

Impact on Alaska of Medicaid Provisions in the BCRA

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Health and Social Services

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Overview of Findings

Medicaid covers one in four people in Alaska—more than 185,000 individuals, nearly half of whom are children.

Alaska is expected to lose \$3.1 billion in federal Medicaid funds between federal FY* 2020 and 2026 from the expansion-related changes and the per capita cap

- This amounts to 28% of Alaska’s current law federal Medicaid funding

To stay under the cap, Alaska will need to cut Medicaid spending by \$632 million (federal and state dollars) between FY 2020 and 2026.

- Reductions double between 2024 and 2026 – and would continue to deepen – as a result of use of CPI as the trend rate beginning in 2025.

Nearly 34,000 expansion adults could lose coverage, and the remaining children, seniors, people with disabilities, and other adults covered by Medicaid are at increased risk for cuts.

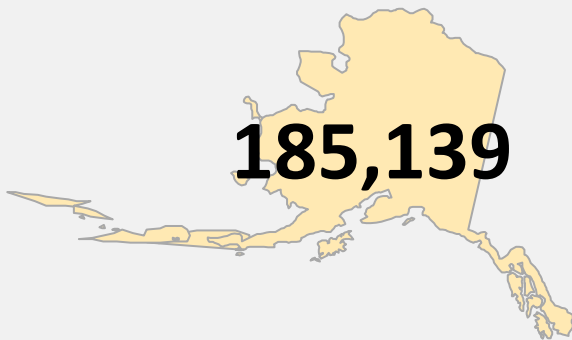
These estimates reflect that individuals who use Indian Health Service (IHS) or Tribal facility services and disabled children are excluded from the cap. In practice, however, rate reductions, benefit cuts and other changes Alaska makes to stay under the cap would adversely affect them.

Role of Medicaid in Alaska

Alaska: Medicaid Enrollment

Medicaid covers **one in four people** in Alaska
Children represent **nearly half** of Alaska's Medicaid beneficiaries

Total Medicaid Enrollment, May 2017

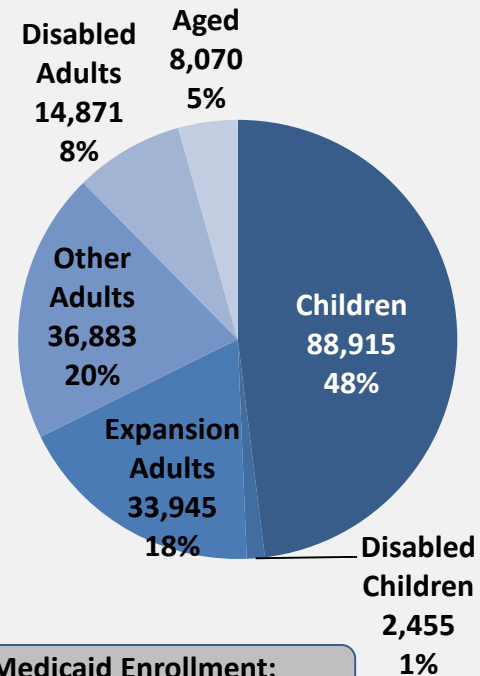


Share of Alaska Medicaid Enrollees in Working Households, 2015



Eight in Ten

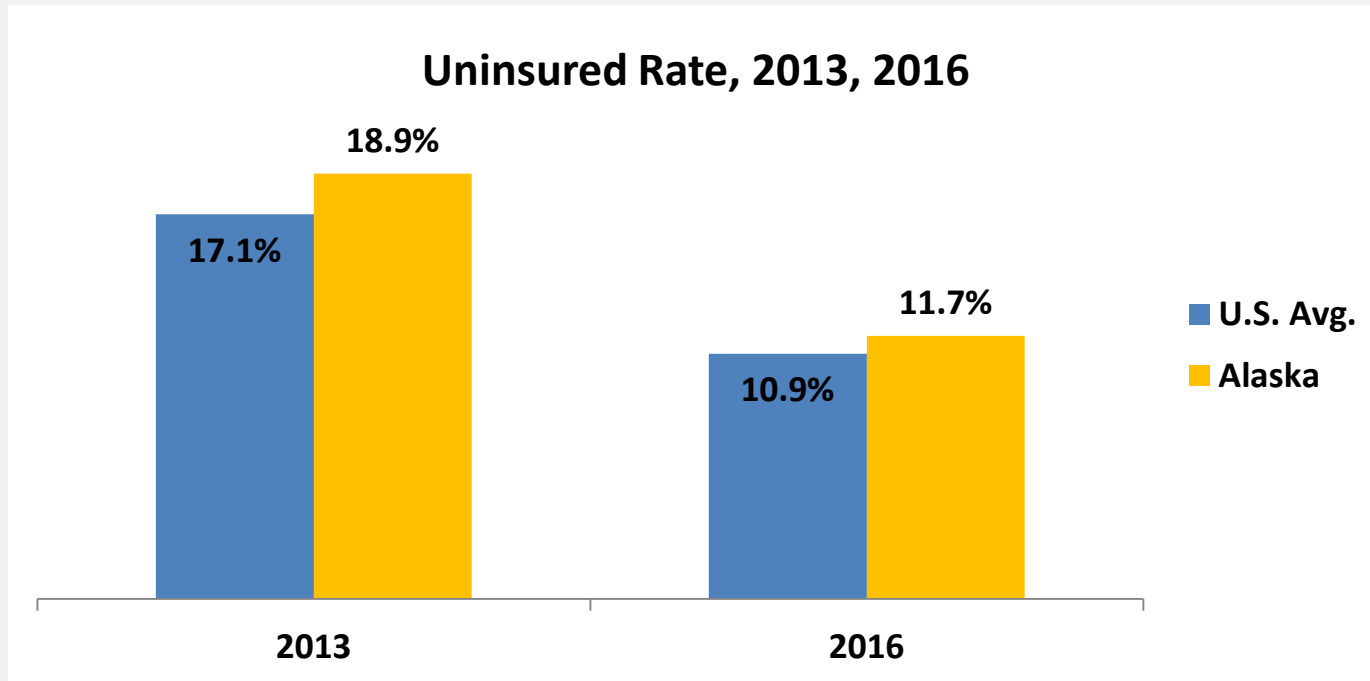
Medicaid Enrollment by Eligibility Category, May 2017



