

SPECIAL SESSION

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**GOVERNORS-ONLY DISCUSSION ON
HEALTH CARE REFORM**

Sources

- **The recent House plan (Obamacare Repeal and Replace Policy Brief)**
- **McKinsey Center for US Health System Reform Exchange Infographics Series: Pricing Trends, Carrier Participation Trends (<http://healthcare.mckinsey.com/reform>)**
- **McKinsey white paper, “Potential Impact of Individual Market Reforms” (<http://healthcare.mckinsey.com/potential-impact-individual-market-reforms>)**

Key takeaways

- **The House plan would alter the individual market and create trade-offs for governors:**
 - **Less federal funding to subsidize coverage, exposing some consumers to new costs**
 - **Expected flexibility for states to oversee their markets, though details and timing are unclear**
 - **Changes in federal Medicaid funding may lead states to shift more people into the individual market who need financial assistance to purchase coverage**
- **Beyond the House plan, there are a range of other policy options that could help stabilize the individual market, which the federal government could implement nationally or give states the flexibility to pursue**

Potential impact of policy changes to stabilize the individual market

Stated policy goal	Potential increase in enrollment (%)	Potential decrease in average premium (%)
Promote appropriate enrollment	Minimal	Up to ~10%
Stabilize risk pools	Up to ~5%	Up to ~15%
Maximize market participation	Up to ~20%	Up to ~5%
Reduce cost of care	Up to ~10%	Up to ~35%

Calculations assume current premium tax credits and cost-sharing reductions remain in place

Numbers are not additive; however, a combination of these initiatives could have a multiplicative effect on improving enrollment and premiums

Note: Sizing based on recent McKinsey white paper, "Potential impact of individual market reforms"

Other potential policy changes to stabilize the individual market¹

Stated policy goal

Example actions (not exhaustive)

Promote appropriate enrollment

- Improved special enrollment period verification process
- Appropriate payment enforcement

Stabilize risk pools

- Reinsurance mechanisms and high-risk pools
- Merged non-high risk Medicaid expansion and individual market

