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State-by-State Impact of Per Capita Cap and Medicaid Expansion Financing Changes In the Better Care Reconciliation Act of 2017

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Senate leadership has released a proposed substitute for the House-passed American Health Care Act (AHCA) known as the Better Care Reconciliation Act of 2017 (BCRA) that eliminates enhanced funding for Medicaid expansion after a three-year phase out, establishes a cap on federal Medicaid funding for nearly all beneficiaries and services, and makes a number of other changes to Medicaid.[1] The Congressional Budget Office (CBO) has estimated that the bill will reduce federal Medicaid expenditures by $774 billion between federal fiscal year (FY) 2017 and FY 2026. While important for evaluating the overall size of the Medicaid cuts and the likely impact on coverage and the federal budget, the CBO estimate is not designed to provide state-specific information. Using the Manatt Medicaid Financing Model, this analysis estimates the state-by-state impact of the cap on Medicaid and elimination of enhanced funding for expansion, taking into account that states may respond to the proposed law in a number of different ways.

Below we lay out the key takeaways from the data and then describe each of the tables from which we drew these takeaways. The details of the BCRA provisions establishing a per capita cap and phasing out enhanced funding for expansion are described in Appendix 1; the methodology used to estimate the state-specific impact of these provisions is explained in Appendix 2.

Key Takeaways

1. Under any scenario, the Senate bill imposes substantial cuts on states that grow markedly over time.

As shown in Table 1, by phasing out and ultimately eliminating enhanced expansion funding and establishing a per capita cap, the Senate bill imposes substantial federal Medicaid funding cuts on states. The 19 states that did not take up the Affordable Care Act (ACA) Medicaid expansion would see federal funding cut due to the per capita cap by an estimated $53.3 billion between FY 2020 and FY 2026. Among the 31 states and D.C. that have expanded Medicaid, the losses will be greater. If these states respond by eliminating expansion when enhanced funding first declines, they would see an estimated 27 percent reduction in federal Medicaid funding and more than 11 million low-income adults could lose coverage starting in 2021. For all states, as shown in Table 5 and discussed in more detail below, the cuts increase markedly over time as Senate policies go into effect that eliminate enhanced expansion funding as of 2024 and tighten the cap starting in FY 2025.

[1] On June 22, Senate leadership released their proposed substitute for the House-passed AHCA, the Better Care Reconciliation Act of 2017 as a discussion draft. On June 26, they updated the discussion draft but the changes did not modify the Medicaid portions of the bill.

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2. Some states could lose more than a third of federal Medicaid funding.

For expansion states, the federal cuts under BCRA are larger, especially if they cannot maintain their expansions. Eight states face legal requirements to eliminate expansion if federal Medicaid matching funds decline and even those that do not may find it difficult to replace the lost federal funds.[2] As shown in Table 2, the 31 states and D.C. with expansion would need to increase their own spending by an estimated $158 billion between FY 2020 and FY 2026 to maintain expansion. On average, the increase in state spending required to maintain expansion for this period represents a 10.7 percent increase, but states such as Kentucky, Montana, Oregon and Washington would need to increase their own spending by 20 percent or more to maintain expansion. If states instead drop expansion in 2021, estimated cuts reach 30 percent or more of all federal Medicaid spending in a number of states (Exhibit 1).

Exhibit 1: States Estimated To Lose More Than 30 Percent of Federal Medicaid Funding if They Eliminate Expansion in 2021 (billions)

State	Federal Medicaid Cuts FY 2020 – FY 2026	Percent Change in Federal Medicaid Spending FY 2020 – FY 2026
California	- $154.2	- 31.4%
Colorado	- $15.6	- 33.3%
Kentucky	- $29.8	- 39.3%
Michigan	- $35.0	- 30.2%
Montana	- $5.3	- 39.6%
Nevada	- $10.0	- 36.5%
New Hampshire	- $3.2	- 31.0%
New Jersey	- $29.5	- 36.7%
New Mexico	- $16.1	- 37.3%
Oregon	- $26.7	- 42.0%
Washington	- $33.5	- 45.6%
West Virginia	- $8.7	- 31.0%

Source: Manatt Medicaid Financing Model.
Note: Includes the impact of both per capita cap and expansion financing changes. Assumes that states eliminate expansion adult coverage with the exception of individuals who would have been eligible under pre-ACA rules.

