The American Health Care Act and MinnesotaCare and Medicaid, Minnesota’s Public Health Care Programs

This brief offers an analysis of the American Health Care Act (AHCA) as it was passed by the U.S. House of Representatives on May 4, 2017.

The legislation would have sweeping consequences in Minnesota.

- The bill goes beyond just repealing the Affordable Care Act, as it reduces federal funding across the entire Medicaid program, which will impact our most vulnerable residents.
- About 1.2 million low-income Minnesotans — including children, seniors and people with disabilities — would face significant cuts in coverage or a loss of coverage altogether.
- Minnesota stands to lose a total of about $2.3 billion in the first 18 months of implementation. This loss accumulates to over $31 billion dollars in federal funding by 2030, a loss which increases and compounds over time, putting a significant strain on our state budget for years to come.
- The bill maintains Medical Assistance (Minnesota’s Medicaid program) as an entitlement program but cuts the federal government’s share of the cost.
- The cuts in funding to public programs would be used to pay for tax breaks for corporations, health insurers and drug companies. At the same time, our most vulnerable residents would lose coverage or access to needed services.

On March 6, Congress introduced the American Health Care Act, H.R. 1628, as a replacement of the Affordable Care Act (ACA). An amended version of the Act was passed by the U.S. House of Representatives on May 4, 2017. This bill would have a direct and detrimental financial impact on Minnesota’s public health care programs that serve 1.2 million Minnesotans.

First, the AHCA significantly reduces federal spending on Medicaid by establishing per capita caps in 2020 (i.e. capping the amount of funding per enrollee, leaving states alone in bearing the burden of the remaining costs for the program, including the rising costs for medical services, devices and pharmaceuticals set by the market.). Second, the bill ends the enhanced federal funds now available to help states cover adults who are eligible for the Medicaid expansion. And third, it eliminates federal funding for MinnesotaCare as a basic health plan under the Affordable Care Act.

Medical Assistance (MA) covers more than one million people, one in every five Minnesotans. MinnesotaCare provides low-cost coverage to about 100,000 Minnesotans who earn too much to qualify for Medicaid but not enough to afford health insurance in the private market.
Minnesota stands to lose billions each year in federal funding for its public health care programs.

The per capita caps in the AHCA would cap federal funding for MA in five categories of enrollees: children, seniors, blind and disabled, Medicaid-expansion adults and other adults. All Medicaid beneficiaries and services would be capped, including people receiving waiver services such as home and community-based supports and services, with a few exceptions.¹

In general, these caps would be allowed to grow at the rate of the medical care consumer price index (CPI), except that seniors and people with disabilities would grow at this rate but be given an additional percentage point.² This would allow for growth in federal spending that adjusts for some medical costs, but not at a rate that would cover the projected higher costs of Medicaid populations. States exceeding their cap limits in any given fiscal year would be responsible to pay back a portion of the excess spending through a reduction in their federal funding in the following fiscal year. The immediate effects of the AHCA on Minnesota’s Medicaid and MinnesotaCare programs would begin Jan. 1, 2020. **By the end of the first 18 months, or state fiscal year 2021, Minnesota would face a total loss in federal funding of about $2.3 billion.** As illustrated below, the magnitude of the lost funding to the state increases substantially over time, as the forecasted spending for these programs exceeds the inflation factor set by the cap formula by an average of 2.3 percentage points.³

1 This bill does exclude certain groups from the caps, including some children receiving child health assistance under title XXI, individuals who receive services that are paid at the enhanced match rate under section 1905(b) of the Social Security Act, people receiving services under the Medicaid breast and cervical cancer services program, and enrollees in partial-benefit programs — emergency medical assistance, Medicare cost-sharing, family planning services and Tuberculosis-related services. Administrative costs, spending on Disproportionate Share Hospital and Medicare cost-sharing are excluded from expenditures eligible for the cap. The bill also provides for an adjustment for any payments to safety-net providers in non-expansion states.

2 The bill would cap growth in per-enrollee payments for most people in Medicaid at no more than the medical care component of the CPI (CPI-M). For those who are disabled or over 65, the bill would cap such payments at no more than CPI-M plus one percentage point, starting in 2020. For more information on the medical component of the consumer price index, see [www.bls.gov/cpi/cpifact4.htm](http://www.bls.gov/cpi/cpifact4.htm)

3 Federal funding caps under AHCA would be based on expenditures for these populations in fiscal year 2016 that are trended forward to 2019 and subsequent years by the consumer price index for medical care.
The AHCA dramatically cuts federal support for Medicaid.