Total Medicaid Enrollment:
185,139

Alaska's Uninsured Rate Dropped After Expansion

Alaska's uninsured rate has fallen considerably since the implementation of the ACA, particularly since the Medicaid expansion took effect



Alaska expanded Medicaid on September 1, 2015

Alaska receives federal funding for all allowable program costs

- **Federal dollars guaranteed as match to Alaska spending**
- **Matching rates vary by population and service**
 - For many beneficiary groups and services, matching rate in FY 2017 = 50.00%
 - Matching rate for expansion adults = 95% in 2017; 90% in 2020 and beyond
 - Indian Health Service and Tribal Facility services matching rate = 100%
- **The federal government and Alaska share in the risk if there are higher than expected health care costs, for example:**
 - Higher than expected enrollment
 - Public health epidemics (e.g., the substance use epidemic)
 - Breakthrough treatments or medications
 - New initiatives related to delivery system reform or access

Major Medicaid Provisions in the BCRA

Like the AHCA, the BCRA includes major changes to Medicaid:

- Converts Medicaid to a per capita cap with state option for block grant for non-disabled/non-expansion/non-elderly adults (very low income parents and pregnant women)
- Phases out enhanced federal funding for Medicaid expansion (2021-2023); enhanced funding ends in 2024

BCRA makes additional cuts to Medicaid over and above the AHCA, including:

- Reduces the per capita cap trend rate to CPI in 2025 and beyond
- Extends ACA DSH cuts for Medicaid expansion states even after enhanced expansion funding is eliminated
- Reduces the allowable provider tax threshold

CBO projects that the BCRA would reduce federal Medicaid spending by \$772 billion over 10 years (2017-2026) and Medicaid coverage by 15 million in 2026

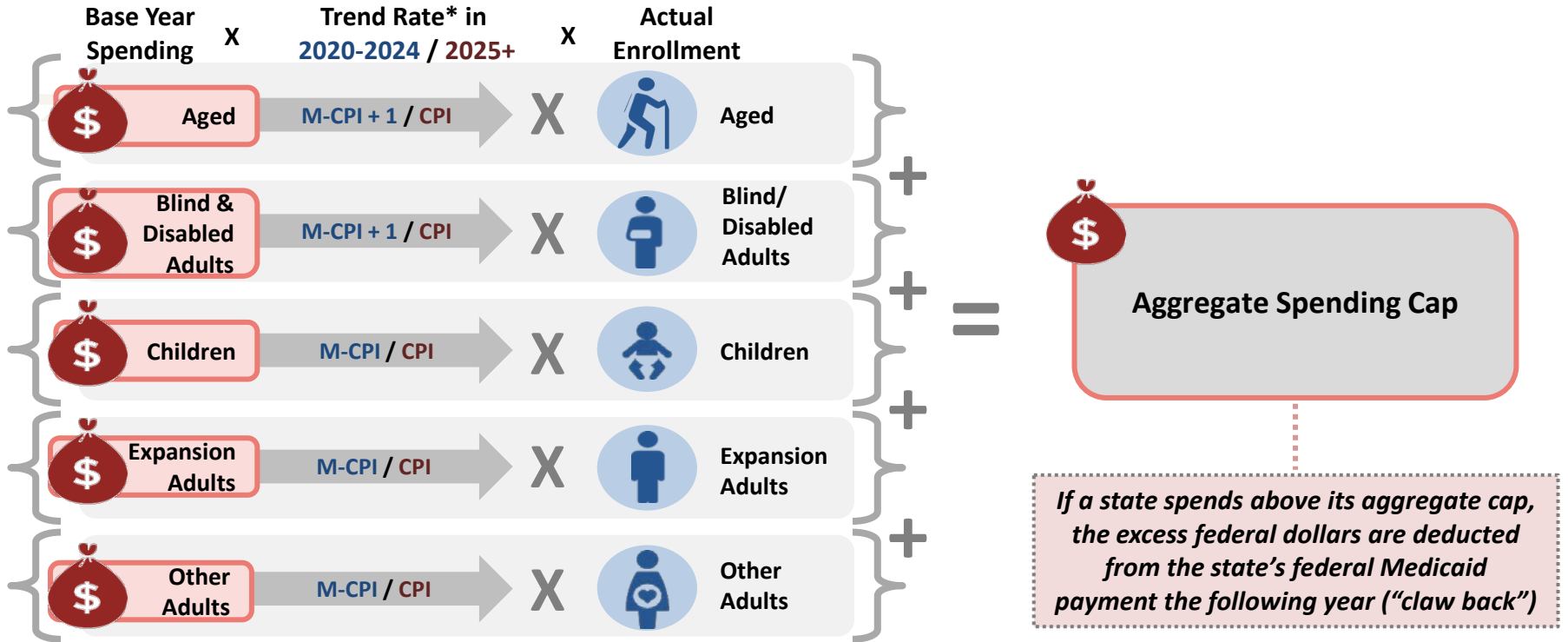
Alaska at Risk for All Spending Above Cap

