September 22, 2017

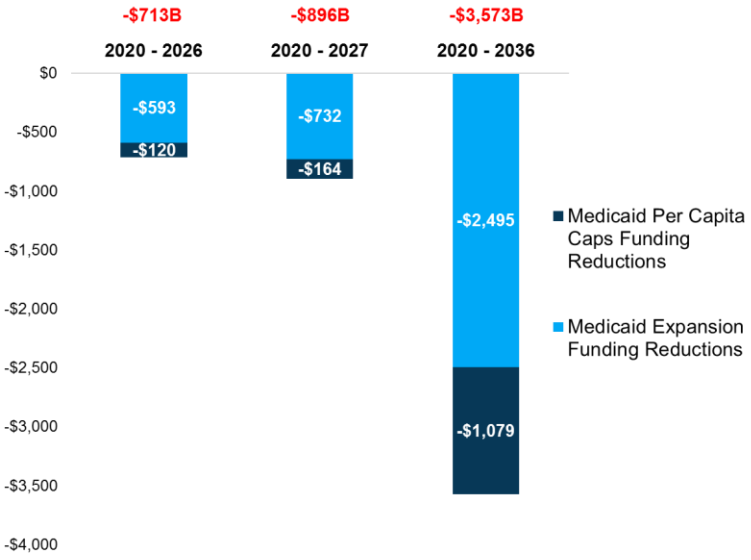
GRAHAM-CASSIDY-HELLER-JOHNSON BILL WOULD REDUCE MEDICAID FUNDS TO STATES BY $713B OVER THE NEXT 10 YEARS

New analysis from Avalere finds that the Graham-Cassidy-Heller-Johnson (GCHJ) bill to repeal and replace the Affordable Care Act (ACA) would lead to a substantial reduction in federal Medicaid funding to states of $713B through 2026 and more than $3.5T over a 20-year period if block grant funding is not reauthorized (Figure 1). States would experience $593B in reductions through 2026 from lower Medicaid funding as part of the block grants, while states would see a $120B reduction due to the Medicaid per capita caps for traditional Medicaid.

The proposed legislation would immediately repeal the ACA's Medicaid expansion in 2020 and instead provide states with a block grant to provide coverage to the population previously covered by the Medicaid expansion, advance premium tax credits (APTCs), cost sharing reductions (CSRs), and the Basic Health Program (BHP). Importantly, states are only permitted to use 15% of these block grant funds for Medicaid and are therefore limited in their ability to use an existing and currently operational program to provide coverage. The remaining funds are required to go to other programs or subsidies for providing health insurance coverage. Additionally, the bill would shift traditional Medicaid from an open-ended approach to a fixed per capita cap on the federal funding going to the states.

"The Medicaid program imposes specific requirements on states related to program eligibility, scope of coverage, and patient protections. Under Graham-Cassidy, states would need to deliver against those requirements with fewer federal dollars," said Caroline Pearson, senior vice president at Avalere. "While block grant funding could be used to support health coverage for very low-income individuals, that coverage would need to be delivered outside of Medicaid."

FIGURE 1: Cumulative Change in Federal Medicaid Funding to States Under GCHJ Compared to Current Law, in Billions



