment, so this provision, which would affect non-expansion states, would have no fiscal impact on Michigan.

Expansion Medicaid Match Rate

Michigan's expansion Medicaid statute (the Healthy Michigan Plan or HMP) states that the program shall terminate once State costs (generally understood as GF/GP costs) exceed State savings. The SFA has estimated that, even without changes to the ACA, this would happen after FY 2019-20. Officials in the Snyder Administration have recently argued that reduced uncompensated care, even reductions that do not impact State expenditures, could be counted as State savings. The increased GF/GP costs incurred under the BRCA or the AHCA would lead to HMP costs that exceed even a State savings estimate that included reductions in uncompensated care. As such, one could simply note that implementation of the BRCA (or the AHCA) would lead to trigger clause being met and the HMP being terminated at some point prior to FY 2024-25.

However, it is important to provide a full estimate of the potential fiscal impact of the legislation, so this analysis, for the moment, ignores the trigger issue to illustrate the GF/GP cost increase that would occur under the Medicaid expansion provisions of the BRCA.

The Medicaid expansion Federal match rate, which is set to decline to 90.0% on January 1, 2020 and remain there in perpetuity under the ACA, would be reduced step by step under the BRCA to equal each State's regular Federal Medicaid match rate by January 1, 2024.

If one assumes Michigan's regular Federal Medicaid rate will remain at about 65.0% over the next few years, this would mean the expansion match rate would decline from 90.0% to 85.0% on January 1, 2021, to 80.0% on January 1, 2022, to 75.0% on January 1, 2023, and to the regular Federal match rate of 65.0% on January 1, 2024.

At present the GF/GP funded Gross portion of the Healthy Michigan Plan (as opposed to the portion funded with special hospital payments as match) is about $3.2 billion in FY 2017-18. For purposes of this analysis, a 2.0% cost growth rate was assumed.

The Senate Fiscal Agency estimates that the BRCA's reduction in the HMP match rate would lead to an increase in GF/GP costs of $127.3 million in FY 2020-21 above what would occur without enactment of the BRCA. Costs in FY 2021-22 would increase by $303.1 million GF/GP. Costs in FY 2022-23 would increase by $485.8 million GF/GP. Costs in FY 2023-24 would increase by $810.8 million GF/GP. These would be increases above the baseline assuming no changes to the ACA. To illustrate it another way, the State would have to add $127.3 million GF/GP in FY 2020-21, then add in another $175.8 million GF/GP to get to $303.1 million in FY 2021-22, etc.

This GF/GP cost increase is slower than the GF/GP cost increase estimated by the SFA in its initial AHCA analysis. In that case the increased cost in FY 2020-21 was $532.7 million GF/GP

(compared to $127.3 million under the BRCA) and $738.9 million GF/GP in FY 2021-22 (compared to $303.1 million under the BRCA). By FY 2024-25, however, the GF/GP cost increases would be very similar, in the $900.0 million GF/GP range.

Again, as noted above, these GF/GP cost increases would quickly trigger the statutory provision that would end the HMP. The purpose of the analysis is to estimate, if the Legislature chose to continue the HMP by changing the statute, the GF/GP cost increases that would occur.

The Federal per Capita Cap on Expenditures

Growth in State expenditures on several eligibility groupings (elderly, blind and disabled, children, expansion population, and all others) would be capped under the BRCA starting in FY 2019-20. In effect the Federal share of any amount exceeding the adjusted cap would be taken back by the Federal government the next year through a reduction in Federal reimbursement. The end result would be any Gross spending exceeding the cap would effectively be 100.0% GF/GP.