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- **The BCRA establishes an aggregate cap on federal Medicaid expenditures for each state beginning in FY 2020 based on per capita caps for 5 eligibility groups**
 - Spending on beneficiaries who use IHS or tribal facility services are excluded from cap
 - Unlike House bill, BCRA also excludes spending for children enrolled based on disability
- **The per capita cap for each eligibility group is based on Alaska's historic spending per enrollee increased by a national trend rate**
 - Through 2024, trend rate is medical component of the consumer price index (medical CPI), with 1 percentage point added for seniors and people with disabilities during 2020-2024
 - Starting in 2025, BCRA (unlike House bill) imposes the lower trend rate of CPI on all groups
 - Alaska and other "low-density" states are exempt from the BCRA provision that adjusts caps for states that are more than 25 percentage points above or below national average
- **All spending over the cap would be fully at state cost. If Alaska spends in excess of cap, federal government will "claw back" overpayments in the next year**

BCRA: Per Capita Cap Formula

Like the AHCA, **aggregate cap** on Medicaid funding is built up from **per capita caps** for five different eligibility groups



Cap calculation excludes certain enrollees (i.e., those receiving any Medicaid-funded services through an Indian Health Service or Tribal facility, children enrolled based on disability, CHIP-financed children, and partial benefit enrollees). Cap also excludes certain types of payments, including administrative funds and disproportionate share hospital (DSH) payments.

*To calculate states' starting caps in FY 2020, base year spending is trended by medical CPI; from 2020- 2024, medical CPI+1 is used to trend and calculate the aged and disabled spending caps, while medical CPI continues to apply to children, expansion adults, and other adults; beginning in FY 2025 and thereafter, CPI is used for all eligibility groups.

Per Capita Cap is Retrospective

States will not know two key elements of the cap - trend rate and enrollment - until after the budget year. Alaska will have to establish its Medicaid budget almost *two years before* it learns the amount of federal Medicaid funding available for that year

Governor and legislature determine Medicaid budget for State fiscal year: July 1, 2019 - June 30, 2020

End of federal fiscal year 2020

Fall-Spring
2018-2019

October 1,
2019

September 30,
2020

Late 2020

Start of federal fiscal year 2020
Caps applied for each federal
fiscal year

State learns final cap for the
year that has ended based on
actual trend rate and final
enrollment tallies

BCRA: Key Medicaid Expansion Provisions

Maintains enhanced federal Medicaid funding for existing expansion states through 2020, before phasing down, and ultimately eliminating, enhanced federal funding in 2024:

- Phases down enhanced funding beginning January 1, 2021:
 - 2021: 85%
 - 2022: 80%
 - 2023: 75%
 - 2024+: State's regular FMAP
- Reduces enhanced federal Medicaid funding for “leader states” after 2017 through 2023
- Re-characterizes expansion group from “mandatory” as “optional” beginning January 1, 2020

Maintains ACA DSH cuts for expansion states only, even after enhanced expansion funding is eliminated

The BCRA puts Alaska's expansion at risk beginning in 2020 even before the phase down of the enhanced match because of the classification of Medicaid expansion as an optional group

Estimated Impact of Changes

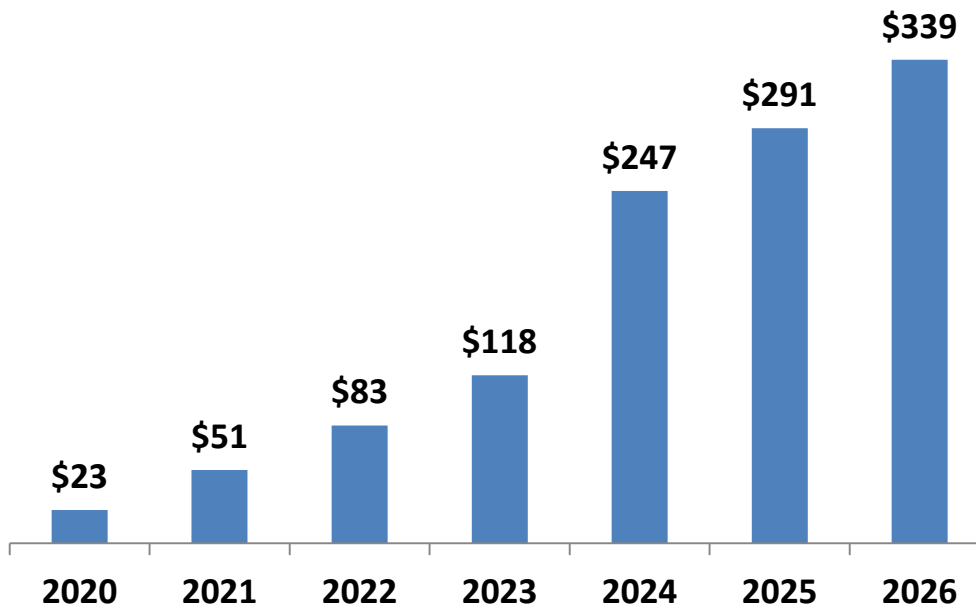
Key Assumptions

Maintaining Current Medicaid Program May Not Be Feasible

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Alaska would have to substantially increase State General Fund spending to maintain current Medicaid program spending under the BCRA

Additional State Funds Required to Maintain Alaska's Current Medicaid Program, FY 2020-2026 (millions)



During FY 2020-2026, Alaska would have to increase its own spending by **\$1.2 billion**, or about **13%**, to replace lost federal funds from expansion financing changes and the per capita cap

The remainder of this analysis assumes that Alaska drops expansion coverage beginning in **2020** and cuts overall Medicaid spending to stay under the BCRA aggregate cap

Source: Manatt Medicaid Financing Model

Note: Additional State funds required to replace federal cuts due to the loss of enhanced expansion funding and the per capita cap (\$1.2 billion) is *not* equal to the federal cut that Alaska would face under these provisions (\$3.1 billion) if Alaska drops expansion coverage in 2020. If Alaska eliminates expansion coverage in 2020, as modeled in subsequent slides, it will lose enhanced federal match *and* forego regular federal matching funds for these individuals.

