Issue Brief

FEDERAL ISSUE BRIEF • JUNE 27, 2017

KEY POINTS

- CBO concludes that the proposed BRCA legislation would increase the number of uninsured Americans by 15 million in 2018 and by 22 million in 2026.
- Federal Medicaid spending would decrease by 26 percent throughout the next 10 years.
- Medicaid enrollment of Americans younger than 64 would drop by 16 percent by 2026.

4712 Country Club Drive
Jefferson City, MO 65109

P.O. Box 60
Jefferson City, MO 65102

573/893-3700
www.mhanet.com

MHA
MISSOURI HOSPITAL ASSOCIATION

CBO Scores Senate's Proposed Health Care Reform Bill; the Better Care Reconciliation Act of 2017; HR 1628

The Congressional Budget Office and the staff of the Joint Committee on Taxation have completed an estimate of the direct spending and revenue effects of the Senate's proposed Better Care Reconciliation Act of 2017. A copy of the 49-page document is at: https://www.cbo.gov/publication/52849.

CBO and JCT estimate that enacting this legislation would reduce the cumulative federal deficit over the 2017-2026 period by $321 billion. That amount is $202 billion more than the estimated net savings for the version of HR 1628 that was passed by the House of Representatives.

The Senate bill would increase the number of people who are uninsured by 22 million in 2026 relative to the number under current law. By 2026, an estimated 49 million people would be uninsured, compared with 28 million who would lack insurance that year under current law.

COMMENT

While the CBO estimates on the savings and number of uninsured appears to be slightly better than the CBO score of the House passed American Health Care Act; i.e., more savings and slightly less uninsured, there is still much concern being expressed by both proponents and opponents of the Senate's actions.

