A Fiscal Perspective for Medicaid: Proposed Innovations
NCSL Legislative Summit Preconference

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Introduction and Background
Medicaid’s Role in State Budgets

State Medicaid Spending as Share of Budget (State Funds Only), FY 2015

- All Other: 33.8%
- Transportation: 8.0%
- Corrections: 4.4%
- Public Assistance: 0.9%
- Higher Education: 13.1%
- Elementary & Secondary Education: 24.1%
- Medicaid: 15.8%

Sources of Federal Funds to States, FY 2015

- Medicaid: 56.1%
- Transportation: 7.2%
- All Other: 21.6%
- Higher Education: 3.6%
- Elementary & Secondary Education: 9.0%
- Public Assistance: 2.5%
- Corrections: 0.1%

Nationally, most Medicaid enrollees are children and non-disabled adults. However, program spending disproportionally supports the aged and disabled groups.

**Estimated US Medicaid Spending and Enrollment by Eligibility Group,** *FY 2016*

<table>
<thead>
<tr>
<th>Eligibility Group</th>
<th>Spending (billions)</th>
<th>Enrollment (thousands)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children</td>
<td>$86.8</td>
<td>28,493</td>
</tr>
<tr>
<td>Adults</td>
<td>$146.6</td>
<td>26,751</td>
</tr>
<tr>
<td>Disabled</td>
<td>$177.5</td>
<td>8,623</td>
</tr>
<tr>
<td>Aged</td>
<td>$92.2</td>
<td>4,555</td>
</tr>
</tbody>
</table>

**SOURCE:** Manatt Medicaid Financing Model

Note: Excludes Medicaid children financed with CHIP funding. *This report adopts the nomenclature for these groups used by the federal government (i.e., “aged” corresponds with “seniors”; “disabled” corresponds with “people with disabilities”.*
Future of Medicaid Expansion
To Date, 31 States and DC Have Expanded Medicaid

Estimated federal funding for expansion, FY 2017

Washington: $3.7 B
California: $16.4 B
North Dakota: $161 M
Iowa: $483 M
Michigan: $3.9 B
Connecticut: $1.3 B
Kentucky: $3.3 B
New Mexico: $1.7 B
Arkansas: $1.3 B

Note: Federal funding does not reflect enhanced funding provided by the ACA to states that expanded before the ACA ("early expansion states"). Total federal funding for all expansion adult enrollees (not just those that are newly eligible) from January 2014 - June 2015 was $78.8 billion.

Medicaid Expansion: Approach to Repeal

Replace “enhanced” funding with regular Medicaid matching rate

- Debate over when phase out should start and length of phase out
- Grandfathering of current enrollees?
- Eliminate opportunity for non-expansion states

Key factors affecting fiscal impact on a state

- Ability to maintain expansion at regular match
- Expansion as a share of Medicaid budget and enrollment
- Coverage of low-income adults prior to the Affordable Care Act
- Extent to which expansion is “baked into” state’s budget

Capped Funding
Medicaid’s Financing Structure Today

Currently the federal government covers a share of all Medicaid expenditures

- Federal dollars guaranteed as match to state spending
- Matching rates vary by population and service
  - Regular matching rate is set at 50% - 76%, depending on state.
  - Matching rate for expansion adults = 95% in 2017; 90% in 2020 and beyond
  - Indian Health Service and tribal facility services matching rate = 100%
- The federal government and states share in the risk if there are higher than expected health care costs, for example:
  - Higher than expected enrollment
  - Public health epidemics (e.g., the substance use epidemic)
  - Breakthrough treatments or medications
  - New initiatives related to delivery system reform or access
  - Economic downturn

**Block Grants**

Most major repeal bills have included an optional block grant

- State option to take a block grant for adults and/or children (depending on proposal)
- State-specific allotments linked to historic funding levels in a base year
- Indexed by CPI; no adjustment for growth in enrollment
- Increase in state flexibility, including with respect to eligibility, benefits and cost-sharing
- State spending requirement
- Provides funding certainty to federal government; shifts risk for enrollment and health care costs to states

Per Capita Caps

All major repeal bills included a per capita cap

- A set amount per beneficiary in an eligibility group; added up across eligibility groups to establish an overall cap
- States still must match expenditures
- Applies to nearly all beneficiaries and services
- Eliminates guarantee that the federal government will match all Medicaid expenditures, but offers some protection against enrollment-driven increases in expenditures

Key design features of recent proposals

- Based on state-specific historic spending levels in a base period
- Per capita limits Increase at national trend rate (e.g., medical inflation or CPI)
- “Downside” only risk for states
- Some groups/services exempted, depending on specific proposal
  - Users of Indian Health Service facilities
  - Children enrolled in Medicaid based on disability
  - Spending on public health emergencies through 2024

Capped Funding May Lock Historical Spending Patterns in Place

Projected Medicaid Spending Per Enrollee, FY 2019

Key
- U.S. Avg.

SOURCE: Manatt Medicaid Financing Model
## Key Drivers of Fiscal Impact

### Base Funding
- What’s in, what’s out?
- Base year?
- Adequacy of base year funding?

### Waivers and Supplemental Payments
- How treated in setting the base?
- Subject to the cap?

### Trend Rates
- National or state trend rate?
- Which trend rate?
- Other adjusters?

### Sharing Savings w/Federal Government
- State option to share in federal savings?
- State option to “bank” savings for future?”

### State Spending Requirements
- State spending requirements changed?
- Change in how states can raise match?

### Flexibility
- Could new flexibilities be achieved through regulation or waiver?
- Are they worth the trade-off in reduced funding?
Trend Rates Matter for Per Capita Calculations

Medical CPI and CPI are relatively volatile measures; not necessarily correlated with Medicaid spending pressures.