Key Assumptions for Alaska Modeling

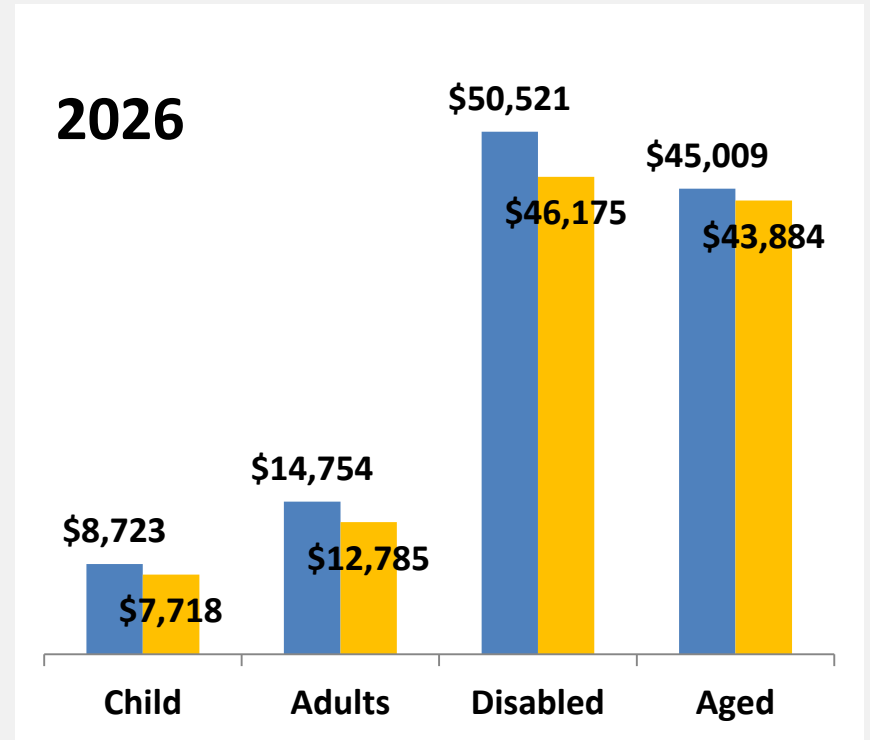
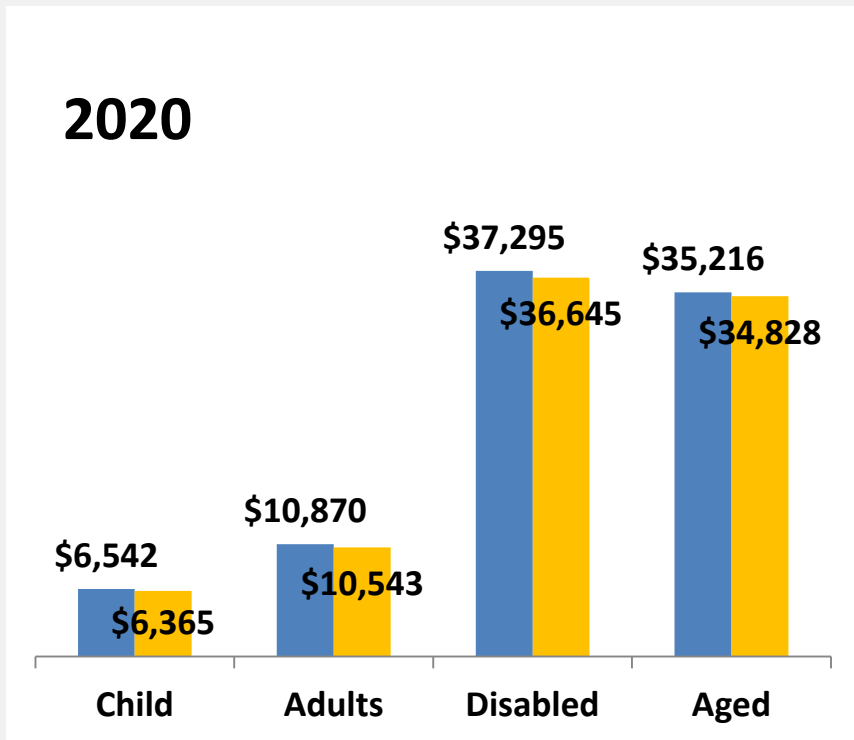
Unless otherwise noted, estimates assume the following:

- **Baseline (current law) spending per enrollee growth** based on Centers for Medicare & Medicaid Services (CMS) Office of the Actuary national projections
- **Medical CPI growth** at 3.7% and **overall CPI growth** at 2.4%, based on Congressional Budget Office (CBO) national projections
- **Individuals who use services through Indian Health Service and Tribal facilities and children who qualify based on disability are excluded from the cap**
- **Alaska's response to policy changes**
 - Expansion is dropped in 2020 given state law and BRCA's re-characterization of the expansion group as "optional"
 - Alaska reduces spending to stay below the cap (ie., state avoids the clawback and does not spend state dollars that will not be matched by the federal government)
- **Estimates are federal FY values**
- **Estimates exclude administrative costs**