[2] If there are reductions in enhanced federal funding for Medicaid expansion, the following states are required to eliminate their expansion: Arkansas, Arizona, Illinois, Indiana, Michigan, New Hampshire, New Mexico and Washington (requirement is to ensure that no additional costs are incurred). In addition, Alaska's expansion is predicated on expansion adults being treated as a mandatory group, but BCRA moves them into optional coverage as of January 1, 2020.

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3. Depending on state responses to reduced federal funding, coverage impacts could be substantial.

If states do not replace lost federal funds with state funds to maintain expansion, more than 11 million people could lose coverage starting in 2021, accounting for 21 percent of Medicaid beneficiaries in expansion states (Table 3).[3] In some states, more than 30 percent of all Medicaid beneficiaries could lose coverage, including: Arkansas (31 percent), Colorado (31 percent), Kentucky (34 percent), Montana (32 percent), Nevada (33 percent), New Jersey (33 percent), Oregon (42 percent), Washington (31 percent) and West Virginia (33 percent). These estimates only consider the impact from the loss of expansion; additional coverage losses may occur due to the per capita cap, particularly in later years when it becomes tighter on states.[4]

4. The per capita cap is a fundamental change in Medicaid financing.

The per capita cap in BCRA would eliminate the federal government's guarantee to share the cost of all qualifying Medicaid expenditures, replacing it with a cap that would limit federal Medicaid spending. Between FY 2020 and FY 2026, the cap could reduce federal spending by an estimated $154.2 billion.[5] Unless states offset all of the federal cuts with an increase in spending from their own resources, they will need to reduce reimbursement rates, cut benefits, increase cost sharing or use other strategies to keep their spending below the cap. If distributed proportionately across all eligibility groups, federal spending reductions would total $35.7 billion for seniors, $52.7 billion for people with disabilities, $31.5 billion for children, and $34.4 billion for low-income adults (Table 4).

5. BCRA Medicaid cuts increase markedly in the later years of CBO's 10-year budget scoring window.

The Senate bill imposes the most significant Medicaid cuts in the "out years" of CBO's 10-year budget window. These changes include use of the Consumer Price Index (CPI) – rather than the medical component of CPI or medical CPI plus one percentage point – in the cap formula beginning in FY 2025, and the elimination of enhanced federal funding for expansion adult coverage after 2023. As shown in Table 5, cuts attributable to the cap increase from an estimated $20.9 billion in FY 2024 to $43.2 billion in FY 2026, a more than doubling within two years.[6] Similarly, the cost to states of maintaining expansion increases from an estimated $16.9 billion in 2023 to $38.7 billion in 2024 (Table 2). For all

[3] These estimates assume that states are expected to continue Medicaid for expansion adults who would have qualified for coverage under pre-ACA rules.
[4] For example, some states may reduce eligibility, particularly for high cost individuals, such as seniors in need of long-term care or people with severe disabilities served in home and community-based waivers, to make it easier to stay beneath their cap, but this possibility is not taken into account in this analysis.
[5] These estimates assume that the 31 expansion states and D.C. eliminate their expansions. If they were, instead, to maintain expansion, the per capita cap would result in a cut of $189.2 billion between FY 2020 and FY 2026 because more people would be enrolled.
[6] These estimates assume states eliminate expansion starting in 2021; if, however, they were all to maintain expansion, the size of the per capita cap cuts would increase from $26.2 billion to $52.1 billion between 2024 – 2026.

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states, these out-year changes mean that the Medicaid cuts grow markedly over time and much of their impact is not picked up in the CBO analysis or these estimates, which end with FY 2026.

6. States – rather than the federal government – bear the risk if future spending pressures lead growth to exceed the trend rates (CPI or medical CPI) that determine the size of per capita cap cuts.