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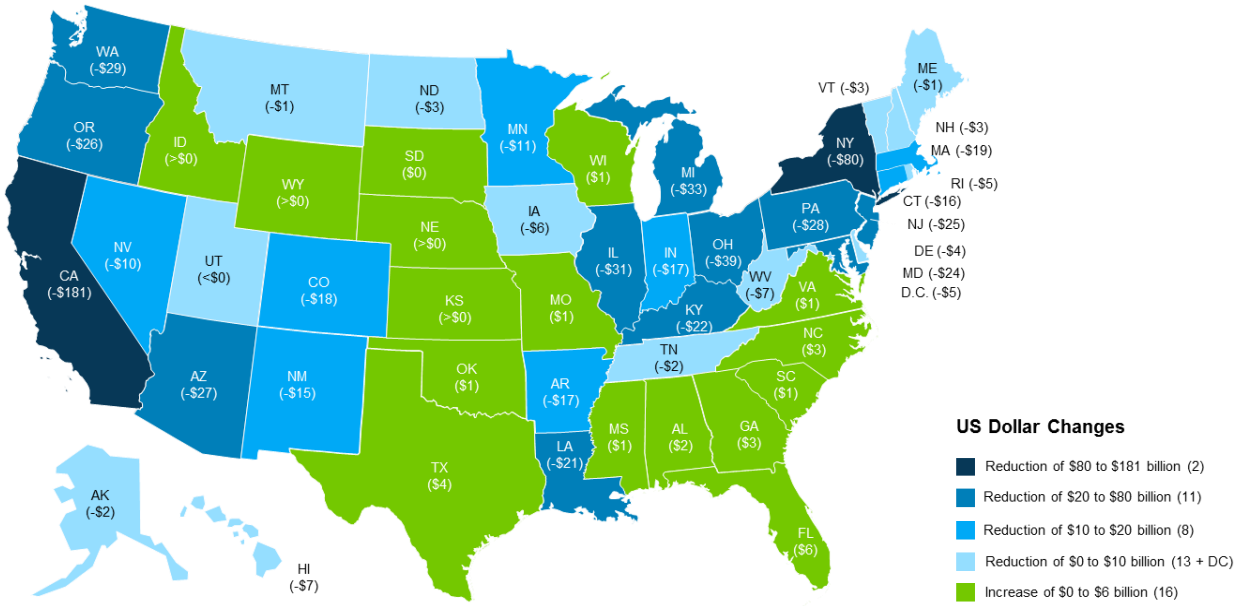
34 states and DC would see Medicaid funding reductions through 2026

Under the bill, 34 states and DC would see substantial reductions in Medicaid funding through 2026. These states include all expansion states and three states (ME, TN, and UT) that see large reductions in their traditional Medicaid spending due to per capita caps. As expansion states are only permitted to use 15% of their block grant allotments in Medicaid, their total Medicaid funding would be substantially reduced.

Notably, states could direct additional funding from their block grants to providing insurance for very low-income residents. However, that additional coverage would need to be delivered outside of Medicaid, and states would be responsible for setting up these new insurance markets.

FIGURE 2: Changes in Federal Medicaid Program Funding Under GCHJ, 2020-2026, in Billions



Through 2026, 16 states could see an increase in their available Medicaid funds

The block grants in the bill are designed to equalize funding between states that decided to expand and those that did not. Since non-expansion states can use up to 15% of their block grant funds for Medicaid, these states could use that money to supplement their existing traditional Medicaid population. The potential Medicaid funding increases range from $0.1B in WY to $6B in Florida. Importantly, were these states to expand Medicaid in future years, they could face cuts under GCHJ.

However, by 2036, all states would see a reduction in their federal Medicaid funding

The bill only establishes block grant funding through 2026, after which point it would need to be reauthorized and appropriated by Congress. If the block grant funding ended as specified in the bill, by 2036, the per capita caps and continued Medicaid expansion funding reductions would result in every state facing Medicaid funding reductions. The cuts range from $1B in WY to $784B in CA. Even if Congress were to reauthorize the block grants after 2026, the Medicaid cuts resulting from lower growth rates for the per capita capos would significantly reduce federal Medicaid funding.

"This bill would place a significant burden on states to establish alternative insurance markets for low-income adults who can no longer be covered by Medicaid," said Richard Kane, senior director at Avalere. "And, setting per capita caps to grow at the rate of overall inflation (CPI-U) for children and adults in traditional Medicaid will likely force states to restrict benefits."

Funding cuts of this magnitude will force states to re-evaluate their Medicaid programs, including the number of individuals covered and the generosity of the provided benefits.

Funding for this research was provided America's Health Insurance Plans (AHIP). Avalere maintained full editorial control.

APPENDIX

EFFECT ON MEDICAID EXPANSION POPULATION

GCHJ legislation would use block grants starting in 2020 to allow states to fund coverage expansion (i.e., Medicaid expansion and BHP) and insurance affordability programs (i.e., premium tax credits and CSR payments). The block grants are funded from 2020 to 2026, after which there is no additional funding appropriated in the bill.