Estimated Impact of Per Capita Cap

Medicaid Spending in Alaska Projected to Exceed Caps

Alaska Baseline Spending Per Enrollee and Estimated Caps, FYs 2020 and 2026

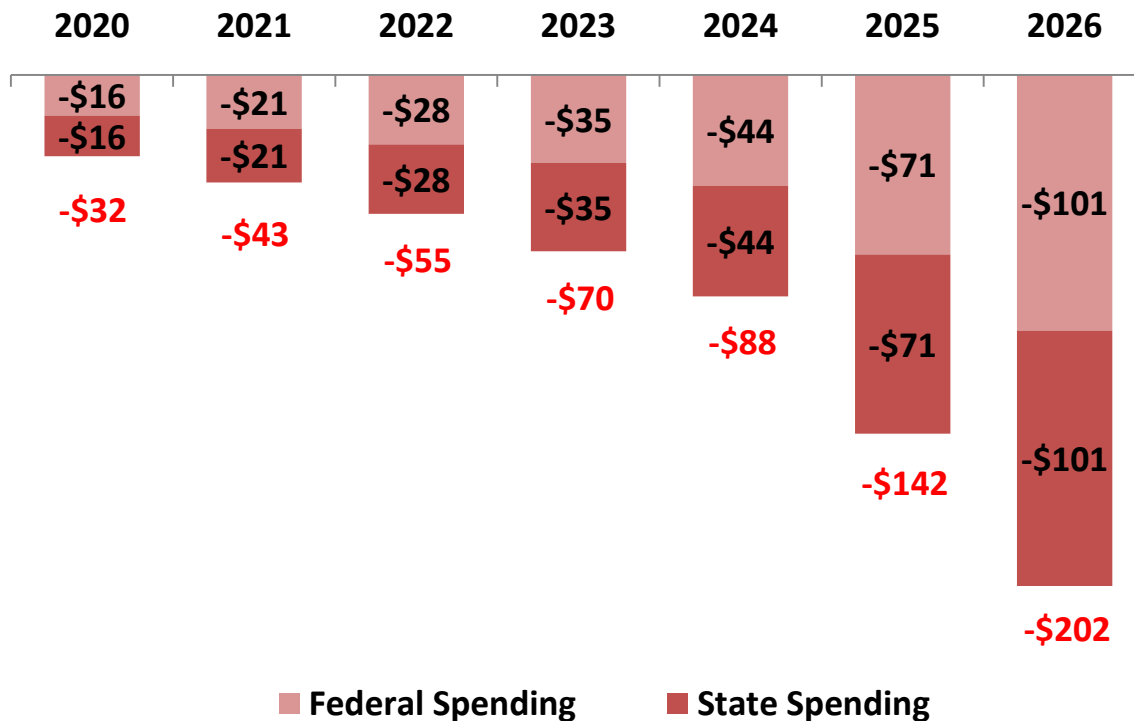


■ Baseline spending in Alaska ■ Estimated caps

Estimated Impact of Per Capita Cap

The per capita cap alone (i.e., without factoring in reduced funding for expansion) is estimated to result in total cuts of more than \$600 million between FY 2020 - 2026

Impact of Per Capita Cap, FY 2020-2026 (millions)

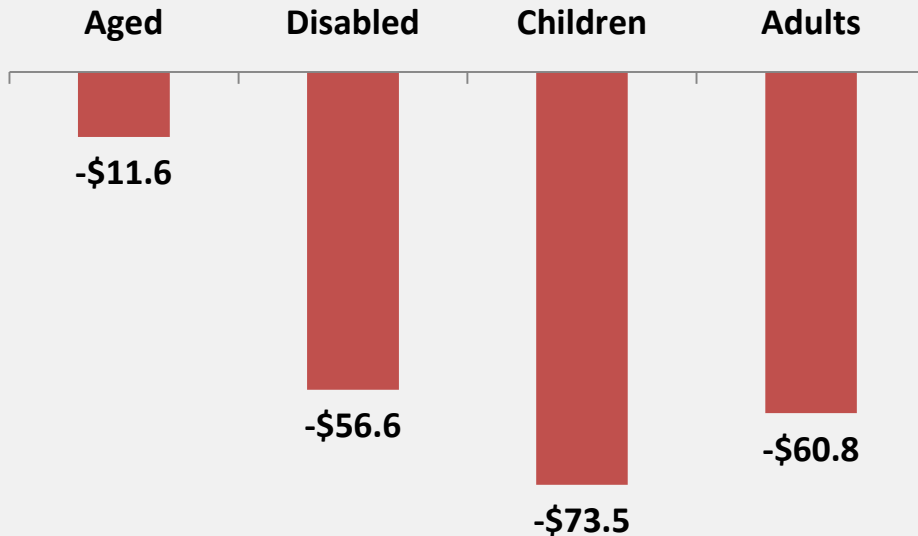


- To keep below the caps, total Medicaid spending (federal and State) in Alaska is estimated to decrease by **\$632 million** during FY 2020-2026,
- Federal spending is expected to drop by **\$316 million**
- **Annual cuts more than double** between 2024 and 2026 because of the lower trend rate

Contribution to Impact of Per Capita Cap Varies by Group, but Resulting Cuts Could Be Applied to Any Group

