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The Senate's Better Care Reconciliation Act: A $737 Billion Equity Gap for Medicaid Nonexpansion States

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In late June, the U.S. Senate released a discussion draft substitute for the U.S. House of Representatives' American Health Care Act. The Better Care Reconciliation Act of 2017, like its House counterpart, rescinds many of the components of the Affordable Care Act.

The ACA made significant changes to the nation's health insurance system, health care finance and delivery, and health coverage. However, since the U.S. Supreme Court decided that the ACA's expansion of Medicaid could not be mandatory, significant state variation in Medicaid has occurred. Although the Medicaid expansion provision came into effect in 2014, 19 states have not accepted federal funds to cover the ACA's expansion population. The result is significant coverage and funding disparities between expansion and nonexpansion states.

The BCRA would fundamentally alter the Medicaid program by contracting the federal funding for Medicaid expansion included in the ACA and transitioning the program's state-federal partnership. These changes would have long- and short-term implications for all states.

This policy brief is designed to help policymakers understand the BCRA's influence on the states that did not expand Medicaid, and illuminate the significant federal funding inequity that exists presently and grows throughout implementation.

Key Findings

The BCRA of 2017 is projected to **reduce federal spending on Medicaid by $772 billion** between 2017 and 2026, **resulting in 15 million fewer Americans enrolled** in the program.

While little is known on how the provisions of the BCRA would impact states that did and did not expand Medicaid under the current law, CMS data for the first two years of the program revealed **an additional $113.6 billion in federal Medicaid funding flowing to expansion states.**

During fiscal year 2015, **Medicaid expansion states received $1,578 per capita** in net federal outlays for Medicaid, while the 19 remaining nonexpansion states received less than half that amount at just **$753 per capita.**

The draft Senate repeal and replace bill includes key provisions designed to restore equity in federal Medicaid spending for nonexpansion states, including a **$10 billion nonexpansion safety net fund** and **$19 billion in restored disproportionate share hospital funding** that was cut under the existing law.

Despite this compensatory relief, **the collective opportunity cost for nonexpansion states resulting from the decision to opt out of the program is estimated to be $737 billion** between 2014 and 2026 under the provisions of the BCRA.

This would result in federal spending on Medicaid in expansion states that would be **$1,987 per capita** by 2026, compared to just **$1,192 in nonexpansion states** — a relative difference of 67 percent.

Executive Summary

Senate leadership unveiled a discussion draft of the BCRA on June 22, 2017, in response to the proposed American Health Care Act, as passed by the U.S. House of Representatives on May 4, 2017.[3] The Congressional Budget Office and Joint Committee on Taxation estimate that the BCRA is projected to reduce federal spending on Medicaid by $772 billion between 2017 and 2026.[4] Included in these cuts, the CBO estimates that Medicaid enrollment would decline by 16 percent, or 15 million beneficiaries, as compared to the current law.[5]

While the Senate working committee on health reform wrote assurances into the BCRA to restore equity in Medicaid spending for the 19 remaining states that have opted out of Medicaid expansion under the current law, little is known on the extent to which those compensatory provisions will return states to a level playing field with respect to federal spending on the program. **This policy brief seeks to illuminate such questions using historical expenditures data and the CBO scoring of the BCRA discussion draft as published by the Senate Budget Committee on June 26, 2017.**

The analysis suggests that by 2026, nonexpansion states will have foregone an additional $737 billion in net federal outlays for Medicaid, compared to states that have opted to expand the program under the existing law. This figure represents the combined opportunity cost under the provisions of BCRA of these states' decision to opt out of the Medicaid expansion component of the ACA. These estimates project that federal spending on Medicaid in expansion states by 2026 will be $1,987 per capita compared to $1,192 in nonexpansion states — a relative difference of 67 percent.

The disparate findings for nonexpansion states in future federal funding under the BCRA hold true after accounting for $19 billion in restored disproportionate share hospital funding for nonexpansion states, retaining $31.9 billion in DSH cuts in expansion states, allocating 93.5 percent of the total projected cuts to expansion states, and distributing $10 billion in safety-net funding to nonexpansion states.