Maximize market participation

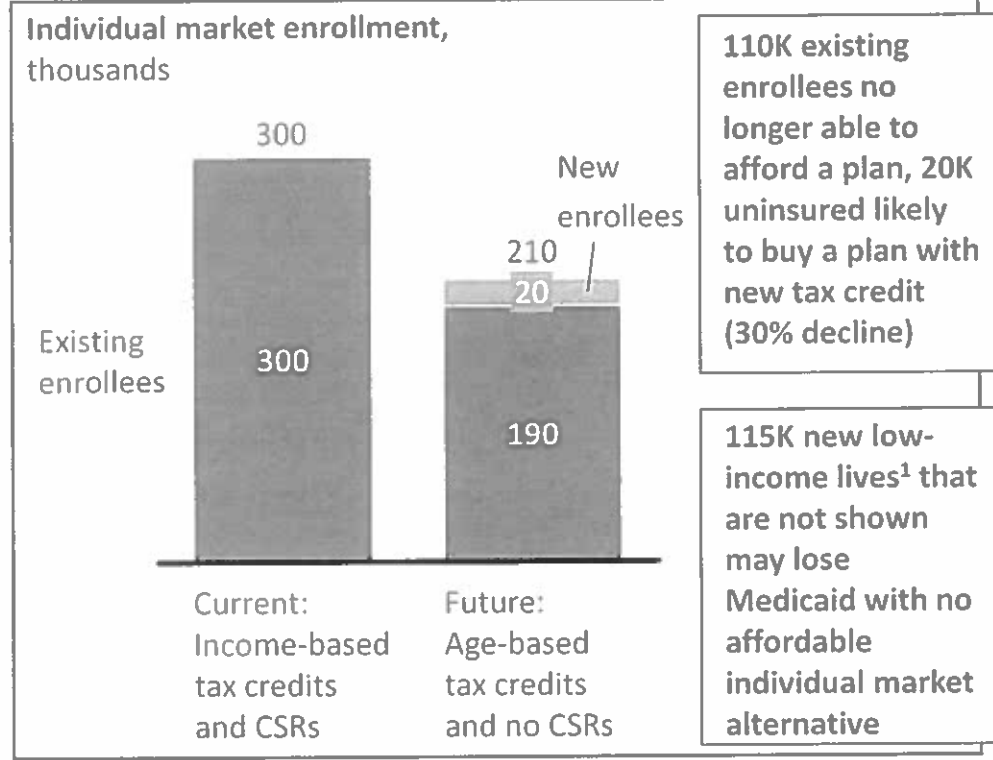
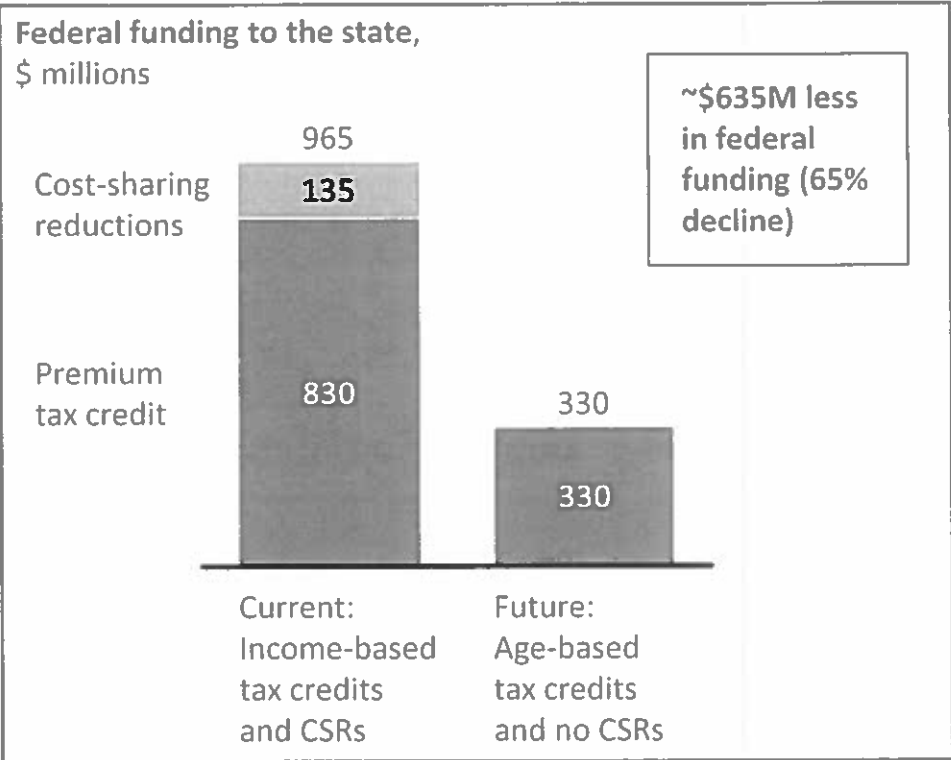
- Continuous coverage with transitional high-risk pool or late fee
- Auto-enrollment for lowest-price plan
- Widened age rating curve
- Lower actuarial value plans for all

Reduce cost of care

- Modified Essential Health Benefits (routine/discretionary care removed, unforeseen catastrophic costs covered, savings vehicles added)
- Value-based insurance design and wellness incentives
- Population-based and episode-based payment models

¹ Beyond the House plan, there are a range of other policy options that could help stabilize the individual market, which the federal government could implement nationally or give states the flexibility to pursue

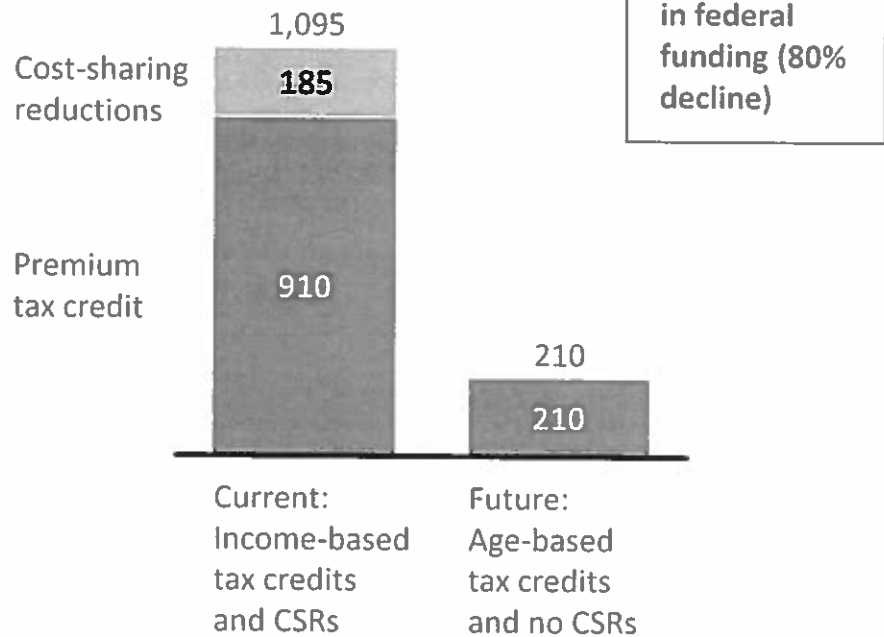
Blinded example: Potential impact of changing subsidy structure in an expansion state