The caps would be based on baseline spending for each eligibility grouping from a state-chosen consecutive eight quarter period between January 1, 2014 and September 30, 2017. Certain expenditures such as DSH payments and Medicare Premium Payments would be excluded from the baseline as those are not controlled by the State. The per capita expenditures for each eligibility grouping would then be trended forward based on the medical CPI + 1.0% for the elderly, blind, and disabled and the medical CPI for the other groupings. In FY 2019-20 the State would be subject to the per capita cap and any Gross expenditures in excess of the cap would result in a reduction in Federal reimbursement the next year. The caps would continue in subsequent years, adjusted by the medical CPI factors as described above until FY 2024-25, when the inflation factor would shift to the typically lower regular urban CPI.

In the March 8 memorandum the SFA outlined how the similar AHCA cap could impact the State based on actual FY 2012-13 expenditures as the base year and FY 2016-17 as the first year of the cap (the same four-year gap that was included in the AHCA, except FY 2012-13 to FY 2016-17 instead of FY 2015-16 to FY 2019-20). In that analysis, the SFA found that the State could exceed a general per capita cap (not split by eligibility groupings) by $220.0 million in FY 2016-17.

Because of the provision allowing the use of a consecutive eight quarter period between January 1, 2014 and September 30, 2017 for the baseline, the SFA does not believe the State will be nearly as much as risk for exceeding the caps as described in the March 8 memorandum. If the State exceeded its caps it likely would be by a relatively small amount, much smaller than the $220.0 million described in the March 8 memorandum. This is because the flexibility to choose a consecutive eight quarter period out of a 15 quarter time period would allow the State to use a relatively higher spending period as the base period.

The Medicaid Block Grant Option

The State would be allowed to opt to receive its Medicaid funding as a block grant. The advantage of this would be the greater flexibility to craft benefit levels and eligibility, with all marginal savings up to a point being 100.0% GF/GP. The risk would be all increased marginal costs would also be 100.0% GF/GP. Additionally, once a state opts in to the block grant option it cannot revert back to the per capita funding option. The BRCA includes provisions requiring coverage of basic medical services and requires that the actuarial value of the coverage be at least 95.0% of the aggregate benchmark coverage set under the ACA, so the ability to restrict reimbursements or

general coverage would be somewhat limited. Recipient cost-sharing would also be limited to 5.0% of family income.

The block grant would be based on the Federal share of the baseline spending used for the expenditure cap described above. It would be trended forward using regular CPI (not medical CPI) and statewide population growth. The State would be required to meet a financial maintenance of effort.

The fiscal impact of the block grant, if Michigan opted to do so, cannot be estimated. It would depend on how robust a program the State implemented under the block grant, which would be based on political decisions made during the implementation process.

Conclusion

The BRCA, if enacted, would lead to significant GF/GP cost increases for the State, ones that would trigger, barring statutory changes, the termination of the Healthy Michigan Plan.

If one leaves aside the trigger issue, the SFA estimates that, in FY 2023-24, the State would spend about $800.0 million more GF/GP to continue the same level of Medicaid services.

The State would actually save money in FY 2017-18 through FY 2019-20, in the range of about $50.0 million GF/GP each year, due to the retroactive eligibility and IMD match changes. By FY 2020-21, with the first reduction in the expansion Medicaid match rate, the State would see a cost increase of about $90.0 million GF/GP and that would continue to grow as the match rate was reduced, reaching the aforementioned net $800.0 million GF/GP increase in FY 2023-24.

The March 8 memorandum on the AHCA noted a similar total cost increase, but the AHCA cost increase would have occurred much faster, with a net increase in excess of $700.0 million GF/GP two years earlier, by FY 2021-22. As such, the BRCA GF/GP cost increases would likely be less difficult to absorb into the State budget, assuming the State chose to continue Medicaid expansion by changing the HMP statute to alter or remove the trigger.

If the State allows the trigger to take effect and the expansion to expire, then the net cost of the BRCA provisions would be near zero, as the GF/GP increase due to the reduction in the QAAP tax rate would be balanced by the savings from changes to retroactive eligibility and the IMD match.

This is a first overview of a very complex subject. We will of course be glad to address any questions you may have as discussion on this legislation and the AHCA continues in Washington.

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c: Ellen Jeffries, Director