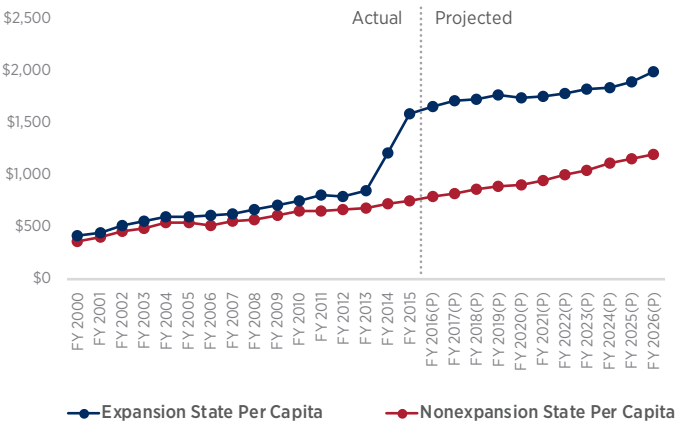
Background

The BCRA is expected to pose significant challenges across states, regardless of individual decisions on Medicaid expansion. One concern is that insurance premiums will become cost prohibitive in non-group markets as a result of healthier individuals self-selecting out of the insurance market, while many with preexisting conditions will remain out of necessity, however some may be forced to pay out of pocket for essential health benefits. In many states, the number of nonelderly adult residents with preexisting conditions exceeds 33 percent.[6] Additionally, more than half of the population in certain counties have conditions that would be considered uninsurable under pre-ACA medically underwritten insurance policies.[7]

The BCRA also includes a budget-neutral redistribution provision for states' per capita Medicaid funding based on whether each state's spending across eligibility groups is more or less than 25 percent of the national average. The adjustments for high-spend states would range from a decrease of 0.5 to 2 percent, while the opposite would occur for low-spend states. A major concern for budget planners at the state level is that the redistributions wouldn't be known until after the start of each fiscal year because of a lag in the availability of data needed to determine the overall distribution. In addition to this uncertainty, the provision makes no accounting for eligibility differences across states that skew the distribution of spending per beneficiary as a result of differences in medical complexity. It is currently estimated that this provision would harm 20 states, many of which are seen as perineal low spenders as a result of stringent eligibility standards, while only 12 states would benefit.[8]

The per capita caps also would be adjusted annually by inflationary components that history suggests are significantly outstripped by the trajectory of Medicaid costs in the U.S. Between 2020 and 2024, the caps would be inflated by the medical component of the Consumer Price Index for all non-aged, blind or disabled beneficiaries, and by the CPI-M plus one percentage point for the adult ABD population (coverage for children with disabilities is untouched by the BCRA). In fiscal year 2025 and beyond, however, the inflationary component is downgraded to the CPI-U, which is designed to reflect purchasing power for urban consumers of a marketbasket of all goods and services. The CBO projects annual Medicaid growth of 4.4 percent, CPI-M growth of 3.7 percent and CPI-U growth of just 2 percent.[9] **In the absence of added efficiencies, this will require states to continue significantly pairing back services and enrollment for low-income residents.** This provision also will be affected by the well-documented inverse relationship between unemployment and inflation, which would result in lower inflationary increases during periods of increased enrollment because of broader economic conditions.[10]

BCRA Per Capita Federal Net Medicaid Expenditures by Expansion Status



The landmark June 2012 Supreme Court decision on the states' option to expand Medicaid under the ACA posed a difficult dilemma. Lawmakers could reject federal funds, while subsidizing expansion in other states, or accept enhanced federal matching funds to expand health coverage to thousands of lower-income constituents.

