MEMORANDUM

HOUSE FISCAL AGENCY

DATE: July 25, 2017

TO: Interested Parties

FROM: Kevin Koorstra, Associate Director

RE: State Impact of the Federal Better Care Reconciliation Act

In its simplest terms, the proposed federal Better Care Reconciliation Act (BCRA) reduces federal health care costs, in part, by increasing the state's health care costs.

While there are a number of requirements and optional provisions that would lessen the state's health care costs, it's unlikely they would offset the impact of the federal match rate reduction to the Healthy Michigan Plan (i.e. Medicaid expansion) that would increase annual GF/GP costs by nearly $1.0 billion. The overall state fiscal impact would depend on how the state chooses to implement the other health care revisions within BCRA (both the Medicaid revisions and the other proposed health care revisions).

With increased Healthy Michigan Plan beneficiaries, FY 2020-21 is now HFA's projected tipping point when state costs will exceed state savings. Prior HFA forecasts had estimated FY 2021-22, at the earliest, would be the tipping point. This memo highlights the state costs assuming state statute is amended so that Healthy Michigan Plan can continue past FY 2020-21.[1]

The information below is based on the Senate Discussion Draft released July 20, 2017 (ERN17500). It's unclear whether BCRA will pass the Senate in its current form, however, most of the proposed revisions that impact the state have stayed relatively consistent across the various iterations of the bill.

MEDICAID REVISIONS

Healthy Michigan Plan: The most significant revision to Medicaid under BCRA would be the reduction to the federal match rate for the Healthy Michigan Plan. Beginning in FY 2020-21, the current 90% federal match rate floor would decline by 5% each year until the match rate reached 75%. The federal match rate for the following year (FY 2023-24) would decline to the state's Federal Medical Assistance Percentage (FMAP), currently 64.78%. As shown in Table A, the state's annual GF/GP cost for the Healthy Michigan Plan would increase by nearly $1.0 billion once the BCRA federal match rate reductions are fully phased in. Healthy Michigan Plan currently provides health care coverage to 670,000 individuals.

Per Capita Caps: Beginning in FY 2019-20, BCRA would establish per capita caps on Medicaid eligibility categories, excluding partial beneficiaries, disabled children, and expenditures during public health emergencies. The elderly and disabled eligibility categories would be indexed based on the consumer price index for all urban consumers, medical care component (CPI-M) plus 1%, and the children and adult eligibility categories would be indexed based on CPI-M. On a total per capita basis (rather than for each eligibility category), annual Medicaid per capita expenditures have consistently tracked below CPI-M, so HFA does not forecast the per capita cap indexed by CPI-M having a state fiscal impact in the near term.

[1] MCL 400.105d requires the Healthy Michigan Plan to sunset whenever state savings are not sufficient to cover the state costs of the program.

Table A
Estimated State Share Cost Increases for the Healthy Michigan Plan (HMP) under BCRA
FY 2017-18 – FY 2025-26
(in millions)

	Current Federal Match Rate	BCRA Federal Match Rate	New HMP GF/GP Costs
FY 2017-18	94.25%	94.25%	$0
FY 2018-19	93.25%	93.25%	$0
FY 2019-20	90.75%	90.75%	$0
FY 2020-21	90.00%	86.25%	$133.6
FY 2021-22	90.00%	81.25%	$318.0
FY 2022-23	90.00%	76.25%	$509.6
FY 2023-24	90.00%	67.33%	$856.9
FY 2024-25	90.00%	64.78%	$972.5
FY 2025-26	90.00%	64.78%	$992.0

Beginning in FY 2024-25, the per capita caps would be indexed by the consumer price index for all urban consumers (CPI-U) instead of CPI-M. On average, CPI-U has an annual growth rate approximately 1.5% less than CPI-M, meaning that over time state Medicaid expenditures would likely exceed the per capita cap. A per capita cap indexed by CPI-U instead of CPI-M over a 10-year period would reduce the total Medicaid expenditure cap by over $2.0 billion.

Failure to provide satisfactory per capita data to the federal government would result in a 1% reduction to the state's growth factor. Any added information technology and personnel costs to revise data reporting are eligible for increased federal reimbursements, so most, if not all, of the added administrative costs to the state should be supported by these increased federal reimbursements.

Members of an Indian Tribe: Upon enactment of BCRA, the federal Medicaid match rate for members of an Indian tribe would be increased to 100%. Presently, Medicaid services provided at an Indian Health Services facility are eligible for 100% federal reimbursement. This revision could reduce annual state match costs by approximately $15.0 million.

Retroactive Eligibility: Beginning in FY 2017-18, BCRA would limit retroactive eligibility from 3 months to the month the individual applies for applicants who are not elderly or disabled. This revision would reduce annual Medicaid costs by $12.0 million Gross ($4.2 million GF/GP).

