

AHCA: Medicaid as a Per Capita Capped Allotment and the CBO's Analysis

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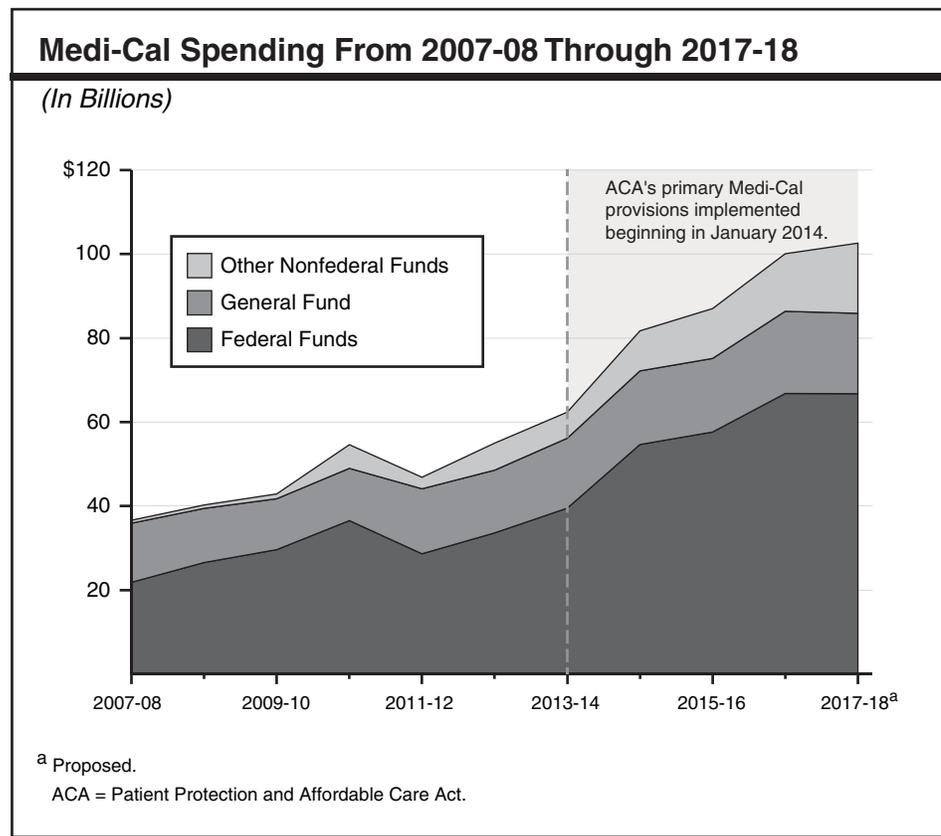




Federal Funding in Medi-Cal



Patient Protection and Affordable Care Act (ACA)-Related Federal Funding Responsible for Much of the Growth in Medi-Cal Spending. Since 2007-08, federal funding for Medi-Cal has grown from \$22 billion to a proposed \$67 billion in 2017-18. About one-third of the increase in federal funding occurred after January 2014, when much of the ACA was fully implemented. Total state spending for Medi-Cal has grown from \$15 billion in 2007-08 to a proposed \$36 billion in 2017-18. The figure below charts the growth in Medi-Cal spending from 2007-08 through 2017-18.





Overview of the American Health Care Act (AHCA)



The AHCA Would Change Major Provisions of the ACA.

The AHCA would change major provisions of the ACA related to Medicaid, including those related to enhanced federal funding for the ACA optional Medicaid expansion. (As discussed on the next page, the ACHA would also make major changes to how the overall allotment of Medicaid funding to states is calculated and structured.)



The AHCA Would Increase States' Share of Costs for the ACA Medicaid Optional Expansion Population.

Under the ACA, the federal government pays most of the ACA optional expansion population's costs. In 2020 and thereafter, the federal government will pay 90 percent of this population's costs.

However, under the AHCA:

- If the individual eligible under current law for the ACA optional expansion enrolls prior to December 31, 2019, the federal government would continue to pay 90 percent of his or her costs in 2020 and thereafter *unless and until* he or she loses Medicaid eligibility for one or more months. If he or she reenrolls after losing eligibility, the federal government would pay its traditional share (50 percent in California) of his or her costs.
- If the individual in the ACA optional expansion population newly enrolls on or after January 1, 2020, the federal government would pay its traditional share (50 percent in California) of his or her costs.



