

**SENATE FISCAL AGENCY
 MEMORANDUM**

DATE: March 8, 2017
TO: Members of the Michigan Senate
FROM: Steve Angelotti, Associate Director
RE: The Proposed Federal "American Health Care Act": Estimated Fiscal Impact on Michigan's Medicaid Program

On March 6, 2017, the leadership of the U.S. House of Representatives released a draft bill that would make a number of changes to the Patient Protection and Affordable Care Act, commonly known as the ACA.

Many of these changes, mostly involving coverage through the health care exchanges and tax credits, would not have a direct impact on State finances or Medicaid and are not discussed in this memorandum. This memorandum focuses on the impact of the proposed legislation on the State of Michigan's Medicaid program.

Synopsis

The bill contains several key provisions tied to Medicaid that would have an impact on current baseline state expenditures beginning in FY 2019-20. The most notable provisions are the per capita cap on Medicaid expenditures and the change in match rate for new expansion Medicaid cases.

The Senate Fiscal Agency (SFA) estimates that the per capita cap could potentially increase State GF/GP expenditures by an indeterminate amount in the low hundreds of millions. Whether or how much State GF/GP costs would increase is dependent on numerous highly variant factors such as medical inflation and Medicaid cost growth (particularly in the pharmaceutical sector), so the SFA would note that the expenditures could also remain below the cap, leading to no net fiscal impact.

The legislation would not end Medicaid coverage for the expansion population covered under the Healthy Michigan Plan (HMP) (and under other similar programs in other states). The bill would instead amend the ACA statute to remove the provision that made Medicaid expansion mandatory for the states. That section was rendered moot by the U.S. Supreme Court in the *NFIB v. Sebelius* decision in June 2012, which ruled the mandatory expansion unconstitutional. Instead the bill inserts the words "at the option of a State" to reflect that states have the choice whether to implement the Medicaid expansion created under the ACA. The bill does not end the Medicaid expansion, merely the (moot) requirement that states expand Medicaid. States would still have the option to provide Medicaid coverage to the expansion population (see Appendix I).

The bill would instead change the financing for many expansion enrollees. After January 1, 2020, the Federal match rate for new expansion enrollees would be reduced from 90.0% to the "regular"

Medicaid match rate, which is 65.15% in FY 2016-17. Those who enrolled in the HMP prior to January 1, 2020, would continue to be reimbursed at the enhanced 90.0% Federal match rate.

The SFA estimates that the reduction in match rate for new expansion Medicaid cases from the enhanced match rate to the traditional Medicaid match rate would increase State GF/GP expenditures by \$134.6 million in FY 2019-20. This GF/GP cost increase, barring any legislative action to change the Medicaid expansion ("Healthy Michigan") statute, would result in termination of Medicaid expansion in Michigan after FY 2019-20 (it should be noted that the SFA has projected that the Healthy Michigan statute's net State costs provision would lead to the termination of the program after FY 2020-21 even absent any Federal changes). If the Healthy Michigan statute was changed to continue the program, the increased cost to the State of the match rate reduction for new cases would grow to \$532.6 million GF/GP in FY 2020-21 and \$738.9 million GF/GP in FY 2021-22.

Key Provisions Affecting Medicaid

The proposed bill would make a number of changes to the Medicaid program. Of most note are the following:

1) The bill would repeal ACA reductions in Medicaid disproportionate share hospital (DSH) allotments. It appears that this is being done to provide more money to states that, unlike Michigan, chose not to expand Medicaid. The intent would be to offset uncompensated care costs in those states.

2) The bill would reduce retroactive eligibility for Medicaid from three months to the month in which a person applied for Medicaid. 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.

3) The bill would implement, beginning in FY 2019-20, a per capita Gross cap on Federal Medicaid reimbursement. If a State's Medicaid expenditures exceeded the Federal share of the Gross cap in a given fiscal year, the Federal reimbursement the State received in the next fiscal year would be reduced by an amount equal to that Federal excess. The cap would be adjusted annually based on the medical consumer price index (CPI) and would be calculated based on individual eligibility groups to offer protection from changes in case mix (for instance, if there was growth in the higher cost Supplemental Security Income disabled caseload the individual eligibility group cap would account for the impact of more costly growth in that eligibility group).