The bill prohibits states from using more than 15% of their block grant allocation in a year to fund their Medicaid program. Given that low percentage, the majority of states would receive far less for their Medicaid programs under GCHJ than under current law.

Under the block grants, funding for the ACA's Medicaid expansion population would be reduced, compared to current law, by $593B, or 77%, from 2020 through 2026. From 2020 to 2036, that reduction is projected to grow to $2,495B, or 93%, relative to current law.

EFFECT ON TRADITIONAL MEDICAID POPULATION

For those who would have historically been covered by Medicaid prior to ACA expansion, federal Medicaid funding would convert to a per capita allotment in 2020 and beyond. Through 2024, the inflation factor would be the consumer price index for medical care (CPI-M) +1% for elderly and disabled and CPI-M for children and adults. After 2024, the inflation factor would be CPI-M for elderly and disabled and the consumer price index for all urban consumers (CPI-U) for children and non-disabled adults. CPI-U measures economy-wide inflation and typically rises at a slower rate than Medicaid or healthcare spending growth. Therefore, tying allotment to CPI-U is projected to lead to significantly lower Medicaid funding for the non-expansion Medicaid population.

Under the per capita caps, funding to states would be reduced, compared to current law, by $120B, or 4%, from 2020 through 2026. This grows substantially to $1,079B, or 12%, from 2020 to 2036.

TABLE 1: GCHJ Federal Medicaid Funding Changes by State Compared to Current Law, in Billions

State	Change in Federal Medicaid Funding Under GCHJ, 2020 - 2026				Change in Federal Funding Under GCHJ, 2020 - 2036			
	Total $	%	Medicaid Expansion /Block Grant $	Per Capita Caps $	Total $	%	Medicaid Expansion /Block Grant $	Per Capita Caps $
Total	**($713)**	**-20%**	**($593)**	**($120)**	**($3,573)**	**-31%**	**($2,495)**	**($1,079)**
AK	($2)	-20%	($2)	($0)	($11)	-30%	($7)	($4)
AL	$2	4%	$2	($1)	($8)	-7%	$2	($11)
AR	($17)	-36%	($17)	($1)	($74)	-47%	($65)	($8)
AZ	($27)	-25%	($21)	($5)	($131)	-37%	($89)	($42)
CA	($181)	-34%	($167)	($14)	($784)	-44%	($645)	($138)
CO	($18)	-34%	($16)	($1)	($80)	-46%	($67)	($13)
CT	($16)	-28%	($14)	($2)	($73)	-39%	($57)	($17)
DC	($5)	-22%	($4)	($1)	($24)	-33%	($15)	($9)
DE	($4)	-24%	($3)	($1)	($18)	-34%	($12)	($6)
FL	$6	4%	$12	($5)	($41)	-9%	$12	($52)
GA	$3	5%	$5	($2)	($15)	-8%	$5	($19)
HI	($7)	-37%	($7)	($1)	($32)	-47%	($26)	($6)
IA	($6)	-21%	($5)	($1)	($29)	-31%	($21)	($8)
ID	$0	1%	$1	($1)	($5)	-10%	$1	($6)
IL	($31)	-25%	($27)	($4)	($149)	-37%	($113)	($37)
IN	($17)	-24%	($16)	($2)	($80)	-35%	($65)	($16)
KS	$0	2%	$1	($1)	($5)	-9%	$1	($6)
KY	($22)	-31%	($21)	($1)	($93)	-42%	($79)	($14)
LA	($21)	-25%	($18)	($3)	($96)	-37%	($73)	($23)
MA	($19)	-21%	($16)	($3)	($92)	-31%	($66)	($26)
MD	($24)	-32%	($22)	($3)	($109)	-44%	($87)	($22)
ME	($1)	-2%	$1	($1)	($9)	-11%	$1	($10)
MI	($33)	-27%	($29)	($4)	($145)	-39%	($114)	($31)
MN	($11)	-17%	($8)	($3)	($57)	-28%	($36)	($21)
MO	$1	1%	$3	($2)	($15)	-10%	$3	($18)
MS	$1	1%	$2	($1)	($10)	-8%	$2	($11)
MT	($1)	-17%	($1)	($0)	($7)	-30%	($5)	($2)
NC	$3	4%	$6	($3)	($20)	-8%	$6	($26)