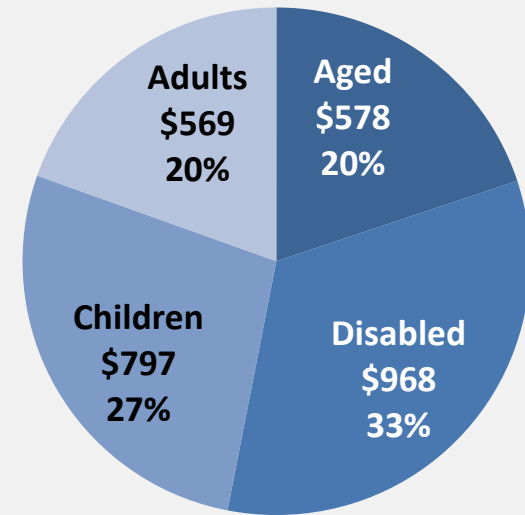
- Estimated FY 2026 spending of \$2.9 billion would leave Alaska \$202 million over its projected cap
- State would need to cut spending by \$202 million in FY 2026, or face a clawback the following year

Estimated Contribution to Impact of the Cap, FY 2026 (millions)



Total: \$202 million

Estimated Spending Prior to Per Capita Cap Cuts, FY 2026 (millions)



Total: \$2.9 billion

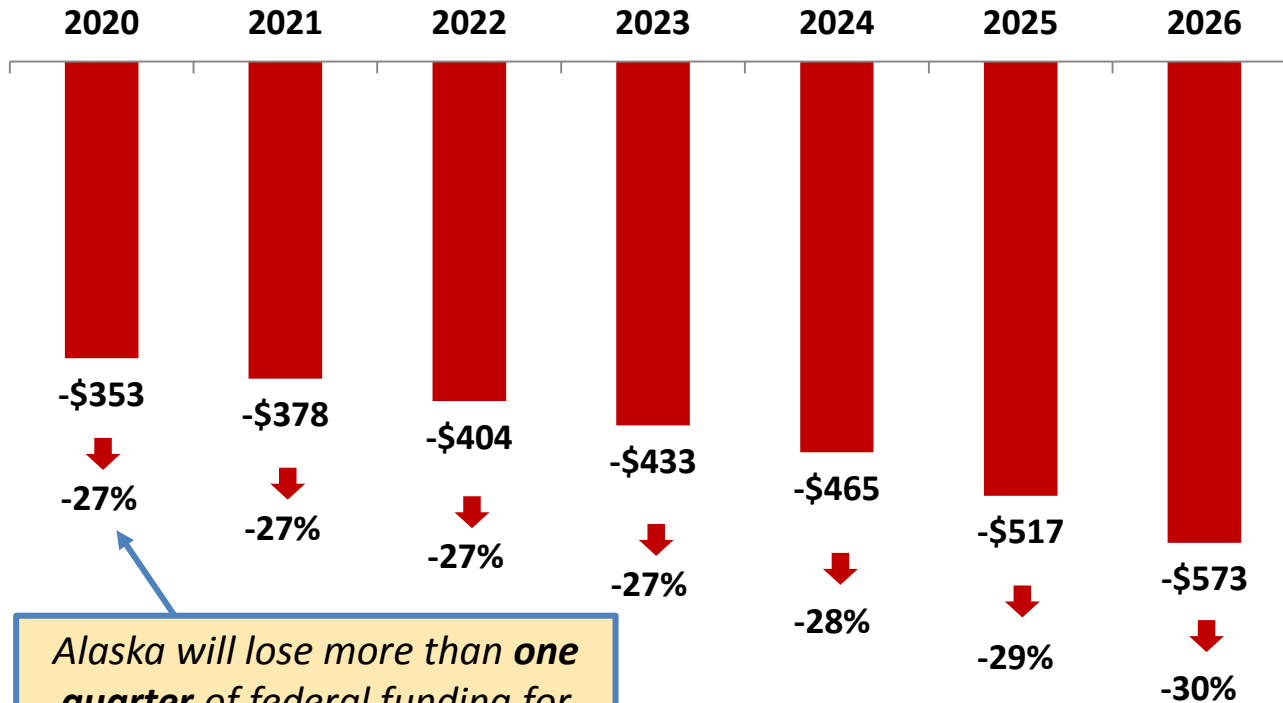
Individuals exempt from the cap – users of IHS and Tribal health facilities and children enrolled based on disability – could be affected by the cuts necessary to stay below the cap

Estimated Impact of All BCRA Medicaid Cuts

Impact on Alaska's Federal Medicaid Funding

The per capita cap and elimination of enhanced funding for expansion would result in substantial federal funding reductions for Alaska

Estimated Cuts to Federal Medicaid Funding, FY 2020-2026
(millions and share of baseline)