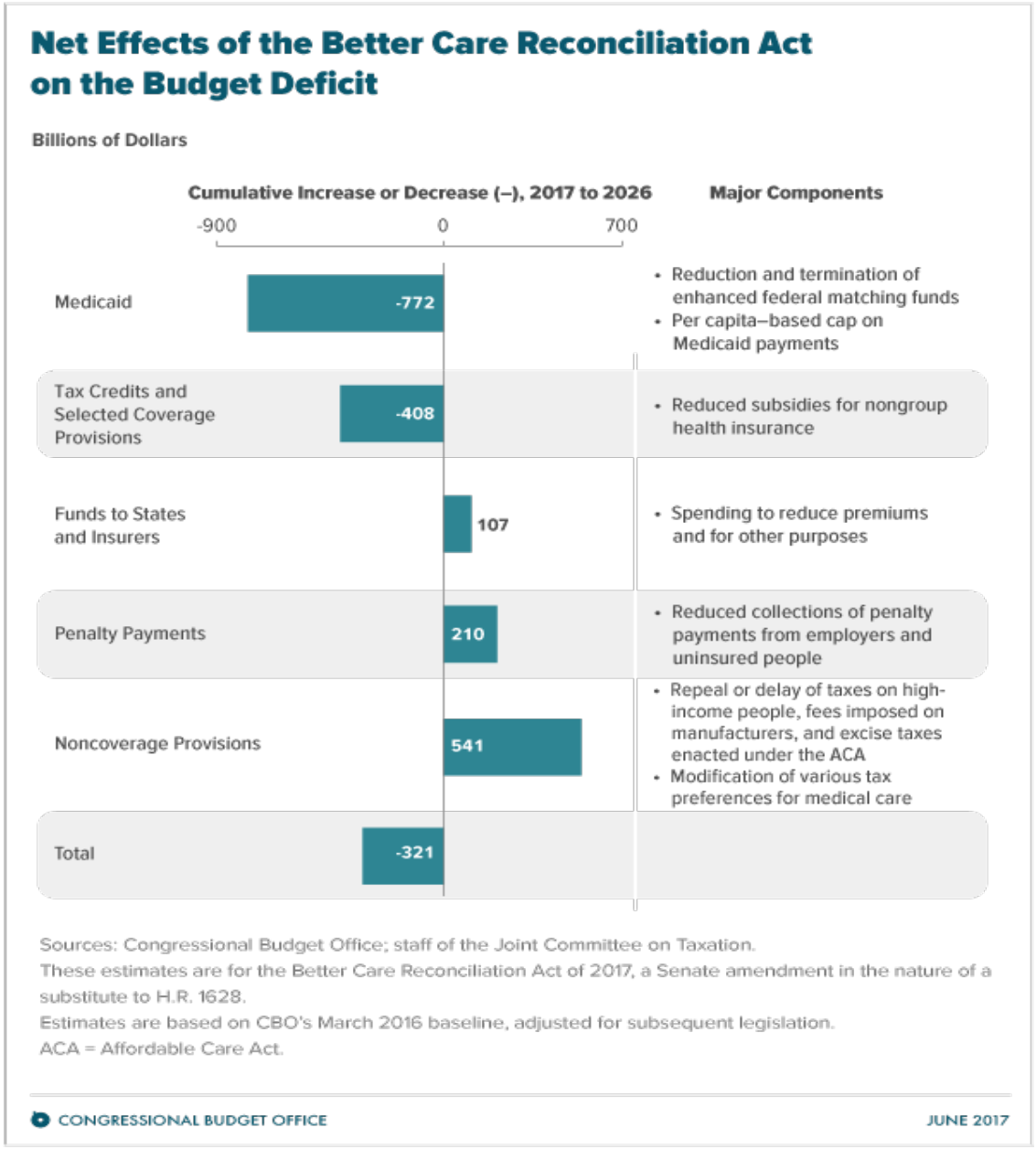
EFFECTS ON THE FEDERAL BUDGET

CBO and JCT estimate that, over the 2017-2026 period, enacting this legislation would reduce direct spending by $1,022 billion and reduce revenues by $701 billion, for a net reduction of $321 billion in the deficit over that period:

- The largest savings would come from reductions in outlays for Medicaid — spending on the program would decline in 2026 by 26 percent in comparison with what CBO projects under current law—and from changes to the Affordable Care Act's subsidies for non-group health insurance. Those savings would be partially offset by the effects of other changes to the ACA's provisions dealing with insurance coverage: additional spending designed to reduce premiums and a reduction in revenues from repealing penalties on employers who do not offer insurance and on people who do not purchase insurance.
- The largest increases in deficits would come from repealing or modifying tax provisions in the ACA that are not directly related to health insurance coverage, including repealing a surtax on net investment income and repealing annual fees imposed on health insurers.

continued

The first table below is CBO's estimates of the Senate proposal. The second table is the CBO's score of the House's passed bill. The third table shows the combined impact.