Medicaid as a Per Capita Capped Allotment Under the AHCA

- Medicaid Is Currently a Federal Entitlement Program.** Currently, the federal government is statutorily required to pay a set share of Medicaid enrollees' costs, no matter how many individuals enroll in a state's Medicaid program and what costs they incur.
- The AHCA Would Cap Federal Medicaid Funding.** Under the AHCA, the federal government would be statutorily required to provide states with annual allotments of Medicaid funding based on historic Medicaid spending that assumes a particular federal-state cost-share. Expenditures in excess of these allotments could be covered fully by states, without any federal financial participation.
- Annual Medicaid Allotments Would Be Calculated for Five Enrollment Groups.** The AHCA identifies five enrollment groups in Medicaid: (1) elderly; (2) blind and disabled; (3) children; (4) optional expansion enrollees; and (5) other nonelderly, nondisabled, and/or non-expansion adults. For each enrollment group in a state, a separate annual allotment would be calculated under the AHCA. This allotment would be based on historic Medicaid expenditures per enrollee in an enrollment group (a "per capita cap"), multiplied by the group's current number of enrollees.
- Medicaid Per Capita Caps Would Be Indexed to Medical Care Component of the Consumer Price Index (CPI-U Medical).** In addition to changes in allotments (increases or decreases) because of changes in Medicaid caseloads, caps would increase by the percentage point increase in CPI-U Medical annually. Recent amendments would increase the caps for blind and disabled as well as elderly enrollment groups by CPI-U Medical plus one percentage point annually.



Medicaid as a Per Capita Capped Allotment Under the AHCA *(Continued)*



State Expenditures in Excess of Allotments Would Be Penalized. If a state spends more than allowed by the allotments in a fiscal year, the state loses an amount of federal funding equal to one-quarter of those “excess” expenditures in the next fiscal year (in addition to being fully responsible for these excess expenditures in the current fiscal year).



Key Budgetary Considerations for States

- ACA Optional Expansion “Churn.”** The rate at which ACA optional expansion enrollees become ineligible for Medicaid because of, for example, changes in their income and then, once again eligible, reenroll (known as churn) could lead to significant reductions in federal funding. The Congressional Budget Office (CBO) projects that fewer than one-third of ACA optional expansion individuals enrolled as of December 31, 2019 will be enrolled two years later nationwide. By the end of 2024, fewer than 5 percent are projected to be enrolled. If the CBO projections for churn held at similar rates in California, this would mean that the state would lose almost all of the *enhanced* federal funding for the pre-2020 optional expansion enrollees by the mid-2020s.
- CPI-U Medical Versus Otherwise Projected Growth in Medicaid Spending.** Under current Medicaid rules, the federal government projects total Medicaid spending to grow at a rate of approximately 6 percent annually, while CPI-U Medical is expected to be between 3 percent and 4 percent per year in the near term. Holding the rate of growth in federal Medicaid funding to the medical component of the inflation rate under per capita capped allotments (as opposed to the rate of growth that otherwise would be projected) could require California to either make cuts to the program and/or pay an increasingly larger share of total Medi-Cal costs in the future.
- Supplemental Expenditures.** The AHCA explicitly excludes Disproportionate Share Hospital (DSH) payments and other “supplemental expenditures” from its calculation of per capita Medicaid expenditures. The extent to which the federal government considers certain current supplemental expenditures (in addition to DSH payments) within California’s Medi-Cal program—including its 1115 waiver funding, Hospital Quality Assurance Fee, and Managed Care Organization tax—as supplemental expenditures could reduce baseline expenditures and, consequently, federal funding for Medi-Cal.



CBO Fiscal Analysis of the AHCA (As Introduced March 6, 2017)



Reduces Federal Deficits by Estimated \$337 Billion From 2017 Through 2026. The CBO estimates the AHCA would reduce federal spending by a net \$1.2 trillion over a ten-year period, primarily from reductions in federal funding for Medicaid and from the elimination of the ACA’s premium tax subsidies and cost-sharing reductions. (New premium tax credits authorized by the AHCA, among other changes, would partially offset reductions in federal spending.) The AHCA, however, would also reduce federal revenues by \$900 billion over ten years, primarily from the elimination of the ACA’s individual and employer mandate tax penalties, taxes on high-income earners, and the fee on health insurers. Taking these projected spending and revenue changes together results in a projected \$337 billion reduction in the federal deficit for 2017 through 2026.

Major Components of CBO’s Estimate of AHCA’s Impact on Federal Deficit			
<i>Cumulative Total, 2017 Through 2026</i>			
Federal Spending Changes (Increases or Decreases)	Impact on Deficit	Federal Revenue Reductions	Impact on Deficit
Decreased federal funding for Medicaid	-\$880 billion	Elimination of the ACA’s taxes on high-income earners	+\$275 billion
Elimination of the ACA’s premium tax subsidies and cost-sharing reductions	-\$673 billion	Elimination of the ACA’s individual and employer mandate tax penalties	+\$210 billion
Increase for AHCA’s new premium tax credits	+\$361 billion	Elimination of the ACA’s health insurer fee	+\$145 billion
Increase for AHCA’s Patient and State Stability Fund grants	+\$80 billion	Various other revenue reductions	+\$270 billion

CBO = Congressional Budget Office; ACA = Patient Protection and Affordable Care Act; and AHCA = American Health Care Act.



Increases Number of Uninsured Nationwide by Estimated 24 Million by 2026. The CBO estimates the AHCA would increase the number of uninsured nationwide by 14 million in 2018, 21 million in 2020, and 24 million in 2026. The 24 million increase in the uninsured reflects 14 million fewer Medicaid enrollees (relative to current law).