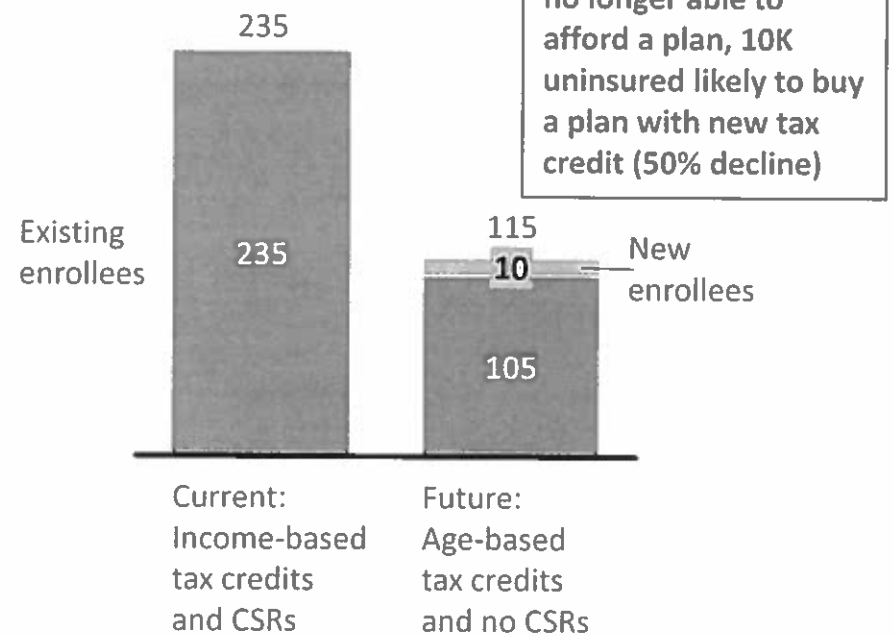
¹ Estimated current Medicaid enrollment between 100-138% FPL that may be shifted to the individual market due to expected federal Medicaid funding changes

Blinded example: Potential impact of changing subsidy structure in a non-expansion state

Federal funding to the state,
\$ millions



Individual market enrollment,
thousands



Key elements of House plan

Age-based, portable tax credits

- Changes subsidy approach from income-based tax credit and cost-sharing reductions to age-based, fixed-dollar tax credit

Enhanced Health Savings Accounts (HSAs)

- Increases HSA contribution limits and relaxes restrictions on spending and contribution

State Innovation Grants

- Offers flexible funding (amount undefined) for states to use in such ways as reinsurance, high-risk pools, lower out-of-pocket costs

Implications for states

- Less federal spending (~\$30B less in premium tax credits and cost-sharing reductions)
- Potential for lower premiums via HSAs, but likely higher cost to access care
- States faced with decision of how to allocate flexible but more limited federal funding
- Possible to have more low-income lives to cover in the individual market due to federal Medicaid changes

Context for individual market reforms

Despite coverage gains, many still uninsured

- ~10 million consumers have enrolled through exchanges to date, but close to 40% of those eligible are still uninsured

Though tax credits partially offset, premiums rising

- Average silver plan gross premium increased 24% from 2016 to 2017, though tax credits offset increases for some

Financial performance varies, but carrier losses rising

- Carrier losses of ~\$20 billion in individual market through 2016, but ~25-30% of carriers profitable

Choice remains, though carrier exits rising

- New entrants continue to enter the market, but carrier exits are rising (1 in 5 consumers can access only 1 carrier)

Agenda

- **Context for individual market reforms**
- **Key elements of most recent House plan**
- **Other potential policy changes to stabilize the individual market**
- **Key takeaways**

Federal Proposals to Stabilize the Individual Market: Impact and Key Considerations for States

February 25, 2017

Many questions remain on how per capita caps would ultimately be designed

Key Considerations

Baseline Funding

- How will year 1 block grant or per capita cap amounts be set?
- Will a single cap apply for all beneficiaries or would different caps be established based on various Medicaid populations (e.g., children vs. disabled)?
- How will Medicaid expansion populations be funded?