The opportunity cost for the 19 remaining states opting to forego expansion has been high. According to the Centers for Medicare & Medicaid Services' expenditure reports, **expansion states received an additional $113.6 billion in federal Medicaid outlays during the first two years of expansion.** Since that time, the expansion decision has become a purple phenomenon, with many traditionally conservative swing and red states adopting full expansion or tailored conservative models under Section 1115 waivers. In addition, new research shows that increased Medicaid spending in expansion states was borne almost entirely by federal funding, and changes in state spending resulting from "woodwork" or other expansion-induced effects were largely insignificant.[11] **Finally, 4.5 million nonelderly uninsured adults in nonexpansion states would gain coverage with expanded Medicaid, and more than half of those (59 percent) fall into the coverage gap and are not eligible for subsidized coverage through marketplace enrollment.**[12] The BCRA discussion draft, as published by the Senate Budget Committee on June 26, 2017, proposes significant changes to the Medicaid delivery system in both expansion and nonexpansion states. The major provisions related to Medicaid begin in 2020, including the transition to per capita caps based on the average spending for eight consecutive quarters between first quarter 2014 and third quarter 2017 chosen by each state, or optional lump sum block grants that the CBO indicates are most appealing to states with shrinking populations.

> In light of the uncertainty posed by the BCRA for all states, these challenges will be compounded in nonexpansion states as a result of extreme inequalities in their beginning vantage points compared to expansion states.

Similar to the House repeal and replace plan, the BCRA would sunset the enhanced federal match rate of 90 percent for Medicaid expansion beneficiaries; typically individuals between traditional Medicaid eligibility and 138 percent of the federal poverty level. However, **the draft discussion bill provides a three-year "glide path" for EFMAP beneficiaries that significantly benefits expansion states, and mitigates other attempts made by the BCRA to restore parity to nonexpansion states** ($10 billion safety-net fund and $19 billion in restored DSH cuts), while actually exacerbating concerns of equity in the AHCA put forward by previous research.[13]

Altogether, the CBO estimates that 15 million Medicaid beneficiaries would lose coverage under the BCRA, which accounts for nearly seven out of every 10 of the 22 million total individuals expected to be uninsured as a result of the policy by 2026. In all, the BCRA is expected to reduce Medicaid spending by $772 billion throughout the next decade.

Results

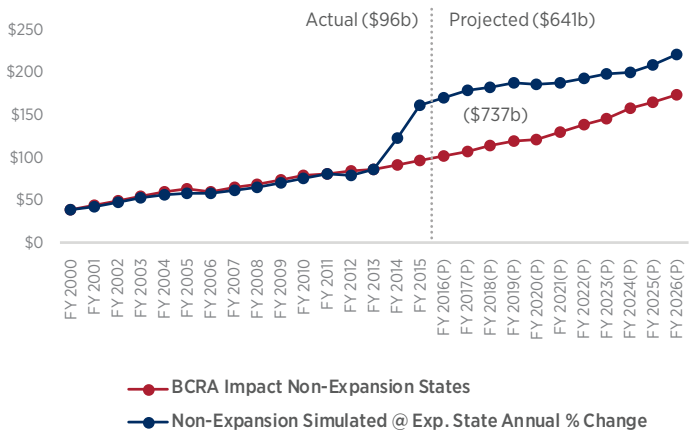
Despite the disproportionate burden of the estimated reductions in federal spending on Medicaid under the BCRA and the $10 billion in compensatory nonexpansion safety-net funding plus $19 billion in DSH relief, states that have opted to expand Medicaid under the ACA are estimated to receive significantly larger shares of federal Medicaid spending throughout the next decade under the provisions of the draft bill intended to provoke discussion. This is largely due to the extreme growth in Medicaid spending observed during the first two years of the Medicaid expansion program. These gains are projected to continue until the major provisions of the BCRA are enacted in 2020, and to a lesser extent, during the three-year "glide path" until EFMAP spending for expansion states concludes in 2024.

On a per capita basis, net federal expenditures for full-expansion states increased 91 percent between 2013 and 2015, while partial-expansion (1115 waiver) states experienced 71 percent growth and nonexpansion states saw just a 13 percent increase. Combined, **in 2015, Medicaid expansion states received $1,578 per capita in federal Medicaid spending compared to $753 per capita in nonexpansion states — a relative difference of 110 percent** (Figure 1 and Table 1).