State	Change in Federal Medicaid Funding Under GCHJ, 2020 - 2026				Change in Federal Funding Under GCHJ, 2020 - 2036			
	Total $	%	Medicaid Expansion /Block Grant $	Per Capita Caps $	Total $	%	Medicaid Expansion /Block Grant $	Per Capita Caps $
ND	($3)	-39%	($3)	($0)	($11)	-48%	($10)	($1)
NE	$0	5%	$1	($0)	($2)	-8%	$1	($3)
NH	($3)	-32%	($3)	($0)	($14)	-42%	($12)	($2)
NJ	($25)	-32%	($24)	($1)	($108)	-43%	($93)	($15)
NM	($15)	-35%	($13)	($2)	($67)	-47%	($53)	($14)
NV	($10)	-44%	($9)	($0)	($41)	-56%	($37)	($4)
NY	($80)	-20%	($63)	($16)	($369)	-30%	($240)	($129)
OH	($39)	-24%	($34)	($5)	($179)	-35%	($134)	($45)
OK	$1	3%	$2	($1)	($9)	-10%	$2	($11)
OR	($26)	-42%	($24)	($2)	($113)	-54%	($98)	($15)
PA	($28)	-19%	($24)	($3)	($116)	-27%	($82)	($34)
RI	($5)	-32%	($4)	($0)	($21)	-43%	($18)	($3)
SC	$1	2%	$2	($2)	($12)	-10%	$2	($15)
SD	$0	3%	$0	($0)	($1)	-8%	$0	($2)
TN	($2)	-1%	$3	($5)	($38)	-10%	$3	($41)
TX	$4	2%	$13	($9)	($69)	-11%	$13	($81)
UT	($0)	-1%	$1	($1)	($9)	-14%	$1	($10)
VA	$1	3%	$3	($1)	($11)	-9%	$3	($14)
VT	($3)	-26%	($2)	($0)	($13)	-39%	($10)	($3)
WA	($29)	-40%	($27)	($2)	($120)	-50%	($104)	($16)
WI	$1	2%	$2	($1)	($10)	-9%	$2	($12)
WV	($7)	-22%	($6)	($1)	($29)	-30%	($22)	($7)
WY	$0	3%	$0	($0)	($1)	-9%	$0	($1)

METHODOLOGY

Current Law Projections Methodology: Avalere used a combination of CMS' Medicaid Statistical Information System (MSIS) and Medicaid Budget and Expenditure System (MBES) data to estimate current Medicaid spending and enrollment. For future Medicaid per enrollee spending and enrollment growth under current law, Avalere relied on the 2016 CMS Medicaid Actuarial Report and U.S. Census Bureau state population projections. Avalere used CBO assumptions for projections of baseline federal Medicaid spending and inflation. Avalere's baseline forecast aligns with CBO's 2016 Medicaid baseline and long-term budget outlook. For the Medicaid expansion population specifically, Avalere projects growth in spending according to the projected Medicaid growth rates in MACPAC's March 2017 Report to Congress on Medicaid and CHIP. Avalere grows the Medicaid expansion enrollment by state specific population and economic projections and does not assume future states expand Medicaid.

To conduct the analysis, Avalere used the Congressional Budget Office's latest September 2017 baseline for Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2017 to 2027 to project federal spending on the ACA's advance premium tax credits, cost sharing reductions, and basic health program through 2027. This created the baseline of expected federal spending for these programs. Avalere then allocated the projected current law federal spending by state using the Centers for Medicare & Medicaid Services (CMS) 2017 Open Enrollment Period State Level Public Use file to determine the average subsidies by state. Avalere then multiplied those by total number of enrollees by state and determined the proportion of spending, for each of the three programs, attributable to each state. For purposes of this analysis, Avalere assumed that relative distribution of enrollees between states remained the same through 2027. For projections through 2036, Avalere assumed that the average historical growth rate for advance premium tax credits, cost sharing reductions, and the basic health program continue.