Medicaid is an entitlement program, which means that anyone who meets the eligibility criteria for the program will receive its services for as long as they need them. The federal government shares in the costs with states through a guaranteed matching-rate structure. The federal government covers at least half of the costs, and the matching percentage rises for states with lower personal per capita income. Currently, in general, Minnesota receives the lowest available federal matching reimbursement rate of 50 percent.

**Under the AHCA, who and what is covered under the Medicaid program does not change but a significant part of the federal government’s funding responsibility would be shifted to the state.** The proposed caps on federal spending are a fundamental departure from the current state-and-federal partnership. The AHCA would force states to make difficult decisions to balance revenue and expenditures.

By federal law, states have limited means to reduce costs as they are required to cover certain populations at minimum income standards, maintain a minimum benefit set and pay providers at reimbursement rates that are designed to produce acceptable access to care. For example, Medicaid is required to cover all drugs that are part of the federal rebate program, preventing states from managing their own drug formulary.

As illustrated below, applying the per capita caps and eliminating enhanced funding for expansion adults and federal funding for MinnesotaCare, as proposed by the AHCA, would have the effect, over time, of greatly increasing the state’s share of public health care program costs.

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- **58%** Minnesota, **42%** Federal
- **37%** Minnesota, **63%** Federal

By state fiscal year 2025, a cumulative **5-year loss of federal funding amounts to $11.4 billion**, with an annual loss of **$2.8 billion**.

By state fiscal year 2030, a cumulative **10-year loss of federal funding amounts to $31.1 billion**, with an annual loss of **$4.8 billion**.
The AHCA’s fundamental change in the state-federal partnership shifts costs to people as well as the state budget.

Drastic cuts in federal funding would limit Minnesota’s ability to respond to the changing health needs of our state. Our hands would be tied during unforeseen economic or public health disasters and increases in the cost of care, including unanticipated spikes in drug prices, increasing need for home care and community supports, and the rising demands for higher wages for low-paid workers. This is especially problematic given the rapidly growing population of seniors combined with a developing workforce shortage, which is expected to exert increasing pressure on state health care budgets. Projected expenditure growth for Minnesota’s Medicaid program through 2021 for seniors and people with disabilities is about 7 percent, compared to 4 percent for adults and children. Currently, seniors and people with disabilities make up about 17 percent of enrollment in Minnesota’s Medicaid program, yet represent over half of the spending in the program.

To compensate for the substantial and ongoing loss in federal dollars under the AHCA, Minnesota lawmakers would need to decide whether to absorb or pay for these losses in the state budget, drastically reduce the cost of care through various changes to the program or reduce other state spending. Other state budget priorities such as education, public health, transportation, agriculture and aid to local governments would be affected as leaders encounter hard decisions about how limited state dollars are spent.

Minnesota has already put many innovations and reforms in place to produce savings in its Medicaid program, which means we have a limited number of options to help guard against the magnitude of these federal cuts. **Minnesota would be unable to absorb increased costs without reducing optional benefits and eligibility levels, including home and community-based services and supports, covering children with disabilities in higher-income families (the TEFRA option) and enrolling people with disabilities who are employed (known as MA-EPD) without an income limit.**

A reduction in federal funding would likely shift costs to:

- **Patients** in the form of lost coverage, increased cost-sharing (co-pays and deductibles), or loss of services.
- **Providers** in the form of reduced reimbursement and uncompensated care.
- **Local governments** such as counties that pay a share of certain Medicaid services like chemical dependency, mental health and longer nursing home stays.4
- **Private market consumers and employers** through higher premiums and costs due to more people becoming uninsured, thereby increasing uncompensated care costs for providers.

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4 Under the existing financing structure for Medicaid, federal matching funds help cover the costs of these requirements, including the cost of supporting the state’s county-based administrative infrastructure. Counties in Minnesota provide case management, eligibility work and other functions related to administering the MA program. In fiscal year 2016, county governments in Minnesota received $284.3 million in federal funding for Medicaid. A large-scale reduction in federal funds with a per capita cap would put a strain on these critical local resources and the state’s ability to sustain funding levels to support a county-based infrastructure. This could force the state to choose between covering enrollees and paying for operational costs and staff.
Furthermore, the per capita caps under the AHCA would make it difficult for states to control for rising costs in one eligibility group by reducing the average cost in another group.