And despite provisions of the BCRA to restore parity in Medicaid spending for nonexpansion states, this analysis suggests that they will not recover from their extremely disadvantaged starting point in 2020, when the major provisions of the BCRA are enacted. The per capita federal spending for expansion states is projected to slow between 2016 and 2019; then experience a significant reduction between 2020 and 2021; however, by 2026, their per capita federal spending on Medicaid is still projected to be 67 percent higher than in nonexpansion states (Table 1).

By simulating the actual and projected federal Medicaid spending in nonexpansion states using annual percentage changes experienced in expansion states during the same period, **it is estimated that nonexpansion states will have collectively foregone $736.97 billion in federal Medicaid spending under the discussion draft of BCRA by 2026.** This includes an actual difference of $96 billion observed during the first two years of Medicaid expansion, and a projected additional $641 billion between 2016 and 2026 (Figure 2).

Figure 2: BCRA Federal Net Medicaid Expenditures for Nonexpansion States: Actual versus Simulated at Annual % Change for Expansion States (in $ billions)



Actual and Projected Net Federal Medicaid Expenditures Per Capita Under the BCRA by State Expansion Status

	ACTUAL			PROJECTED									
	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Nonexpansion States	***$681***	***$716***	***$753***	***$785***	***$819***	***$858***	***$891***	***$897***	***$947***	***$994***	***$1,036***	***$1,110***	***$1,148***	***$1,192***
Expansion States	**$849**	**$1,208**	**$1,578**	**$1,655**	**$1,705**	**$1,723**	**$1,765**	**$1,733**	**$1,748**	**$1,777**	**$1,823**	**$1,832**	**$1,898**	**$1,987**
Relative % Difference	25%	69%	110%	111%	108%	101%	98%	93%	85%	79%	76%	65%	65%	67%

Data Sources and Methods

Historical state and federal Medicaid expenditures data at the state level for 2000-2015 were gathered from CMS-64 Expenditure Reports and served as the historical basis of projected Medicaid spending estimates.[14] Projected total Medicaid expenditures for 2016-2025 for the U.S. were obtained from the CMS Office of the Actuary, National Health Expenditures Accounts files, and used to project spending under the current law.[15] Projected Medicaid budgetary effects of the BCRA between 2017 and 2026 were taken from the CBO and Joint Committee on Taxation analysis, Cost Estimate of H.R. 1628 Better Care Reconciliation Act of 2017, as posted on the website of the Senate Committee on the Budget on June 26, 2017.[16] Projections for state-level total population and population living below 138 percent of the federal poverty level, which are used to distribute the nonexpansion state safety-net fund between 2018 and 2022, were retrieved from the U.S. Census Bureau.[17] Finally, information on state expansion decisions — full expansion, partial expansion under a Section 1115 waiver, or nonexpansion — were obtained from the Kaiser Family Foundation, Status of State Action on the Medicaid Expansion Report.[18] States opting to expand Medicaid on or after FY 2016 (Alaska, Montana and Louisiana) were kept in the nonexpansion group because historic federal expenditures data from CMS were only available through 2015, which captured the actual effects of the first two years of the program in expansion states.

To simulate the effects of the BCRA compared to the current law, net federal Medicaid expenditures were projected under the ACA status quo compared to the CBO-estimated $772 billion reduction in federal outlays between 2017 and 2026. First, historical net federal expenditures data were gathered from the CMS-64 Expenditure Reports between fiscal years 2000 and 2015. These data include information on net federal outlays for the traditional and expanded Medicaid populations at the state level. Beginning in 2016 and carried through to 2025, each state's federal Medicaid expenditures were adjusted to reflect increased program spending estimates from the CMS Office of the Actuary using actual expenditures from 2015 as a basis for projections. Projections for 2026 were calculated with the percent change between the 2024 and 2025 projections as a result of CMS Office of the Actuary data being available only through 2025. Beginning in 2017, the EFMAP for expansion state Title VIII ACA spending was reduced from 100 to 95 percent, and gradually reduced to 90 percent by 2020 as codified under the existing law.