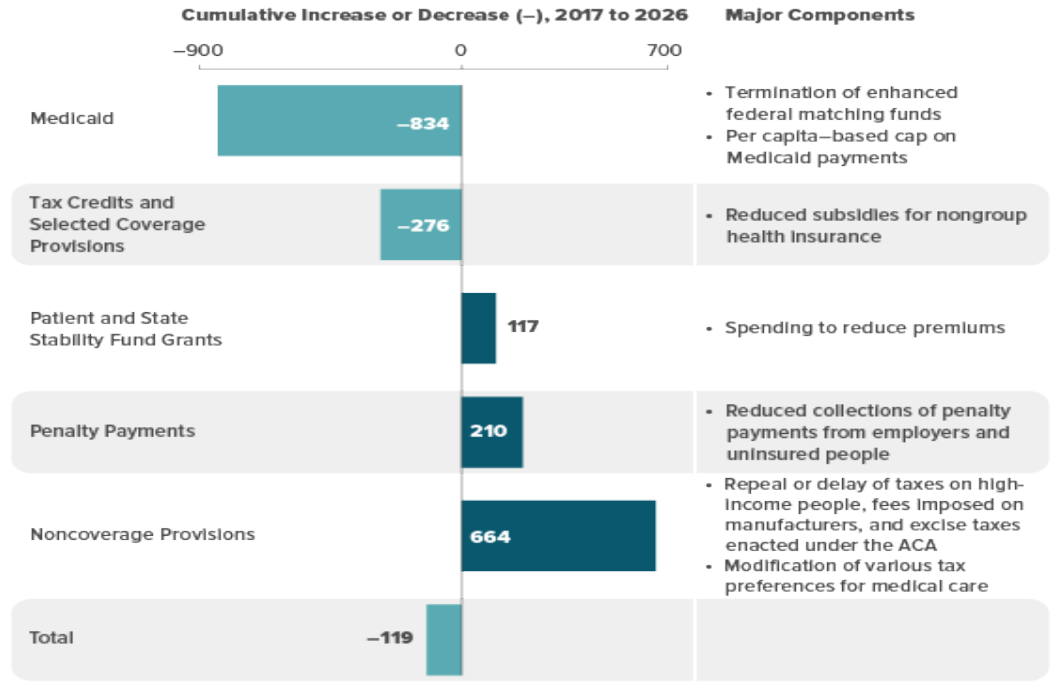


MISSOURI HOSPITAL ASSOCIATION

continued

Net Effects of H.R. 1628 on the Budget Deficit

Billions of Dollars



Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.
These estimates are for H.R. 1628, the American Health Care Act of 2017, as passed by the House of Representatives on May 4, 2017.
ACA = Affordable Care Act.