Provider Taxes: Beginning in FY 2020-21, the federal limit on health care provider taxes would phase down from 6% to 5%. This revision should not impact the state's quality assurance assessment program (QAAP) on hospitals, but it would impact the state's QAAP on nursing homes and hospital long-term care units. There should not be an immediate impact, but would lead to a GF/GP cost of $2.8 million from a smaller state retainer and a net provider benefit reduction of $13.2 million in FY 2022-23. Once fully phased-in in FY 2024-25, the state GF/GP cost from a smaller state retainer would be $7.7 million and the net provider benefit reduction would be $36.7 million.

Quality Performance Bonus Payments: BCRA would appropriate $2.0 billion in each FY 2022-23 through FY 2025-26 in Quality Performance Bonus Payments. To be eligible, states would have to spend less than their per capita cap and meet quality measures. The allocation formula is not established in statute and would be established by the HHS Secretary. Therefore, the state fiscal impact is unknown. If the state qualifies for 3% of these funds,[2] the state could receive $60.0 million in each FY 2022-23 through FY 2025-26.

Planned Parenthood: For a 1-year period upon enactment of BCRA, no federal Medicaid funding would be available to reimburse Planned Parenthood through either fee-for-service or managed care payments. HFA forecasts this provision would not have a noticeable state fiscal impact.

Optional Revisions: BCRA also includes a number of optional changes to Medicaid. It is unclear whether the state would implement any of the following changes:

- Beginning in FY 2017-18, redetermine Medicaid eligibility more frequently than every 12 months for the non-disabled and non-elderly.
- Beginning in FY 2017-18, require non-disabled, non-elderly, and non-pregnant adults to satisfy work requirements as a condition of Medicaid eligibility.
- Beginning in FY 2018-19, cover qualified inpatient psychiatric hospital services for individuals between 21 and 65 years old.
- Beginning in FY 2019-20, receive a federal block grant (instead of a per capita cap) for non-disabled, non-elderly adults. Many of the federal statutory requirements of the Medicaid program would still be in effect under a federal block grant.
- Beginning January 1, 2020 through December 31, 2023, the state could apply for a competitive $8.0 billion demonstration project to increase payments to home- and community-based waiver providers.

"Non-Expansion State" Funding Enhancements: BCRA offers a number of funding enhancements to "non-expansion states", which Michigan is not eligible to receive. These funding enhancements include $10.0 billion, over 5 years, to Medicaid providers and maintaining current disproportionate share hospital (DSH) allocations instead of implementing the DSH reductions required under the Affordable Care Act.

EXCHANGES AND PRIVATE MARKET REVISIONS

While the BCRA-proposed revisions to the private health care market should not have a direct fiscal impact to the state, they could lead to indirect state costs. On the whole, the BCRA would reduce the number of persons selecting health insurance coverage and would reduce the federal financial subsidies currently provided through the private health care marketplace.

Individual and Employer Mandates: BCRA would retroactively (Tax Year (TY) 2016) eliminate the individual and employer tax penalties associated with not purchasing, or providing, health insurance coverage.

Individual Market Waiting Period: Beginning January 1, 2019, if an individual had a break in health care coverage for longer than 63 days, that individual would be required to wait 6 months before re-enrolling.

[2] Both Michigan's population and share of Medicaid expenditures nationwide are approximately 3%.

Advance Premium Tax Credits: Beginning in TY 2020, Advance Premium Tax Credits would be revised as follows:

- Revise eligible income range from 100%-400% of the federal poverty levels (FPL) to 0%-350% FPL.
- Include age as a factor, meaning premium contribution rates would increase with age.
- Reduce the actuarial value of health insurance (the average percent of total health care costs for which an insurance plan pays) on which the tax credit is based. The tax credit would be based on health insurance that pays 58% of health care costs (Bronze Plans have an actuarial value of 60%) rather than based on Silver plans with an actuarial value of 70%.
- Expand eligibility to include individuals who select a catastrophic coverage plan.
- Eliminate eligibility for anyone with an offer of employer-sponsored health coverage.
- Maintain geography as a factor.

There are approximately 235,000 Michigan residents currently receiving an Advance Premium Tax Credit at an annual value totaling over $750.0 million.[3] On average, the amount an individual receives in Advance Premium Tax Credits would be lower under BCRA since the actuarial value of the benchmark plan is reduced. Individuals would have to respond either by contributing more of their income toward premiums or by selecting a health plan with higher out-of-pocket costs.

Cost-Sharing Reduction Subsidies: Also beginning in TY 2020, cost-sharing reduction (CSR) subsidies authorized under the Affordable Care Act would be repealed. There are approximately 140,000 Michigan residents currently benefiting from CSR subsides.[3] CSR subsides are paid to health insurers so that health insurers can offer coverage that have higher actuarial values to low- and moderate-income households.