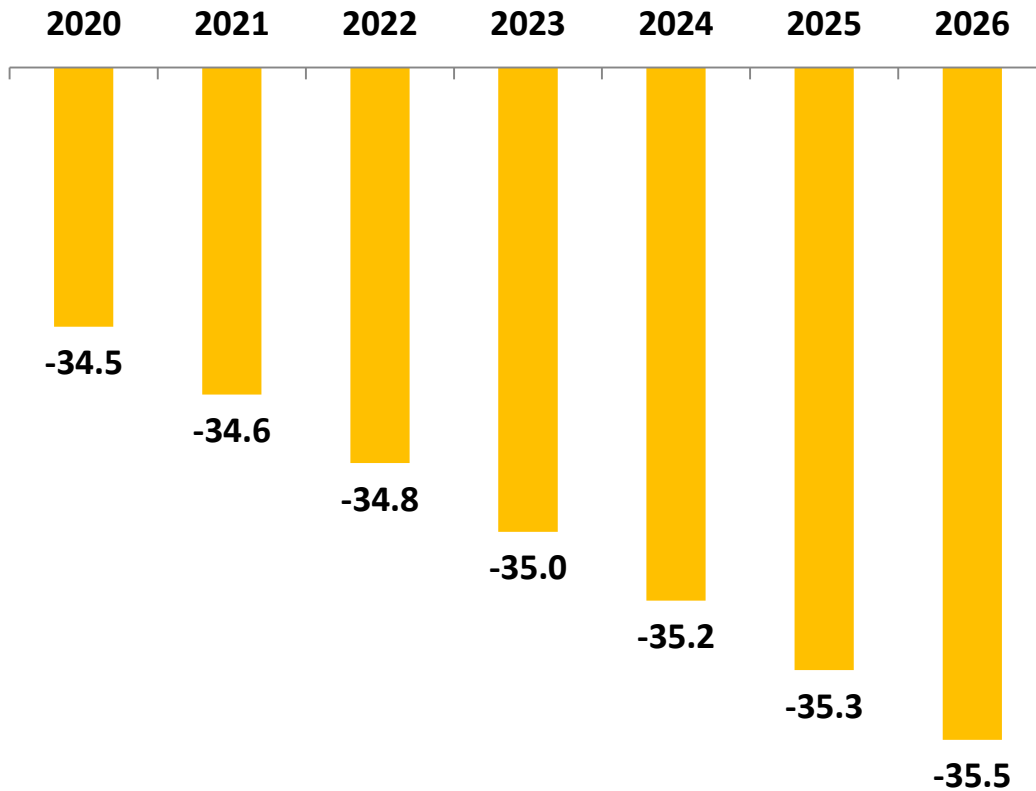


\$3.1 billion (27.9%) reduction in federal funding for Alaska's Medicaid program during FY 2020-2026

Alaska will lose more than **one quarter** of federal funding for Medicaid relative to baseline **in the first year**

Alaska Medicaid Enrollment Will Drop Substantially

Drop in Expansion Adult Enrollment,
FY 2020-2026 (thousands)



State legal authority for maintaining the expansion would be in question under the BCRA because the bill changes the characterization of the expansion from “mandatory” to “optional”

Enrollment changes could be more significant than estimated here – and extend beyond expansion adults – if Alaska responds to the per capita cap by scaling back coverage

Uncertainty and Risk Under Per Capita Cap

Estimates of the impact of a per capita cap are highly sensitive to key assumptions, including:

- Baseline spending growth
- Projections of medical CPI

Alaska's financial exposure may be even greater if reality differs from key assumptions and projections

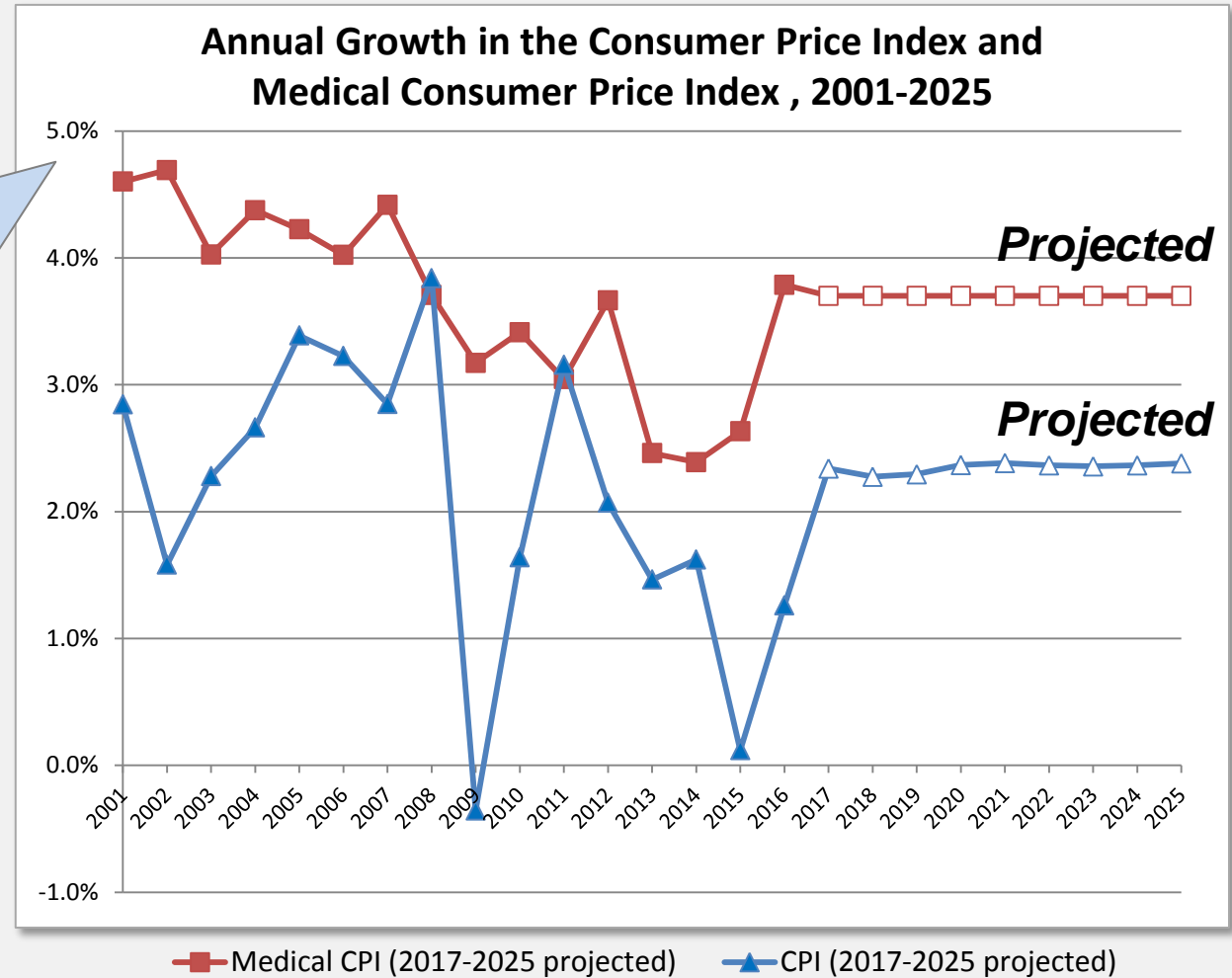
- Unanticipated spending pressures:
 - Continued worsening of substance use epidemic or other public health crisis
 - Breakthrough treatments or medications
 - Increase in pre-term births that drives up per capita cost of serving children
- Trend rate diverges from expectations:
 - Higher or lower medical CPI than projected
 - Further legislative changes to the trend rate