In these estimates, we assume that Medicaid spending will grow at rates projected by the Centers for Medicare & Medicaid Services (CMS) Office of the Actuary, and that medical CPI will grow at an average annual rate of 3.7 percent and CPI at an average annual rate of 2.4 percent, as projected by CBO. In practice, future health care spending pressures and trends are unknowable. To date, the risk of higher-than-expected spending has been split between states and the federal government, regardless of whether it was due to a public health crisis such as the opioid epidemic, breakthrough treatments and drugs, an aging population or other factors. Under a per capita cap, however, states bear the full risk for any spending in excess of the allowable trend rates, which are themselves volatile and difficult to predict. For example, if medical CPI happens to come in at 3.2 percent – rather than the 3.7 percent currently projected by CBO – federal spending reductions from the per capita cap would increase from an estimated $154.2 billion to $225.1 billion. Conversely, if medical CPI is higher than expected, it would create a more generous cap for states, reducing the size of cuts. For example, if medical CPI were 4.2 percent – rather than the 3.7 percent projected by CBO – the size of federal cuts attributable to the per capita cap would drop to $75.4 billion.[7]

Explanation of Tables

Table 1 shows the state-by-state impact on federal Medicaid funding of the per capita cap; the changes to expansion financing; and the combined impact of the cap and expansion financing changes. The estimates are provided for a scenario under which states eliminate expansion as of 2021 and a scenario under which they maintain it.

Table 2 shows the impact on state Medicaid spending if states replace the federal funds lost due to the phasing out of enhanced expansion funding to maintain expansion with state dollars, as well as if they replace the federal cuts attributable to the per capita cap with their own funds.

Table 3 shows the number of low-income adults that would lose Medicaid coverage starting in 2021 if states eliminate their expansions, as well as the share of Medicaid beneficiaries that this would represent.

[7] The 3.2 percent and 4.2 percent medical CPI scenarios both assume that the trend rate moves to 2.4 percent CPI growth starting in 2025. Even if medical CPI growth is closer to 4.2 percent than the 3.7 percent assumed for the state-by-state estimates presented in this analysis, a plausible scenario is that states will aim to keep their spending somewhat below their anticipated cap to create a "buffer" against the risk of a federal clawback. If so, even if medical CPI were to reach 4.2 percent, the magnitude of the cuts could be closer to the levels estimated when we use 3.7 percent.

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Table 4 illustrates the impact of the per capita cap reductions on seniors, people with disabilities, children and low-income adults if states spread the cuts that they must make to avoid exceeding the per capita cap evenly across all eligibility groups between FY 2020 and FY 2026. In practice, states will need to decide how to distribute the cuts.

Table 5 shows on a national basis the year-by-year change over time in the size of federal reductions for the per capita cap, the changes in expansion financing, and the combined effect of these two provisions. It presents the impact under two scenarios – one in which all states maintain expansion and one in which they eliminate it.

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Appendix 1: Key Medicaid Provisions in BCRA

The state-by-state estimates reflect the two most significant Medicaid provisions in BCRA – the reduction in enhanced funding for expansion and the per capita cap. BCRA includes a number of additional Medicaid provisions not taken into account in these tables, including restoration of disproportionate share hospital payments for the 19 states that have not expanded Medicaid; elimination of retroactive eligibility as of October 1, 2017; a quality incentive pool for FY 2021 – FY 2023; a "supplemental payment allotment" for non-expansion states for FY 2018 – FY 2022; a state option to conduct more frequent renewals of Medicaid for expansion adults; and a work requirement option.

Medicaid Expansion

BCRA phases out enhanced funding for the Medicaid expansion. Current expansion states – those that have expanded as of March 1, 2017—would continue to receive enhanced federal Medicaid funding through December 31, 2020 (one year longer than the House-passed AHCA). As of January 1, 2021, the enhanced funding would phase down over a three-year period, until it reaches the regular Medicaid matching rate in January 2024. Under current law, the matching rate for newly eligible individuals would be 90% for calendar years 2020 and beyond; the Senate bill changes this by providing 85% match in 2021, 80% match in 2022, and 75% match in 2023. Beginning in January, states' regular matching rates would apply. By comparison, the House-passed legislation also allowed expansion to continue, but only permitted states to claim enhanced federal dollars for "grandfathered individuals" who were enrolled on December 31, 2019 and remained enrolled without a break of a month or more in coverage.

BCRA also reduces and eventually eliminates the early expansion "leader match" for states that expanded coverage to adults prior to passage of the ACA. The ACA included a transition percentage designed to bring the matching rate of these states into parity with states that expanded under the ACA over time. Like the House-passed AHCA, the Senate bill stops phasing in the higher matching rate for leader states after 2017 and then eliminates it entirely in 2024. As noted in the methodology section, these estimates assume that leader states will maintain coverage at the levels in place prior to passage of the ACA using state funds to replace lost federal dollars.