The caps would be based on FY 2015-16 expenditures per eligibility category updated for the medical CPI through FY 2018-19. The adjusted FY 2018-19 amounts would be the basis for calculating whether a State exceeded its cap in subsequent fiscal years. The base expenditure amount would not include disproportionate share hospital (DSH) payments nor Medicare Premium Payments made by the State on behalf of those dually eligible for Medicare and Medicaid. Excluding these two expenditures appears to be reasonable; the DSH allotments are effectively set by Congress and the Medicare premium payments are determined by the Federal Medicare program; the State has no ability to change expenditures in the Medicare Premium Payments lines.

If a State exceeded its cap, it would be penalized by the amount of the excess Federal funds in the subsequent fiscal year, with 1/4th of the Federal excess withheld from Federal reimbursement in each quarter of the subsequent fiscal year. This would, by reducing Federal matching

payments, effectively increase State GF/GP expenditures by the Federal excess in the previous year.

4) The bill would reduce, after January 1, 2020, the enhanced expansion Medicaid match rate for new enrollees in expansion Medicaid to the traditional Medicaid match rate. On January 1, 2020 the match rate for expansion enrollees will be 90.0%. Michigan's traditional Medicaid match rate will be 64.78% in FY 2017-18; for purposes of this memorandum the SFA assumes a 65.0% Federal match rate in FY 2019-20 and beyond.

There are also other Medicaid related provisions, including one barring Medicaid eligibility for winners of large lottery prizes and one eliminating an enhanced match rate for certain home and community based services that are not discussed in this memo.

Initial Projection of the Fiscal Impact of These Provisions

DSH Allotment Change

The DSH allotment change would not have a direct GF/GP fiscal impact on the State. The State would have the ability to increase DSH payments in lieu of other hospital payment increases that would come under the per capita cap, so the DSH increase could provide a way to avoid expenditure increases that would be penalized under the per capita cap.

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 would be in a similar range.

Per Capita Cap

The per capita cap would not take effect until FY 2019-20 and the State would not face any penalties until FY 2020-21.

In order to estimate the potential impact of the cap, one would need to 1) forecast growth in per capita Medicaid expenditures, adjusted for case mix, from the base year FY 2015-16 to FY 2019-20, 2) forecast the change in the medical CPI from the base year FY 2015-16 to FY 2019-20, and 3) know the Federal Medicaid match rate for FY 2019-20.

Obviously each of these items is difficult or nearly impossible to forecast with any degree of certainty. However, it is possible to use past years' data to see how such a proposal would have affected the FY 2016-17 Medicaid budget if it had been in effect with a base year of FY 2012-13.

The SFA has taken the actual expenditure data from FY 2012-13, FY 2013-14, FY 2014-15, FY 2015-16, and the FY 2016-17 appropriations adjusted for the proposed FY 2016-17 expenditure adjustments included in the detail of Governor Snyder's Executive Budget proposal of February 8, 2017. The SFA has removed the two excluded items, DSH payments and Medicare Premium Payments, from the expenditure data.

Furthermore, to ensure the most accurate apples to apples comparison, the SFA has limited this estimate to traditional Medicaid and excluded expansion Medicaid costs, as that program took effect during the middle of FY 2013-14 so expenditures from that program would skew the expenditure data. The SFA has also removed certain special actuarial soundness payments that were made in some years and not others; to whiten the actuarial soundness reimbursement for the Medicaid managed care Use Tax (which was in effect from April 1, 2014 to December 31, 2016) and the actuarial soundness adjustment to reflect the cost to Medicaid health plans of the ACA health insurance fee in 2015 and 2016.

Removal of these items leads to a reasonable estimate of the growth in traditional Medicaid costs subject to the per capita cap from FY 2012-13 to FY 2016-17. The one biggest concern is that this estimate does not include per capita expenditures by eligibility groups; these data were not available to the SFA at the time of writing this memo. These data should be available at a subsequent time, but it seems instructive to illustrate how the cap could work by using a general per capita amount.

Using Medicaid expenditure data provided by the State Budget Office, with adjustments based on appropriations history, and caseload data from DHHS caseload reports, the SFA would estimate an increase in average per case expenditures between FY 2012-13 and FY 2016-17 of 16.30%.