CONGRESSIONAL BUDGET OFFICE MAY 2017

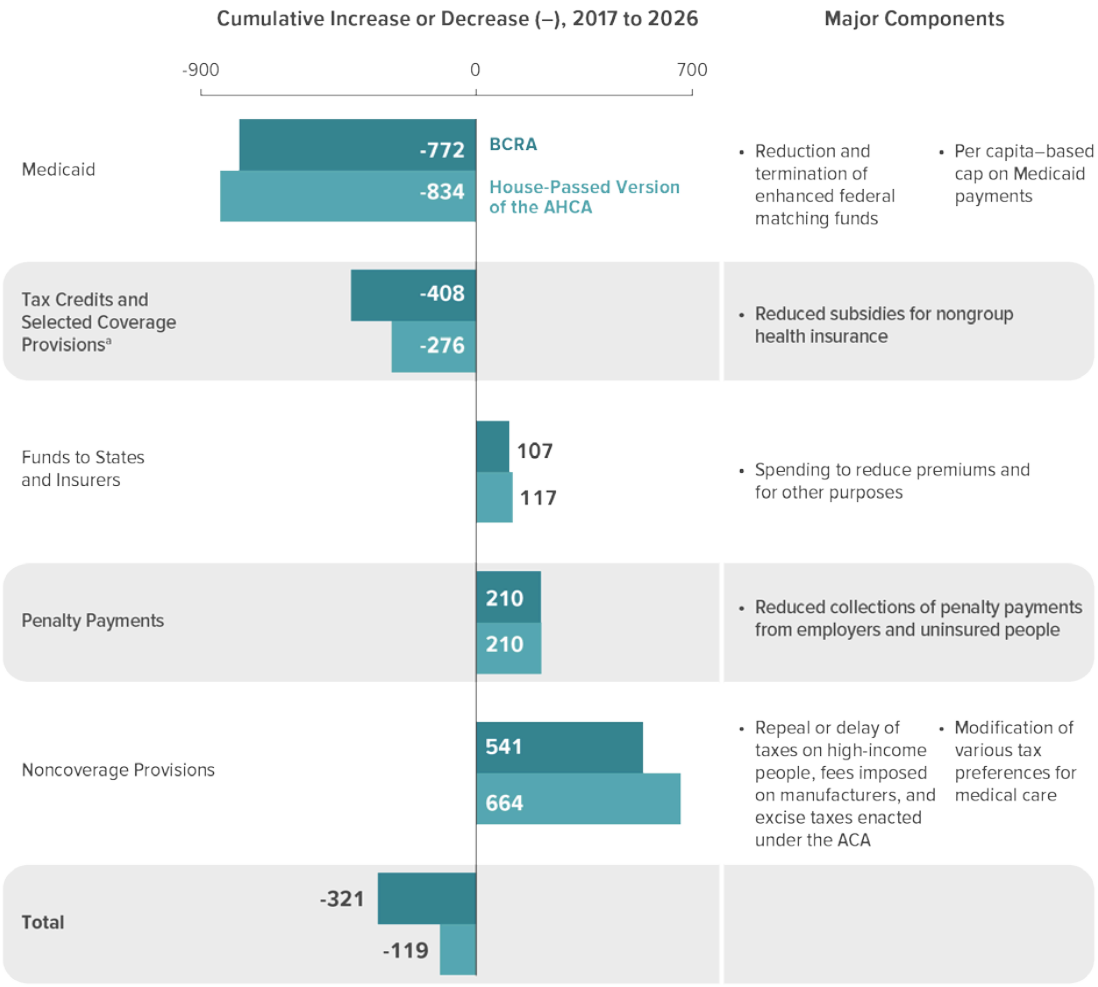
MISSOURI HOSPITAL ASSOCIATION

continued

Figure 5.

Net Effects of the Better Care Reconciliation Act and of the House-Passed Version of the American Health Care Act on the Budget Deficit

Billions of Dollars



Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

These estimates are for two versions of H.R. 1628: the Better Care Reconciliation Act of 2017 (BCRA), a Senate amendment in the nature of a substitute; and the American Health Care Act of 2017 (AHCA), as passed by the House of Representatives.

Estimates are based on CBO's March 2016 baseline, adjusted for subsequent legislation.

ACA = Affordable Care Act.

a. Includes subsidies for coverage through marketplaces and related spending and revenues, small-employer tax credits, tax credits for nongroup insurance, Medicare, and other effects of coverage provisions on revenues and outlays.

continued

MEDICAID

The House passed bill would lower overall Medicaid payments by some $834 billion from 2017 through 2026, while the Senate's proposal would lower payments by $772 billion.

SENATE'S LEGISLATION

CBO and JCT anticipate that, under this legislation, non-group insurance markets would continue to be stable in most parts of the country. Although substantial uncertainty about the effects of the new law could lead some insurers to withdraw from or not enter the non-group market in some states, several factors would bring about market stability in most states before 2020.

COMMENT

CBO and the JCT provide a significant explanation of what may occur in the insurance markets, but do so with caveats about such estimates and what actually may happen.

MAJOR PROVISIONS OF THIS LEGISLATION

Upon enactment, CBO notes that the legislation would eliminate penalties associated with the requirements that most people obtain health insurance coverage and that large employers offer their employees coverage that meets specified standards. States would be allowed to meet fewer criteria to waive the ACA's requirement establishing essential health benefits and many other requirements related to subsidies and the marketplaces as long as the changes would not increase federal deficits; states would be provided funding to develop applications for waivers.

In 2018, the legislation would provide funding to health insurers to stabilize premiums and promote participation in the marketplaces.

In 2019, four major coverage provisions would take effect:

- Appropriating funding for grants to states through the Long-Term State Stability and Innovation Program.
- Requiring insurers to impose a six-month waiting period before coverage starts for people who enroll in insurance in the non-group market if they have been uninsured for more than 63 days within the past year.
- Setting a limit whereby insurers would charge older people premiums that are up to five times higher than those charged younger people in the non-group and small group markets, unless a state sets a different limit.
- Removing the federal cap on the share of premiums that may go to insurers' administrative costs and profits (also known as the minimum medical loss ratio requirement) and effectively allowing each state to set its own cap.

In 2020, the following additional major coverage provisions would take effect:

- Changing the tax credit for health insurance coverage purchased through the non-group market and repealing current-law subsidies to reduce cost-sharing payments. People with income below 100 percent of the federal poverty level who are not eligible for Medicaid would become eligible for the tax credit, and people with

MISSOURI HOSPITAL ASSOCIATION

continued

income between 350 percent and 400 percent of the FPL would no longer be eligible. The maximum percentage of income specified by the bill that people would pay at different ages toward the purchase of a benchmark plan would be lower for some younger people and higher for some older people. The benchmark plan used to determine the amount of the tax credit would have a lower actuarial value.

- Capping the growth in per-enrollee payments for nondisabled children and nondisabled adults enrolled in Medicaid at no more than the medical care component of the consumer price index and for most enrollees who are disabled adults or age 65 or older at no more than the CPI-M plus 1 percentage point, starting in 2020 and going through 2024. Starting in 2025, the rate of growth in per-enrollee payments for all groups would be pegged to the consumer price index for all urban consumers.