Beginning in 2018, the Medicaid-related provisions of the BCRA were distributed across states by expansion status using the annual CBO scores for the program under the proposed law. Between 2018 and 2023, $10 billion in nonexpansion state safety-net funding was distributed across nonexpansion states in proportion to each state's population under 138 percent of the FPL among all nonexpansion states. DSH cuts totaled

Table 2: Allocation of Medicaid-Related Provisions of BCRA Used to Inform Analysis (in billions)

	PROVISION	TOTAL AMOUNT	NON-EXPANSION STATE ALLOCATION	EXPANSION STATE ALLOCATION
CBO Itemized	Sec. 125 - Medicaid Provisions	-$19.30	24.53%	75.47%
	Sec. 127 - Restoring Fairness in DSH Allotments	$19.00	100.00%	0.00%
	Sec. 128 - Reducing State Medicaid Costs	-$5.00	24.53%	75.47%
	Sec. 129 - Providing Safety Net Funding for Non-Expansion States	$10.00	100.00%	0.00%
	Sec. 132 - Provider Taxes	-$5.20	24.53%	75.47%
	Sec. 135 - Medicaid and CHIP Quality Performance Bonus Payments	$3.00	24.53%	75.47%
CBO Non-itemized	Sec. 126 - Medicaid Expansion	-$471.30	0.00%	100.00%
	Sec. 130 - Eligibility Redeterminations	$5.22	24.53%	75.47%
	Sec. 131 - Optional Work Requirement for Able Bodied	$5.22	24.53%	75.47%
	Sec. 133 - Per Capita Allotment for Medical Assistance	-$313.85	24.53%	75.47%
	Subtotal Nonitemized Medicaid Cuts	-$774.50	24.53%	75.47%
Total Medicaid Cuts (CBO)		-$772.20	6.72%	93.28%
Estimated Retained DSH Cuts for Expansion States (non-CBO)		-$31.90	0.00%	100.00%
Total Impact Used for Analysis		-$804.10	6.46%	93.54%

$19 billion as provisioned under the ACA also were restored beginning in 2018, and redistributed to nonexpansion states in accordance with the annual CBO estimates and provisions of the BCRA. An estimated $31.9 billion in DSH cuts remained intact for expansion states between 2018 and 2026. Expansion-agnostic sections of the BCRA that were itemized in the CBO scoring were allocated across states based on their portion of actual federal net Medicaid expenditures observed in FY 2015. Nonitemized portions related primarily to the per capita caps and sunsetting of Medicaid expansion under the ACA were distributed across four sections of the BCRA (sections 126, 130, 131 and 133) using conservative estimates that shifted the majority of the $772 billion total reduction to expansion states. The three-year glide path for the phaseout of enhanced FMAP for Medicaid expansion beneficiaries was simulated using CMS-64 Expenditure Report data beginning in 2021, with three consecutive annual 5 percentage point reductions, and standard FMAP applied in 2024-2026. In addition, a 5, 10 and 15 percent attrition rate for expansion spending was applied in the three years leading up to the glide path to account for states exiting the program, or anticipating the cliff effect in 2024. During the 2021-2023 glide path period, an attrition rate of 30, 40 and 50 percent respectively, was applied to expansion spending as a result of the large shifted burden to states and anticipation of the cliff effect. In 2024-2026, it was assumed that expansion states would only be able to support 25 percent of the expanded Medicaid program compared to the existing law. Individual state decisions on opting into the proposed block grant program in lieu of the per capita caps were not attempted in this analysis; however, the probable impacts of these decisions would likely be marginal compared to the default per capita caps. Table 2 includes a detailed allocation of the Medicaid-related provisions of the BCRA by expansion status that was used to inform this policy brief.

This analysis estimates that expansion states would shoulder 93.54 percent of the total CBO-estimated reduction of $772 billion in Medicaid spending between 2017 and 2026, while nonexpansion states would experience just 6.46 percent of the overall reduction.

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