Without CSR subsidies, out-of-pocket costs increase rapidly for individuals transitioning off of Medicaid and into the individual market (rather than phasing in) as shown in Figure 1. If CSR subsidies are repealed, an individual whose income increases from 100% FPL to 150% FPL would transition off of Medicaid and would select a Bronze Plan (i.e. the plan that most closely aligns with the BCRA-proposed Advance Premium Tax Credit), meaning all of that individual's income growth ($5,900) could have to go toward meeting a Bronze Plan deductible (on average, over $6,000 in 2017). Given the out-of-pocket cost increase, it is possible the elimination of the CSR subsidies could deter individuals from transitioning off of Medicaid and into the individual market since federal statute prohibits out-of-pocket costs for Medicaid from exceeding 5% of the individual's income.

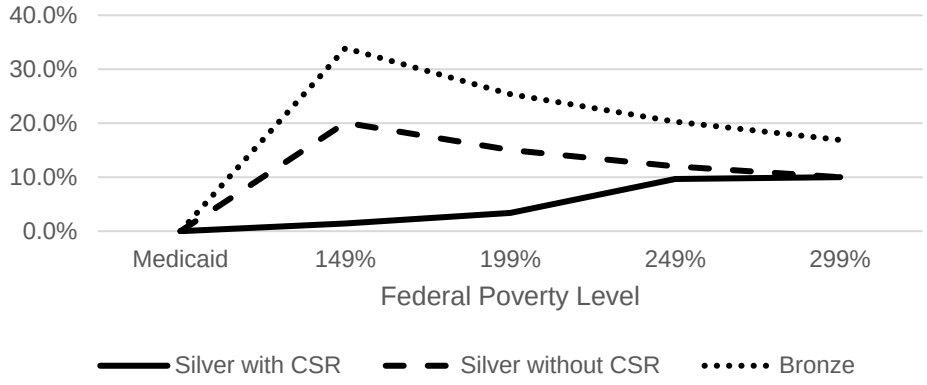
OTHER REVISIONS TO HEALTH CARE

Sec. 1332 Waivers: The Affordable Care Act allows states to seek Sec. 1332 waivers to pursue strategies for providing health insurance that are at least as comprehensive in coverage, affordable, and federal deficit neutral as coverage without the Sec. 1332 waiver. BCRA would require a Sec. 1332 waiver to be approved so long as the Sec. 1332 waiver request has provided all required information and would not increase the federal deficit. BCRA would also increase the amount states can receive in waiver funding.

There are many ways the state could use this added waiver flexibility and financing, and as such, it is unclear how added flexibility with Sec. 1332 waivers would impact the state. Presumably, any approved waivers would have a positive state fiscal impact.

[3] Source: Kaiser Family Foundation: Total Marketplace Enrollment and Financial Assistance, February 2017.

Figure 1
Health Plan Deductibles of Individuals Transitioning off of Medicaid as a Percentage of Income by Metal Tier



Health Insurer Fee: The Affordable Care Act health insurer fee would be repealed beginning January 1, 2017. The FY 2017-18 DHHS budget already assumes this fee would be repealed, so there would be no additional fiscal impact to the state.

Opioid Substance Use Disorder Treatment Funding: In FYs 2017-18 through 2025-26, $5.0 billion would be appropriated annually for opioid and substance use disorder treatment and recovery support grants to the states. The allocation formula is not established in the bill, so it's difficult to calculate a precise state impact. If the state receives 3% (a proportional share) of the allocation, the state would receive $149.2 million annually.

State Stabilization and Innovation Program Funding: Beginning in Calendar Year (CY) 2018, the State Stabilization and Innovation Program would provide $50.0 billion over 4 years to health insurers to "assist in the purchase of health benefits coverage by addressing coverage and access disruption and responding to urgent health care needs within States." Beginning in CY 2019, the State Stabilization and Innovation Program would also provide $132.0 billion over 8 years to states for four purposes:

- To reduce premiums for high-risk individuals in the individual market.
- Other uses to help with the purchase of insurance in the individual market by stabilizing premiums and promoting health insurance market participation.
- To pay providers.
- To assist with reducing out-of-pocket costs.

These funds would require a state match beginning at 7% in CY 2022 and growing to 35% by CY 2026 (see Table B). If the state received 3% of these funds, the annual appropriation would range from $240.0 million to $576.0 million, while the state match would start at $40.3 million and increase to $201.6 million. Currently, the state does not financially interact with the individual marketplace, so these additional funds would be used to support additional state responsibilities within the individual marketplace. BCRA would prohibit these funds from being used on Medicaid expenditures.

Table B
State Stability and Innovation Program Grants to the State
2019 – 2026
(in millions)

Calendar Year	Federal Grant Estimate	State Match Cost
2019	$240.0	$0
2020	$420.0	$0
2021	$420.0	$0
2022	$576.0	$40.3
2023	$576.0	$80.6
2024	$576.0	$121.0
2025	$576.0	$161.3
2026	$576.0	$201.6

Please do not hesitate to contact me if you have any questions regarding this information.