Graham-Cassidy-Heller-Johnson Bill Projections Methodology: To project the funding available under GCHJ, Avalere used the latest bill text available on the Cassidy Senate website as of September 18, 2017. For purposes of determining the state 2020 baseline funding amounts available to each state, Avalere grew each state's 2017 premium subsidy, cost sharing reduction, and basic health program spending forward by CPI-M until 2020, using the CMS 2017 Open Enrollment Period State Level Public Use. Similarly, to determine the base for the Medicaid expansion population, Avalere used the total spending for the first quarter of 2016, extrapolated to a year, from the CMS 64 Total Medical Assistance Expenditures VIII Group Break Out Report from June 2017.

Avalere also modeled the distribution of the $15B stability funding available for 2020, the $6B available in 2020 for low-density and non-expansion states, and the $5B available in 2021 for low-density and non-expansion states. For purposes of distributing this money, Avalere distributed it to eligible states according to their relative share of the 50% to 138% FPL population.

Importantly, the bill text specifically uses 45% to 133% FPL as the range for distributing the funds. However, given the modified adjusted gross income (MAGI) 5% de minimis, Avalere used 50% to 138% FPL. This is in line with the public statements and analyses from the bill's authors.

For purposes of determining the distribution of funds linked to the population in each state from 50% to 138% FPL, Avalere assumes that the current state distribution, as determined by the most recent 2016 American Community Survey (ACS) data remains stable through 2036. Avalere does not attempt to project state level shifts in poverty.

Avalere was required to make additional assumptions for purposes of determining the number of individuals in each state enrolled in credible coverage from 50% to 138% FPL. Starting in 2024, the formula incents states to offer credible coverage to individuals in this income group. However, states have historically had substantially different reactions to offers of federal funds to cover this population. Additionally, Avalere is not attempting to project which states implement programs to more aggressively cover this population. To provide a proxy, Avalere assumed that the distribution of coverage of these individuals between states would be similar to the 2016 state Medicaid coverage of these individuals. As such, Avalere used the 2016 ACS data on the number of individuals in that income range who had coverage to determine the allocation of these funds between states under the GCHJ block grant formula.

The bill provides states with the option to receive a 5% advance of their 2026 funding in 2020. For purposes of this analysis, Avalere does not assume states utilize that options. Additionally, Avalere does not model the risk adjustment mechanism or state level adjustments to account for higher or lower relative healthcare costs between states. As such, this analysis may underestimate the amount of funding available to states like Alaska, which have substantially higher average healthcare costs than other states. However, as the bill does not provide specific formulas or instructions on how these adjustments would be made, Avalere does not include them in the analysis. Additionally, Avalere does not include disproportionate share hospital (DSH) payments, neither the cuts nor the non-applicability to low-grant states, in its analysis.

As the bill does not appropriate block grant funding to states after 2026, Avalere does not assume any state block grant funding available from 2027 onwards. For the Medicaid per capita caps, Avalere's forecast for this analysis for the years beyond 2026 extends the CMS per enrollee growth projections and Census Bureau state population projections.

Medicaid Funding Reductions Specific Assumptions: For purposes of this analysis, Avalere assumed that the maximum 15% of the allocated block grants that states are allowed to use for Medicaid represents the potential Medicaid funding under the block grants. This amount, in combination with the expected federal funding under per capita caps for the traditional Medicaid population is determined to be the total Medicaid funding available to states. To determine the expected state reduction in Medicaid funding, Avalere compared the available funding under GCHJ to the total expected federal funding projected under current law.

For per capita caps, Avalere does not model an implementation delay for any low-density states.

Specifically for Medicaid expansion, Avalere compared the 15% available under the block grants to the amount of funding a state would have received under the Medicaid expansion. That comparison serves as the basis of the estimates of reduction in funding for Medicaid expansion. Importantly, states are permitted to use their block grant funding, and even encouraged to do so, for the population that was previously Medicaid expansion eligible. However, that coverage must be provided outside of Medicaid, and the Medicaid coverage rules, drug rebates, reimbursement rates, and other provisions that are exclusive to the Medicaid program, and therefore is not counted as Medicaid funding.

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