The Federal cap is based on the growth in the medical CPI. The SFA has the data on the growth in the medical CPI from 2013 to 2016 and has used the 7-year average increase (3.04%) as a proxy for the medical CPI increase in 2017.

The SFA estimates that the medical CPI, using the estimated figure for 2017, would increase by 13.13% over the four year time period.

The 16.30% increase in per capita expenditures exceeds the medical CPI 13.13% increase by 2.81% (mathematical note: the correct way to calculate the percentage excess is to divide $1+16.30\%$ by $1+13.13\%$ and then subtract 1 rather than subtracting 13.13% from 16.30%).

As the increase in per capita costs would exceed the medical CPI growth over the time period, if this legislation had used FY 2012-13 as a base year with FY 2016-17 as the first years where penalties could take effect, Michigan would be penalized in FY 2017-18. Because the gap is 2.81% in this scenario, the Federal government would penalize Michigan by 2.81% of its Federal match in FY 2017-18; this would lead to an estimated \$220.0 million reduction in Federal match funds in FY 2017-18, which would have to be supplanted with GF/GP. Therefore, a very rough estimate of the impact of the legislation would imply there could be a significant financial penalty to the State in the first year. It would be likely that such a penalty would continue in subsequent years unless cost growth was somehow restrained. (See Appendix II for background on data sources.)

Caveats on the Projected Excess Calculation

The calculation above is extremely rough and should not be accepted as precise in any meaningful way. It is based on an earlier time period, is dependent on a number of factors, omits other factors, and reflects cost changes that may not be relevant to the FY 2015-16 through FY 2019-20 time period that would be the basis of the calculation in the proposed Federal bill. Furthermore, the State would have ways to reduce non-GF/GP funded Medicaid expenditures to reduce its risk of exceeding the cap.

The calculation above is based on FY 2012-13 through FY 2016-17 costs. The actual proposed legislation's cap builds off of FY 2015-16 costs and the calculation would be based on cost growth after FY 2015-16. Even leaving that aside, the calculation is dependent on an estimate of the medical CPI for 2017 that could certainly vary by 1.0% or more, which would have a large impact on the result (each 1.0% variance in the medical CPI would affect the potential penalty by about \$80.0 million).

The calculation, due to the timeframe involved, does not include expansion Medicaid spending. Growth in expansion spending could be different from growth in traditional spending and thus could impact the calculation as well. The calculation uses global per capita expenditures while the bill would use separate per capita amounts for each major eligibility category.

Furthermore, there was a major increase in expenditures during FY 2015-16 related to the decision to cover new drugs to treat hepatitis C and cystic fibrosis. These costs would be part of the base for the FY 2015-16 through FY 2019-20 calculation, so the cost increase from FY 2012-13 through FY 2016-17 may be larger than the one from FY 2015-16 through FY 2019-20.

Finally, the State would have ways to control non-GF/GP related Medicaid spending, in particular spending on the Michigan Access to Care Initiative (MACI), the Hospital Rate Adjustor (HRA), the Quality Assurance Assessment Programs (QAAP), the Physician Adjustor (PA), and the Specialty Network Access Fee (SNAF) program. These payments use non-GF resources, either provider tax or public clinic payments, as match to earn Federal match dollars, and are usually increased to the maximum allowable Federal amount each year to give providers such as hospitals, nursing homes, and physicians at public clinics reimbursements well in excess of typical Medicaid fee screens. If the State changed the annual adjustments to these programs the overall Gross spending growth would slow down, enough to reduce any potential penalties. The State could also shift some hospital related spending to take advantage of the increased DSH allotment as DSH payments are not subject to the cap.

Given these uncertainties, while the SFA's surface analysis shows the potential for a penalty in excess of \$200.0 million for FY 2019-20 that would effectively be paid in FY 2020-21, the SFA would note that the State could very easily end up spending less than the cap and could avoid any penalties.

Reduction in the Expansion Medicaid Match Rate for New Clients

The bill would effectively reduce the match rate, effective January 1, 2020, for newly enrolled expansion Medicaid (known in Michigan as the Healthy Michigan Plan or HMP) from 90.0% to the regular Medicaid match rate. As noted above the SFA assumes that the Federal traditional Medicaid match rate in FY 2019-20 and beyond will be 65.0%.