Actual Trend Rates - Which are Highly Volatile - Will Determine Impact on Alaska

Between 2001-2016, annual growth in medical CPI ranged from a low of 2.4% to a high of 4.7%.

CPI is even more volatile

Even a 0.1% difference in the actual trend rates can have a significant impact when calculating a state's aggregate spending cap under a per capita cap.



Key Implications

The Stakes for Alaska: Recap

Medicaid covers one in four people in Alaska—more than 185,000 individuals, nearly half of whom are children.

Alaska is expected to lose \$3.1 billion in federal Medicaid funds between federal FY* 2020 and 2026 from the expansion-related changes and the per capita cap

- This amounts to 28% of Alaska’s current law federal Medicaid funding

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Appendix

Growth in Medicaid Spending Per Full Benefit Enrollee, FY 2000-2011

Children		
Rank	State	Average Annual
1	NM	11.6%
2	VT	10.2%
3	RI	9.4%
4	VA	8.9%
5	TX	8.4%
...		
22	AK	5.8%
...		
U.S. Avg.		5.3%
...		
47	OR	1.8%
48	CO	1.7%
49	UT	1.6%
50	HI	1.1%
51	ME	0.4%

Adults		
Rank	State	Average Annual
1	NM	14.4%
2	AR	12.1%
3	VT	12.0%
4	MO	11.7%
5	PA	10.9%
...		
36	AK	5.7%
...		
U.S. Avg.		5.6%
...		
47	NY	2.9%
48	IL	2.5%
49	ME	1.8%
50	TN	1.5%
51	IA	0.3%

Disabled		
Rank	State	Average Annual
1	HI	15.5%
2	AZ	8.1%
3	MS	6.9%
4	TN	6.8%
5	CA	6.6%
...		
14	AK	5.4%
...		
U.S. Avg.		4.5%
...		
47	ME	2.1%
48	RI	2.0%
49	IL	1.5%
50	KS	1.4%
51	NH	0.5%

Aged		
Rank	State	Average Annual
1	TN	13.3%
2	MS	10.8%
3	AK	8.3%
4	AR	8.3%
5	FL	7.3%
...		
U.S. Avg.		3.7%
...		
47	MI	-0.3%
48	NE	-0.5%
49	IL	-0.7%
50	WA	-1.4%
N/A	NM	N/A

Additional Medicaid Provisions New to BCRA

- Reduces allowable provider tax threshold from 6% to 5% in FY 2025 and beyond; phase down begins in FY 2021
- Offers states the option of covering mental health and substance use disorder services provided to Medicaid beneficiaries ages 21 to 65 in Institutes of Mental Disease (IMDs) under certain conditions; match rate will be 50%
- Establishes new bonus pool to reward states that spend below their aggregate caps and meet quality metrics in a given FY (available from FY 2023-FY 2026)
- Permits 6-month redetermination of expansion adults at state option
- Permits states to continue “grandfathered managed care waivers” in perpetuity through state plan authority, subject to meeting certain conditions
- Requires HHS Secretary to solicit advice from state Medicaid agencies and Medicaid Directors before promulgating proposed rules with impacts to Medicaid program operations and financing

Additional Medicaid Provisions in Both BCRA and AHCA

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- Ends the requirement for states to provide beneficiaries with retroactive coverage effective October 1, 2017
- Lowers minimum income eligibility for children ages 6+ from 133% FPL to 100% FPL effective January 1, 2020
- Eliminates option for states to expand Medicaid to adults with income > 133% FPL after December 31, 2017
- Permits state option to condition Medicaid eligibility on work requirements for certain adults ages 19 to 64 beginning after October 1, 2017
- Prohibits states from using Medicaid funds to pay for services provided by Planned Parenthood clinics for a period of one year from enactment of the bill
- Ends the requirement that alternative benefit designs for Medicaid meet the EHB standard as of January 1, 2020
- Ends two provisions that provide people with temporary coverage pending a full review of their application, effective January 1, 2020
- Eliminates the six percentage point increase in the federal match rate for home and community-based services for community integration, effective January 1, 2020

Designed to assess state-by-state impact of Medicaid financing changes

- Per capita cap
- Block grant
- Reductions in federal funding for expansion

Uses publicly-available data to establish baseline for each state, for example:

- CMS-64 data on total Medicaid expenditures and expansion adult and total enrollment
- MSIS/MAX data on expenditures by eligibility group
- State-specific population growth projections from the Census Bureau
- CMS and CBO national growth projections by eligibility group
- CMS and CBO projections of medical CPI

Allows for sensitivity analysis

- Alternative inputs
- Diversion from projections
- State behavioral response