Growth Factors

- What growth rate will be used to index annual federal funding?
- Will the growth rate vary by eligibility group (aged vs children)?

Population and Services Included

- Could some products or services be carved-out of federal funding caps and paid separately?
- How will administrative costs and DSH funds be paid?
- How will funding respond to new, high-cost products or services?
- Will federal rules around prescription drug coverage and the collection of drug rebates change along with the change in funding?

Growth rates are critical for long-term budget impact

- Policymakers can limit federal Medicaid spending by selecting growth rate factors that are lower than historical program spending growth

From 2001 to 2013, total annual Medicaid spending growth averaged 6.3%

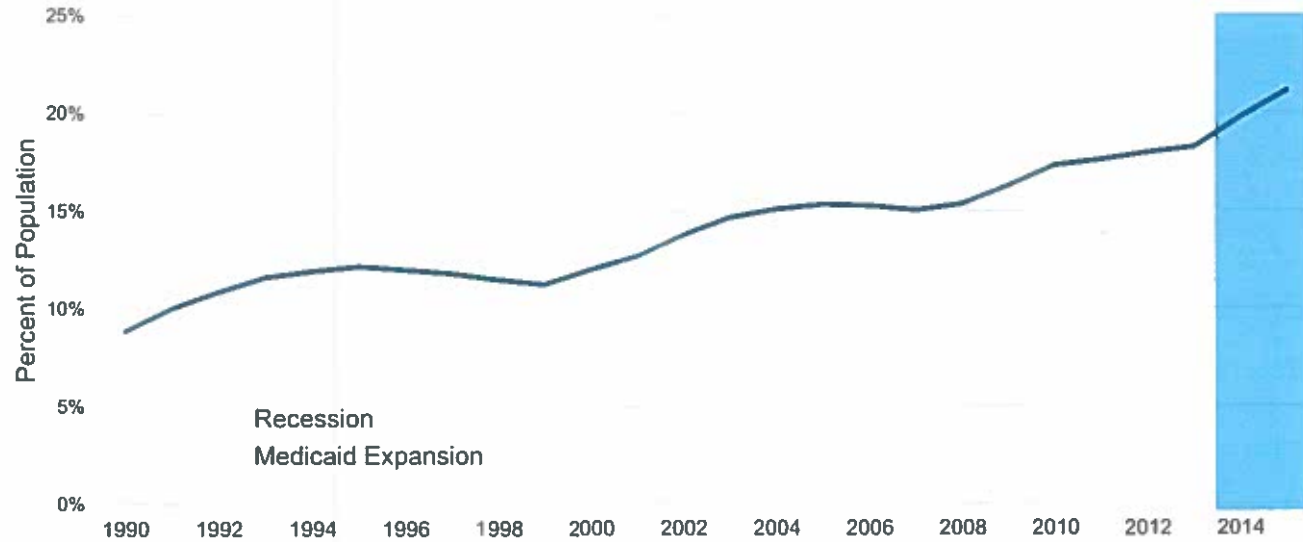
Growth Factor	Projected Average Annual Growth Rate 2017 - 2025 ¹	Considerations
Consumer Price Index (CPI)	2.6%	Variations of overall inflation are the most common growth factors recommended in block grant and per capita cap proposals
CPI + population growth	3.5%	
CPI + 1 percentage point	3.6%	
Medical Care Inflation (CPI-M)	4.2%	Medical care inflation has historically grown more quickly than overall inflation and reflects increasing healthcare costs
Gross Domestic Product (GDP)	5.0%	GDP growth fluctuates between economic upturns and downturns
National Per Capita Health Expenditures (NHE)	4.8%	NHE is reported annually

1. Inflation projections are from CMS 2016 Medicaid Actuarial Report. GDP and NHE projections are from CMS NHE Projections, 2015-2025

During recessions, Medicaid enrollment rises; block grants would not adjust in response