In order to estimate the impact of this provision one needs to know how quickly the caseload changes. In other words, if 10,000 people leave the caseload in January 2020 and, assuming a stable total caseload, 10,000 new people join the caseload, the bill would dictate that the new 10,000 people would be reimbursed at a lower match rate while all others on the caseload will remain at the 90.0% match rate.

The Medical Services Administration has provided data on the length of time on the caseload for HMP recipients. While these data are from 2017 and apply to years prior, the SFA believes the data serve as a useful proxy for modeling the impact of the reduction in the match rate.

This analysis is based on the following assumptions: That the HMP caseload on January 1, 2020 will be 650,000 (roughly the same as it is today) and that the annual cost per case will be about \$6,000 or \$500 per month. This would mean total full-year expenditures of \$3.9 billion, with the State covering 10% of the cost from January 1, 2020 onward (see Appendix II).

Based on the data on the current HMP caseload, the SFA estimates that, by September 30, 2020, 34.8% of the caseload will have enrolled between January 1, 2020 and September 30, 2020. This is based on data from DHHS and modeling by SFA indicating that 34.8% of the caseload has been on the caseload for fewer than nine months. Based on the months of tenure data the SFA estimates this will result in 1,077,000 case months being from new cases in FY 2019-20. At \$500 per month this would mean that \$538.5 million in expenditures would be subject to the 65.0% match rate. This would lead to an increase in GF/GP costs of \$134.6 million (90.0% - 65.0% times \$538.5 million).

For the moment the SFA shall ignore the trigger in the HMP statute regarding net GF/GP costs to illustrate how this provision in the proposed Federal law could affect HMP in subsequent years. Based on the DHHS HMP tenure data, the SFA would estimate that 4,261,200 case months would be from new cases in FY 2020-21. At \$500 per month this would mean that \$2,130.6 million in expenditures would be subject to the 65.0% match rate in FY 2020-21, which would lead to an increase in GF/GP costs in FY 2020-21 of \$532.7 million over the status quo situation if the HMP continued in effect. In FY 2021-22 the GF/GP cost increase would be \$738.9 million. For comparison's sake, if the match rate for all HMP cases went from 90.0% to 65.0%, the GF/GP cost increase with 650,000 cases at \$500 per month would be \$975.0 million.

The HMP statute included a trigger dictating that the program be terminated once net GF/GP costs exceed net GF/GP savings. The HMP statute states that the section defining the program shall not apply "If federal government matching funds for the program described in this section are reduced below 100% and annual state savings and other nonfederal net savings associated with the implementation of that program are not sufficient to cover the reduced federal match." The SFA has estimated that, even without any Federal changes, this trigger would be reached, depending on how nonfederal savings are calculated, in FY 2020-21 and perhaps a year earlier.

The new Federal law would increase GF/GP costs sufficiently to trigger this provision by the end of FY 2019-20. Thus, assuming no changes to the statute, the Healthy Michigan Plan would terminate.

If the State opted to continue the program (which would require Legislative action and a gubernatorial signature to change the statute), the GF/GP costs would increase significantly in subsequent years as noted above. Obviously, if the Federal legislation is enacted, the decision on whether to change the statute to continue the HMP would be impacted by the fiscal considerations outlined above.

Conclusion

The bill contains four key provisions with a fiscal impact on Michigan: 1) The restoration of past DSH cuts, which would have no net GF/GP impact. 2) The reduction of retroactive Medicaid eligibility from three months to the month of enrollment, which would reduce expenditures by between \$10.0 to \$15.0 million GF/GP. 3) The FY 2019-20 implementation of a cap on per capita Medicaid expenditures, which would have the potential to increase GF/GP costs by hundreds of millions if the State exceeded the cap, although providing a precise estimate is difficult given the number of variables. 4) A reduction in the match rate for new Medicaid expansion cases after

January 1, 2020, which would result in a significant GF/GP cost increase of \$134.6 million in FY 2019-20 and would, barring changes in the Healthy Michigan statute, result in the termination of the State's Medicaid expansion, the Healthy Michigan Plan.