Per Capita Cap

The Senate bill would implement an aggregate cap on federal Medicaid funding beginning in FY 2020. The aggregate cap is built from per capita caps for five "eligibility groups"— (1) elderly; (2) blind/disabled adults; (3) children; (4) expansion adults, and (5) other adults (e.g., pregnant women and low-income parents not eligible under pre-ACA rules). Children who are enrolled in Medicaid based on disability are excluded from the cap.

The cap for each eligibility group is set based on a state's historical spending in a base period trended forward to FY 2019 by medical inflation (as measured by the growth in the medical care component of the CPI), and actual FY 2019 spending and enrollment. After FY 2019, trend factors vary by timeframe and eligibility group. From 2020 through 2024, the trend factor for children, expansion adults, and other

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adults is set at growth in medical CPI. For the elderly and blind/disabled adults, it is set at medical CPI plus 1 percentage point. Starting in FY 2025, the trend factor is reduced to the growth of CPI for all eligibility groups. To the extent a State's total Medicaid expenditures are higher than the cap, it must repay the federal share of any "excess" spending in the following year. If a State's expenditures come in below the cap, they are not allowed to carry over the "room" to a subsequent fiscal year or to receive the federal share of any under-spending. Although not taken into account in these estimates, the Senate proposal also includes a "redistribution" provision that would reduce a state's cap in a fiscal year if is classified as a high spending state and increase it if it is classified as a low spending state.[8]

Appendix 2: Methodology

The state-by-state estimates in this analysis are derived from the Manatt Medicaid Financing Model, which uses publicly-available data from the following sources, among others, to establish a state-specific Medicaid enrollment and spending baseline:

- Spending reports, referred to as "CMS-64" data that provide information on aggregate Medicaid spending by state, currently available through FY 2015.
- Tabulations of CMS-64 data from the Medicaid and CHIP Payment and Access Commission (MACPAC) that provide additional detail on supplemental payments beyond what is publicly available from CMS.
- Medicaid enrollment by eligibility group derived from Medicaid Statistical Information System (MSIS) data reported by states to CMS through FY 2013, augmented with more recent information on total and expansion adult enrollment through 2016 from CMS-64 data.
- Tabulations of per enrollee spending by eligibility group derived from MSIS data, trended forward to be consistent with CMS-64 aggregate spending totals.
- For enrollment and spending through FY 2027, state-specific population growth projections by age from the Census Bureau and national spending per enrollee growth projections by eligibility group from CMS.

To analyze the Senate bill, we assess the impact of the proposed changes to expansion financing and the per capita cap on spending and enrollment by state. Key factors that affect the size of estimated spending reductions include assumptions about trend rates for per capita caps, current law growth, and state responses to the cap and other changes in the BCRA. Unless otherwise noted, the estimates here

[8] For a more detailed explanation of the provision and a preliminary analysis of its implications, see Guyer, Grady and Striar, *Manatt on Medicaid: The Senate's New Per Capita Cap Redistribution Policy*, June 26, 2017, available at https://www.manatt.com/Insights/Newsletters/Medicaid-Update/The-Senates-New-Per-Capita-Cap-Redistribution-Pol

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assume that medical CPI growth averages 3.7 percent annually and CPI growth averages 2.4 percent, as projected by CBO. For current law spending per enrollee, we assume the growth rates projected by the CMS Office of the Actuary for each eligibility group. In response to the per capita cap, we assume that states will reduce their total Medicaid expenditures to avoid exceeding the cap and facing a clawback. In practice, federal cuts may be larger if states take a more conservative approach and target their spending to come in somewhat below the caps to create a buffer and minimize the risk of a "clawback" of federal funds.

The per capita cap estimates take into account the Senate provision excluding certain populations from the per capita cap calculations, such as children eligible based on a disability and CHIP-financed Medicaid children. They do not take into account the quality bonuses potentially available to states in FY 2023 through 2026; nor do they reflect the redistribution provision that, at the discretion of the Secretary of Health and Human Services, could result in a state receiving a temporary increase or decrease in its per capita cap if it was considered a "high" or "low" spending state relative to the national mean in the preceding year.

With respect to expansion, the estimates display the impact on each state of phasing out enhanced federal funding if a state maintains expansion and if it eliminates it. In the scenarios displaying the impact if a state eliminates expansion, the estimates nevertheless assume that states would retain coverage at the regular matching rate for individuals who would have been eligible under pre-ACA rules.

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