Medicaid Reforms

- Expansion states are given a six-year "glide path" to regular federal matching funds rates They receive three years (fiscal years 2018 to 2020) at the rates specified in the current ACA law and then begin a three-year phase-down that ends in FY 2024. *This benefits the expansion states.*
- The per capita cap for Medicaid is adjusted by the growth rate specified in the House bill until FY 2025 ― the Consumer Price Index for Medical Services rate for nonelderly, nondisabled adults, children and expansion populations, and the same rate plus one for aged and disabled enrollees. For FY 2025 and after, the annual growth adjustment for all populations is lowered to be the CPI-U (Consumer Price Index for Urban Consumers). *The growth rate follows the House version of the AHCA until FY 2025, when it significantly lowers the growth rate to the CPI-U. The additional language is projected to cost Missouri an additional $2 billion from FY 2025 to 2028.*
- States have flexibility to use any period of eight consecutive quarters from Q1 2014 to Q2 2017 as a base period for the per capita cap.
- Disabled children will be excluded from the per capita cap system.
- The block grant option available to states will not include the elderly, disabled or children. *The Senate included children in the exclusion.*
- The Medicaid DSH allotment reductions slated to take effect under current law on October 1, 2017, will not occur in nonexpansion states. Those reductions in Medicaid DSH allotments will occur in expansion states. Allotments will be adjusted beginning in 2020 to bring nonexpansion states whose per-enrollee Medicaid DSH allotments are below the national average up to the average. A*s a nonexpansion state, Missouri will benefit by being exempted from the Medicaid DSH allotment reductions. Missouri is a high-DSH state and is not expected to benefit from the adjustments to bring some states up to the average.*
- For nonexpansion states, a $2 billion annual fund will be paid out through supplemental payments by raising the federal matching funds percentage to 100 percent for FYs 2018 to 2021 and then lowering it to 95 percent for FY 2022. *This will benefit Missouri and other nonexpansion states.*
- The federal cap on state provider taxes in the Medicaid program is lowered by 0.2 percent each year between 2021 and 2025, effectively lowering the cap to 5 percent in 2025 from the current 6 percent. *At the current federal matching funds rate, a reduction in the federal provider tax cap to 5 percent from 6 percent would reduce hospital provider tax revenues by $100 million. The net effect on hospitals would be a loss of $60 million in federal funds if all the provider tax funds could be used for payments.*
- A Medicaid Institution of Mental Diseases exemption will be available to psychiatric hospitals for specified treatments in 30-day increments, with a cap of 90 days in a calendar year. *This will benefit psychiatric hospitals.*

Market Reforms

- Cost-sharing reduction payments are explicitly funded through 2019, but will be subject to a separate procedural vote.
- Funding of the Stabilization Fund for CMS marketplace plans is excluded from the Senate bill for procedural reasons, but is expected to be included in the CHIP reauthorization

legislation expected to be considered later in the summer. The funding would drop from $15 billion in FY 2018 to $4 billion in FY 2026, totaling $50 billion.

Tax Credits

- The current tax credits available under the ACA will continue for 2018 and 2019, with enhanced targeting for low-income and elderly populations.
- Failure of enrollees to maintain continuous coverage will incur a six-month waiting period.
- Beginning in FY 2020, premium tax credits will be available for coverage of non-Medicaid enrollees with household incomes up to 350 percent of the federal poverty level. Currently, they are available to those with household incomes between 100 and 400 percent of the federal poverty level. *This should enhance access to coverage in non-expansion states such as Missouri.*
- The affordability test is removed for employer-sponsored coverage offerings. *Employer plans may be recognized as meeting the standards of the law, but not be affordable in practice.*
- Beginning in FY 2020, the benchmark plan no longer would be the 2nd lowest cost silver plan, but akin to a bronze plan with greater participant cost-sharing obligations. *This is expected to increase enrollee cost-sharing obligations.*

State Flexibility

- States are given incentives to apply for section 1332 "innovation" waivers from CMS and are allowed to waive "essential health benefit" standards but not the ACA's guaranteed issue or premium rating requirements or coverage of dependents up to age 26.
- States are allowed to set their own medical loss ratios for insurers.
- Premiums may vary by age, but within a 5:1 range. *The House version of the AHCA would allow a broader range of premium variance based on age.*

Miscellaneous Provisions

- The Medicaid ACE Demonstration Program for children would be excluded from Medicaid reforms.
- The ACA's taxes, except the "Cadillac Tax" on high-value coverage, would be repealed. The Cadillac tax would be delayed.