Other parts of this legislation would repeal or delay many of the changes the ACA made to the Internal Revenue Code that were not directly related to the law's insurance coverage provisions. Those with the largest budgetary effects include these:

- Repealing the surtax on certain high-income taxpayers' net investment income, effective for tax years beginning after December 2016.
- Repealing the annual fee on health insurance providers, beginning in calendar year 2017.
- Delaying when the excise tax imposed on some health insurance plans (Cadillac plans) with high premiums would go into effect. It is currently scheduled to take effect for tax years beginning after December 2019; the legislation would delay the effective date for six years.
- Repealing the increase in the Hospital Insurance payroll tax rate for certain high income taxpayers, effective for earned income received beginning in 2023.

CAPS ON FEDERAL MEDICAID SPENDING

Under current law, the federal government and state governments share in the financing and administration of Medicaid. All federal reimbursement for medical services is open-ended, meaning that if a state spends more because enrollment increases or costs per enrollee rise, additional federal payments are automatically generated. This bill would establish a per capita cap on most Medicaid spending for medical services and offer states an option for a block grant to provide medical services for certain adults.

Per Capita Cap for Medicaid

Under this legislation, beginning in fiscal year 2020, the federal government would limit the amount of reimbursement it provides to states. That limit would be set for a state by calculating the average per-enrollee cost of medical services for most enrollees who received full Medicaid benefits over eight consecutive quarters of the state's choosing between the first quarter of federal fiscal year 2014 and the third quarter of 2017. Those enrollees would be in five specified categories: the elderly, disabled adults, nondisabled children, adults made eligible for Medicaid by the ACA, and all other adults.

MHA
MISSOURI HOSPITAL ASSOCIATION

continued

The Secretary of HHS would then inflate the average per enrollee costs for each state for most nondisabled children and nondisabled adults enrolled in Medicaid using the CPI-M and for most enrollees who are disabled adults or age 65 or older using the CPI-M plus 1 percentage point. Disabled children would be excluded from the per capita caps and covered as under current law.

Beginning in 2025, the inflation factor for all groups would be the consumer price index for all urban consumers. The final limit on federal reimbursement for each state starting in 2020 would be the average cost per enrollee for the five specified groups of enrollees, reflecting growth from the base period in the relevant inflation factors multiplied by the number of enrollees in each category. If a state spent more than the amount eligible for federal reimbursement, the federal government would provide no reimbursement for spending over the limit.

CBO's projects that for the 2017-2024 period, the limit on federal reimbursement would reduce outlays because Medicaid spending, on a per-enrollee basis, for non-disabled children and nondisabled adults under current law (after the changes to the Medicaid expansion population have been accounted for) would grow faster, at 4.9 percent, than the CPI-M, at 3.7 percent. However, for most enrollees who are disabled adults or age 65 or older, that rate is 3.3 percent, lower than the CPI-M plus 1 percentage point. The per capita cap would have a small effect on spending for those groups, even though the cap would not generally be binding for them, because some shifting of costs among groups would probably occur, and spending for a particular group in a particular year could be affected.

In 2025 and beyond, the differences between spending growth for Medicaid under current law and the growth rate of the per capita caps for all groups would be substantial, as CBO projects the growth rate of the CPI-U in those years to be 2.4 percent.

Block Grant Option for States

Starting in 2020, under this legislation, states would have the option to receive federal aid in the form of a block grant rather than under a per-enrollee cap. A state's initial block grant would be determined by multiplying the amount of the per capita cap, as estimated by the Secretary of HHS, for the state's nondisabled adult population by the state's total number of nondisabled adult enrollees in the year before the preceding fiscal year, adjusted for population growth plus 3 percentage points. In subsequent years, the block grant amount would grow at the rate of the CPI-U.