While M-CPI Grew by 3.8% between 2015 and 2016
Nationally, M-CPI Growth Varied Greatly by Region

*San Francisco and San Diego regions use variation between 2012-2013 as 2015-2016 data was not available
Emerging Proposals
Portman Proposal

- Designed to give states a way to replace some of the coverage lost if expansion eliminated
  - Combine remaining premium tax credits and Medicaid-financed cost-sharing assistance
  - Also could use new “stabilization” funds
- State option to secure federal matching funds for cost-sharing assistance
  - Pay premiums
  - Provide greater cost-sharing protection
  - No waiver required
- Strict federal budget neutrality test
  - Premium tax credits + cost of Medicaid “wrap” cannot be more than the cost of covering the individual in Medicaid directly
  - May be difficult to meet given higher cost of commercial coverage and size of tax credits

Included in Senate replacement bill
Without an additional subsidy, the cost of care for adults losing Medicaid would consume from 60% to 104% of their total annual incomes.

**NOTES:**

(a) Premiums are the net premiums paid for the BCRA benchmark plan (58% AV), after tax credits are applied.

(b) Deductibles are based on the 2017 national average for a bronze plan ($12,393 for a family). Bronze plans have a 60% AV.

Graham/Cassidy Proposal

Now receiving considerable attention from White House and states

- New block grant
  - Eliminates Medicaid expansion funding, premium tax credits and cost-sharing reductions
  - Less federal money than under current system
    - National allotments set at levels about 15 percent below current levels
    - Grows at about 2 percent a year
- Complex formula for distributing block grant funds among states
  - In general, money redistributed from states with higher per capita income to states with lower per capita income; some states could lose up to 25% of funds
  - Set asides for more rural states and states with sizeable population ages 45 - 64
  - Some temporary allowance for expansion states to receive additional funds
  - Significant HHS discretion to modify statutory formula
- Significantly more state flexibility to use funds
  - Not limited to coverage; can also use for reinsurance, high-risk individuals and payments to providers
  - Lack of direct link to coverage may make the block grant more susceptible to cuts
Disproportionate Share Hospital (DSH) Payments
Background on Disproportionate Share Hospital Payments

Since 1981, states have been required to make payments to hospitals serving a high proportion of Medicaid and uninsured patients

Each state receives a state-specific DSH allotment that can be used for payments

- Based largely on DSH spending patterns before federal limits were established in 1992
- Size of allotment varies from less than $15 million to more than $1 billion
- Accounts for less than 1 percent to as much as 16.9 percent of states’ Medicaid expenditures

DSH is an important source of funding for many hospitals and nursing homes

- Particularly important for rural hospitals, public hospitals, and teaching hospitals
- Used to cover cost of serving the uninsured and to address “Medicaid shortfall”

Reduced under the Affordable Care Act in light of expected reductions in uninsured patients

- Delayed multiple times
- Now expected to go into effect on October 1, 2017

Federal DSH Reductions

- HHS issued a proposed rule on July 27th, 2017 outlining its approach for distributing cuts across states
  - Bigger cuts for states with lower uninsured rates
- Reductions start at $2 billion in fiscal year 2017; grow to $8 billion by 2024

**DSH Reduction Amount as % of Unreduced DSH Allotment**

- Greater than 25% (2+D.C.)
- 20%-24.9% (6)
- 15%-19.9% (12)
- 10%-14.5% (15)
- 5%-9.9% (7)
- 0%-4.9% (7)


Note: Under section 1923(f)(G)(A)(vi) of the Act the DSH allotment for Tennessee is established at $53.1 million per year for FY 2015 through FY 2025. Therefore, Tennessee is not subject to reductions under section 1923(f)(7) of the Act.
Children’s Health Insurance Program
The Children’s Health Insurance Program (CHIP)

Background:

- CHIP was established in 1997 to provide health coverage for children who exceed Medicaid eligibility but whose families could not afford or had no access to private insurance.

- Like Medicaid, CHIP is jointly financed by states and the federal government; states receive an enhanced federal match under CHIP, including an additional 23 percentage point bump.

- Unlike Medicaid, CHIP is operated as a block grant. Federal allotments to states are capped, though over the past decade, allotments have far exceeded expenditures.

- States have flexibility in both program and benefit design:
  - States may operate CHIP either as a Medicaid-expansion program, a separate CHIP program, or a combination of the two.
  - Benefits must meet certain minimum standards; greater flexibility to tailor benefit packages than Medicaid.
  - States have broad discretion to set income eligibility standards and as a result, CHIP eligibility varies across states. However, states are required to maintain 2010 Medicaid and CHIP eligibility levels for children through FY 2019.
CHIP funding will expire on September 30, 2017, raising multiple issues for states:

- Level of allotment and duration of extension
- Whether Affordable Care Act (ACA) enhanced funding will be maintained
- Whether ACA maintenance of effort requirements\(^1\) will be continued
- Reauthorization timing

\(^1\) ACA requires states to maintain 2010 Medicaid and CHIP eligibility levels for children through FY 2019

Federal Funding for CHIP Expires on September 30, 2017

Four states are projected to exhaust their federal CHIP funds during the first quarter of FY 2018, and all states are projected to exhaust their funds by September 2018.

Key Takeaways

Looking ahead:

- The fundamental structure of Medicaid financing remains in place.
- To a surprising degree, efforts to modify Medicaid financing have focused renewed attention on the responsiveness of the current structure to enrollment and health care expenditure trends.
- The federal landscape is likely to remain unsettled terrain for a while, but, states have significant flexibility under the current financing structure to pursue their own priorities.
- Recommend taking advantage of current flexibility and financing structure to pursue your agenda. Don't wait for Congress!
Questions?
Thank you
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