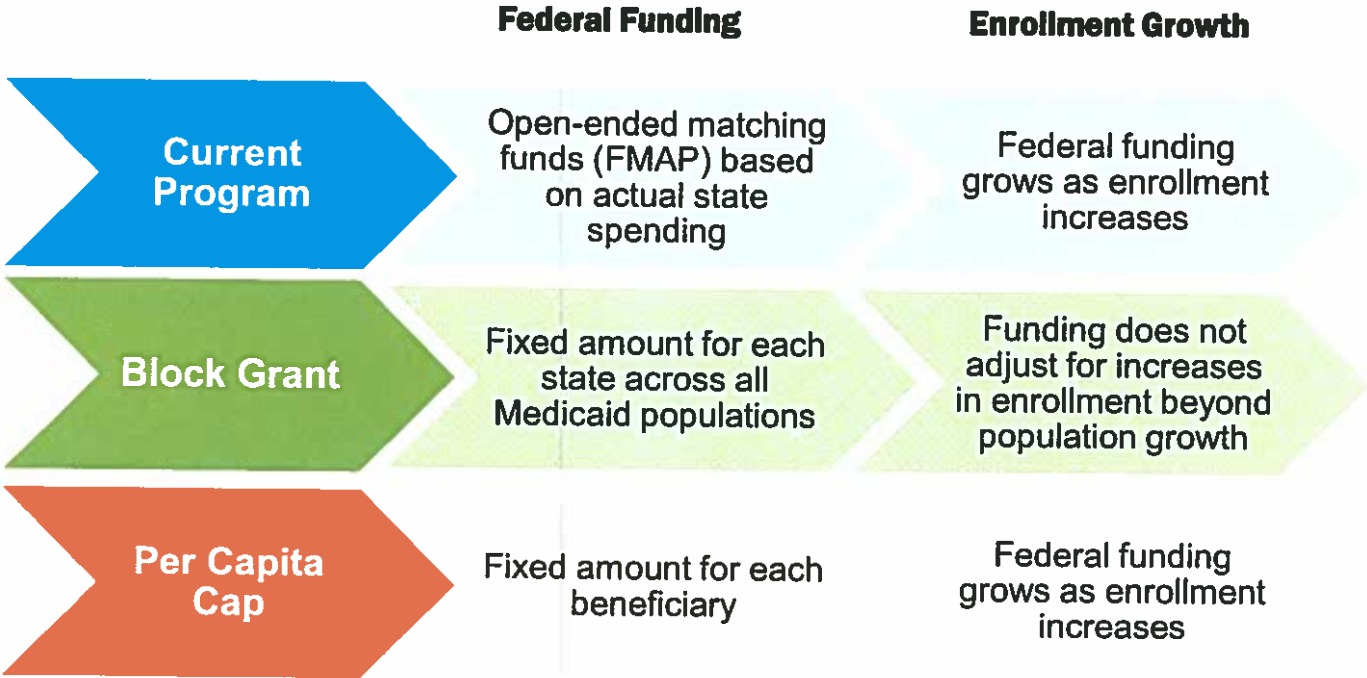
- Medicaid enrollment grows faster during economic downturns when unemployment increases

Historical Medicaid Enrollment as a Percent of the US Population



Source: MACPAC. "MACStats: Medicaid and Chip Data Book, December 2016. All numbers exclude CHIP-financed coverage. Enrollment counts are full-year equivalents and FYs 2012-2015 are projected; those for FYs 1999-2015 include estimates for Puerto Rico and the Virgin Islands.

Key differences exist between the capped funding proposals



FMAP: Federal Medical Assistance Percentage

Medicaid Presentation: Appendix

For additional questions...

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Key Takeaways

- **Medicaid caps are likely to result in state funding gaps**
- **Capped funding is likely to be paired with more flexibility for states on coverage and benefits**
- **Because states must balance their budgets annually, reductions in federal funding may lead to cuts in eligibility, benefits, or payment rates**
- **Per capita caps offer more flexibility to respond to enrollment growth, but they cannot easily adapt to new products or technology (e.g., high-cost drugs)**

Potential impact on states from reduced federal Medicaid funding

Reduced Enrollment

Fewer people enrolled in Medicaid.

Uncompensated Care

Increased uncompensated care for providers.

Economic Impact

Lower state revenues, reduced economic activity, and possible negative impact on job growth.

States have options for controlling program spending in a capped funding arrangement

To help manage Medicaid spending, states are expected to be granted flexibilities that would allow them to pursue changes to enrollment, services, or payments.