The caps are derived from an average cost per person in five separate eligibility groups from 2016, trended forward to the capped year, and multiplied by the number of enrollees in each category. To keep total spending below the caps, Minnesota would be required to reduce the average per capita cost within each eligibility category.

The chart below shows the projected loss in federal funding in total and by eligibility group in the first five and ten years of implementation, in 2025 and 2030. Minnesota’s losses for persons with disabilities and the elderly far outweigh the losses in the other three categories, because the trend rate for medical care CPI is much lower than the forecasted trend for these people. Increased efficiencies and reduced eligibility or coverage in the three other eligibility categories — children, parents and other adults — would do little to make up for the losses attributed to the first two groups — elderly and people with disabilities.

As illustrated in the following chart, Minnesota’s Medicaid program under the AHCA caps would be cut.

- In 2025, losses of federal funding, over the cap, for seniors and people with disabilities is about two-thirds of the total loss across all groups.
- In 2030, the state is expected to exceed the cap for people with disabilities by an amount greater than the combined cap for all other populations groups.
- Therefore, the state would still experience a significant gap in federal funding on the higher-cost populations, seniors and people with disabilities, even if the state eliminates coverage for other lower-cost populations in the future, like adults without children.
Minnesota would fare worse under the AHCA than most other states in terms of loss of federal funding.

Federal funding cuts under the caps will not account for any program savings or efficiencies that Minnesota has produced and from which the federal government has benefited over the last several years. This punishes our state for being an early innovator, implementing reforms that have saved money and lowered rates. Minnesota has created efficiencies through efforts to reform care delivery and purchasing, streamline the program and change how we deliver long-term care so people can remain living in their homes while they receive community-based health care. Minnesota has accomplished this all while ensuring a comprehensive coverage continuum.

Also, by eliminating the enhanced federal matching rate for the expansion population, states would have to default to their “regular” federal match to cover those individuals. In Minnesota, this would mean moving from a 90 percent enhanced federal match to a regular 50 percent federal match for those covered through our Medicaid expansion.

Because we have one of the lowest regular matching rates in the country, we will lose billions as a result of this funding change. States like Alabama and Mississippi, who could still decide to expand their program, would be able to cover newly eligible individuals at a much higher regular matching rate, 70 and 74 percent respectively. This rewards states that have higher regular matching rates and penalizes states like Minnesota who already have an established expansion but who would receive a much lower federal matching rate to continue covering eligible individuals.

The AHCA’s approach to a per capita cap puts the state at greater risk than a cap under a Medicaid waiver.

This per capita cap approach to financing Medicaid is not the same as mutually agreed-upon caps in Medicaid waivers. Caps in demonstration project waivers are designed to ensure that the federal government pays no more than the current forecasted cost of the program. The caps in the bill, however, are designed to cut federal spending.

Caps in waiver programs generally allow for the higher upfront investments needed to conduct a demonstration program because the state can balance these costs over a five-year period. For example, a demonstration that expands coverage in order to save costs over time would have an upfront cost that produces offsetting savings over time. Without that ability, states cannot fund the necessary costs that produces efficiencies in the program over time. Per capita caps would provide a disincentive for states to produce savings to the federal government through a demonstration waiver; states would have the incentive to spend up to or just over the cap to ensure federal funding is not further reduced.

The caps under the AHCA would not reset; they are permanent. The base year used in the bill to set the funding caps is 2016, therefore costs that occur years later, such as in 2030, no longer have any relationship or relevance.

Efficiencies Not Accounted for In AHCA Caps

- Over the last five years, Minnesota’s Medicaid program saved the state and federal government $1 billion through its purchasing and delivery reforms.

- For the base year (2016) when the caps are determined, Minnesota saw a significant reduction in Medicaid costs due to its managed care purchasing reforms that resulted in rates that were 12 percent lower than 2015 rates. This savings, which was already provided to the state and federal government, will permanently lower the state’s funding for Medicaid for all future years.
to the costs in the base year. Caps in Medicaid waiver programs reset every five years, so that we can adjust for unanticipated costs. Under the proposed caps, the risk of unanticipated costs is exponential.