A state would be required to contribute, at a minimum, an amount calculated using its matching rate for enrollees under the Children's Health Insurance Program, not including the 23 percentage-point decrease for such rates established under the ACA. (The state matching rate for CHIP ranges from 18 percent to 35 percent, depending on the state, and averages 30 percent.) Because this option would be attractive mainly to a few states that expect to decline in population (and not in most states experiencing population growth, as it would further constrain federal reimbursement), CBO expects this option would have little effect on enrollment in Medicaid.

States would not have substantial additional flexibility under the per capita caps. Under the block grant option, states would have additional flexibility to make changes to their Medicaid program—such as altering cost sharing and, to a limited degree, benefits.

FEDERAL MATCHING RATE FOR MEDICAID COSTS (MEDICAID EXPANSION)

Under current law, states are permitted, but not required, to expand eligibility for Medicaid to adults under 65 whose income is equal to or less than 138 percent of the FPL (who are referred to here as newly eligible).

The federal government pays a larger share of the medical costs for those people than it pays for those who were previously eligible. Beginning in fiscal year 2021, this legislation would reduce the federal matching rate for all newly eligible adults from 90 percent of the medical costs for them to 85 percent in 2021, 80 percent in 2022, and 75 percent in 2023. Thereafter, that rate would fall to the matching rate for other enrollees.

The 31 states and the District of Columbia that have already expanded Medicaid to the newly eligible cover roughly half of that population nationwide. In its March 2016 baseline, CBO projected that under current law, additional states will expand their Medicaid programs and that, by 2026, roughly 80 percent of newly eligible people will reside in states that have done so. Under this legislation, largely because states would pay for a greater share of costs for enrollees, CBO expects that no additional states would expand eligibility, thereby reducing both enrollment in and spending for Medicaid, compared with the amounts anticipated under current law.

FEDERAL PAYMENTS TO STATES

For a one-year period following enactment, this legislation would prevent federal funds from being made available to an entity (including its affiliates, subsidiaries, successors, and clinics) if it is:

- A nonprofit organization described in section 501(c)(3) of the Internal Revenue Code and exempt from tax under section 501(a) of the code;
- An essential community provider that is primarily engaged in providing family planning and reproductive health services and related medical care;
- An entity that provides abortions—except in instances in which the pregnancy is the result of an act of rape or incest or the woman's life is in danger; and
- An entity that had expenditures under the Medicaid program that (when combined with the expenditures of its affiliates, subsidiaries, successors, and clinics) exceeded $350 million in fiscal year 2014.

Restoring "Fairness" in DSH Allotments

Under current law, Medicaid allotments to states for payments to hospitals that treat a disproportionate share of uninsured and Medicaid patients — known as allotments for "disproportionate share hospitals," or DSH allotments — are to be cut significantly in each year from 2018 to 2025. The cuts are currently scheduled to be $2 billion in 2018 and to increase each year until they reach $8 billion in 2024 and 2025.

MHA
MISSOURI HOSPITAL ASSOCIATION

continued

This legislation would eliminate those cuts, starting in 2018, for states that did not expand Medicaid under the ACA. In addition, the Secretary of HHS would calculate each state's ratio of its allotments for disproportionate share payments per Medicaid enrollee and increase the allotments for states that did not expand Medicaid by an amount sufficient to bring their allotments for 2020 to 2023 up to the national average per enrollee. Those changes would increase outlays by $19 billion over the next 10 years, CBO estimates.

Providing Safety Net Funding for Non-Expansion States

This legislation would provide $2 billion in funding in each year from 2018 to 2022 to states that did not expand Medicaid eligibility under the ACA. Those states could use the funding, within limits, to supplement payments to providers that treat Medicaid enrollees. Such payments to providers would not be subject to the per capita caps.

Analysis provided for MHA by Larry Goldberg, Goldberg Consulting

FINAL COMMENT

From the provider perspective, most Medicare reimbursement changes made by the ACA are not being addressed in either the House or Senate bills. Therefore, providers may incur significant payment shortfalls on the Medicare side.

At this stage, the issue of "repeal and replace" stills seems clouded. If the Senate should enact its proposal, it would need to be reconciled with the House version. Considering the politically restive state in Washington, it will still be a while for actions to be sorted out.

In the meantime, much of the ACA is still in place.

MHA
MISSOURI HOSPITAL ASSOCIATION