The SFA will continue to follow developments in Washington and provide updates as needed. Please don't hesitate to contact us if you have any questions or want further clarification on this matter.

/lms
Attachments

c: Ellen Jeffries, Director

Appendix I: The Proposed Changes to Medicaid Expansion

Part of the confusion over the proposed American Health Care Act is due to the title of one provision: “SEC. 112. REPEAL OF MEDICAID EXPANSION”. A careful reading of the legislation makes it clear that what would be repealed is the mandatory nature of the expansion.

The proposed Federal legislation would amend 42 U.S.C. 1396(a)(10)(A), which begins “A state plan for medical assistance [Medicaid] **must** [emphasis added]”. Section (10)(A)(i)(VIII) was added in the ACA and specifies that states, if they opt to run a Medicaid program, must cover what is generally known as the Medicaid expansion population.

The proposed Federal legislation would amend (10)(A)(i)(VIII) to make the mandatory expansion “at the option of the state”. This in effect makes Medicaid expansion optional in statute. Of course, due to the Supreme Court’s ruling in *NFIB v. Sebelius*, the expansion was effectively optional because the ruling made it so states could not be penalized for opting not to expand.

The legislation does not amend another part of the ACA which permitted states to expand Medicaid prior to January 1, 2014, with no enhanced match rate. 42 U.S.C. 1396a(k) specifies this optional coverage. This would be the legal basis for continued optional state coverage of the expansion population.

The bill would amend 42 U.S.C. 1396d(y)(1), which specifies the enhanced match rate for expansion Medicaid recipients, to apply the enhanced match rates, after January 1, 2020, only to cases that had been enrolled as of December 31, 2019 and have not had a break in enrollment of greater than one month. This change means that the Federal match for all other expansion cases (that is new expansion cases after January 1, 2020) would revert to the default match rate for Medicaid, that is the “regular” Medicaid match rate. The ongoing “grandfathered” expansion cases would continue at the enhanced match rate.

Appendix II: Notes on Data Sources

The expenditure data used to estimate the impact of the cap were derived from actual line item expenditure data provided by the State Budget Office. The expenditure adjustments to remove now moot actuarial soundness payments were based on budget bill documents maintained by the SFA. The caseload data came from Department of Health and Human Services data. The FY 2016-17 expenditure estimate was based on the original budget adjusted for the FY 2016-17 changes included in the State Budget Office Executive Recommendation for FY 2017-18. The caseload estimate for FY 2016-17 was made by the SFA. The source for the medical CPI data was the Federal Bureau of Labor Statistics. The 2017 estimated medical CPI adjustment was based on the average annual increase in the medical CPI from 2009-2016.

The estimate of the shift in Healthy Michigan cases from those reimbursed at the enhanced Medicaid expansion match rate to those new cases reimbursed at the "regular" Medicaid match rate was based on data provided by the Department of Health and Human Services on the number of consecutive months the current February 2017 Healthy Michigan Plan caseload had spent. Data were provided covering the first 12 months. In estimating the shift in cases the SFA assumed a flat caseload of 650,000 individuals, with an equal number of case openings and case closings each month. The SFA assumed a program cost of \$500 Gross per case per month.

The estimate for the first twelve months was based on a smoothing of the data provided by DHHS. After the first 12 months, based on the implicit shifting of case closures and case openings among the ongoing population, the SFA estimated that, in each month, 5% of the ongoing caseload would leave and be replaced by an equal number of new cases. For instance, if, after one year, in January 2021, the number of ongoing grandfathered HMP cases had gone from 650,000 cases to 350,000 cases (with the other 300,000 cases being individuals who joined or rejoined the program during that year), the SFA would assume 5% of that 350,000 ongoing grandfathered caseload, or 17,500 cases, would leave the rolls and be replaced by 17,500 new cases. In February 2021 the SFA would assume that there were 317,500 "new" cases reimbursed at the lower match rate (300,000 plus 17,500) and 332,500 "old" grandfathered cases reimbursed at the enhanced match rate (350,000 less 17,500). This process would continue after that point. This was the basis for the caseload shift and resultant GF/GP cost estimates derived above.