Enrollment

- Tighten eligibility criteria
- Require beneficiaries to meet job search or work requirements
- Enact lockout period for missed payments or appointments

Service Use

- Limit covered benefits
- Tighten utilization management
- Incorporate wellness programs to shift utilization patterns

Payment

- Reduce provider payment rates
- Reduce capitation rates to health plans
- Increase beneficiary cost-sharing
- Increase rebates for prescription drugs

Illustrative example: state impact of per capita caps & repeal of Medicaid expansion

Non-Expansion State (1M Enrollees)		
	2018	5-Year Total
Current Law		
Total Annual Spending	\$8.6 B	\$47.5 B
Federal Spending	\$4.3 B	\$23.8 B
State Spending	\$4.3 B	\$23.8 B
Per Capita Cap		
Percent Change in Federal Spending	-2%	-6%
State Spend Required to Close Gap	\$87 M	\$1.5 B

Expansion State (1M Enrollees; 17% New Eligibles)		
	2018	5-Year Total
Current Law		
Total Annual Spending	\$8.2 B	\$46.9 B
Federal Spending	\$4.5 B	\$25.6 B
State Spending	\$4.3 B	\$23.8 B
Per Capita Cap & No Expansion		
Percent Change in Federal Spending	-21%	-24%
State Spend Required to Close Gap	\$942 M	\$6.2 B

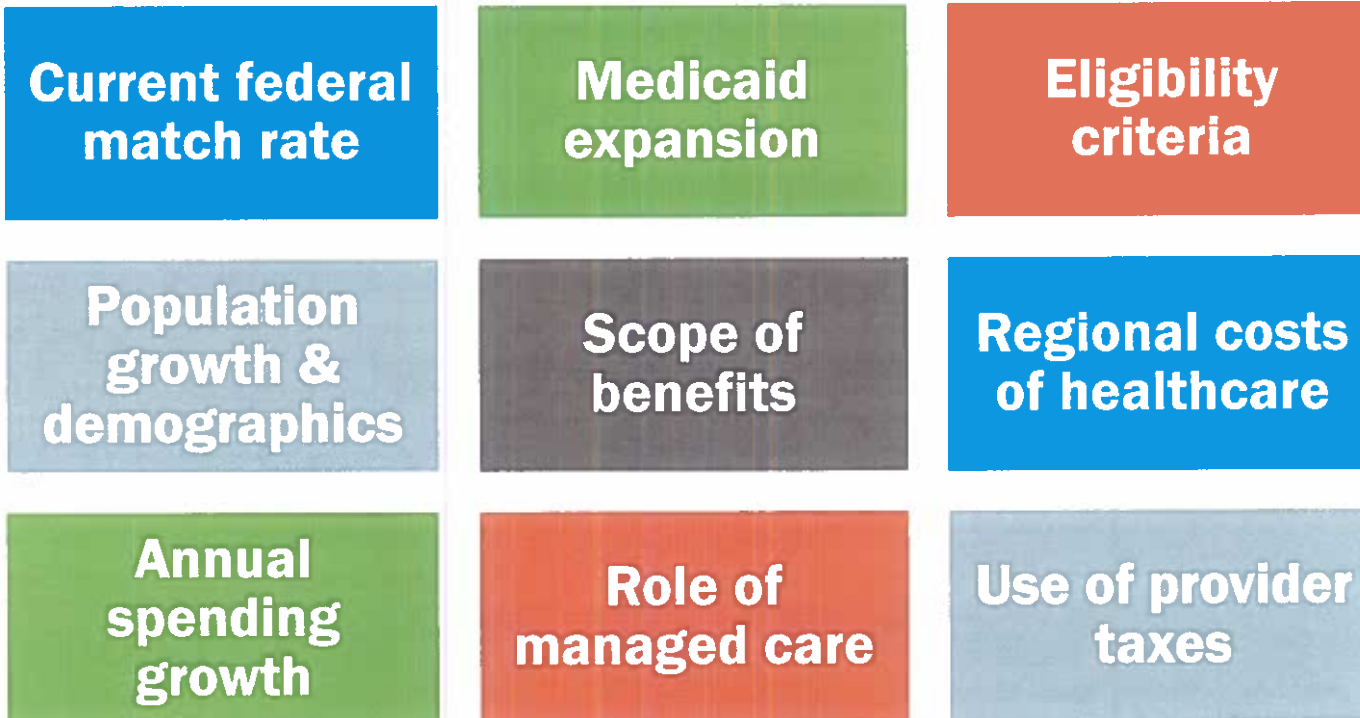
State funding gap accelerates over time.

Gap reduced if standard match rates maintained for expansion population.

Assumptions:

- Distribution of enrollees by eligibility group (aged, disabled, children, adults) based on national average.
- FMAP is 50%. Per capita allotment set equal 2017 national average spending for each group and growing each year at CPI

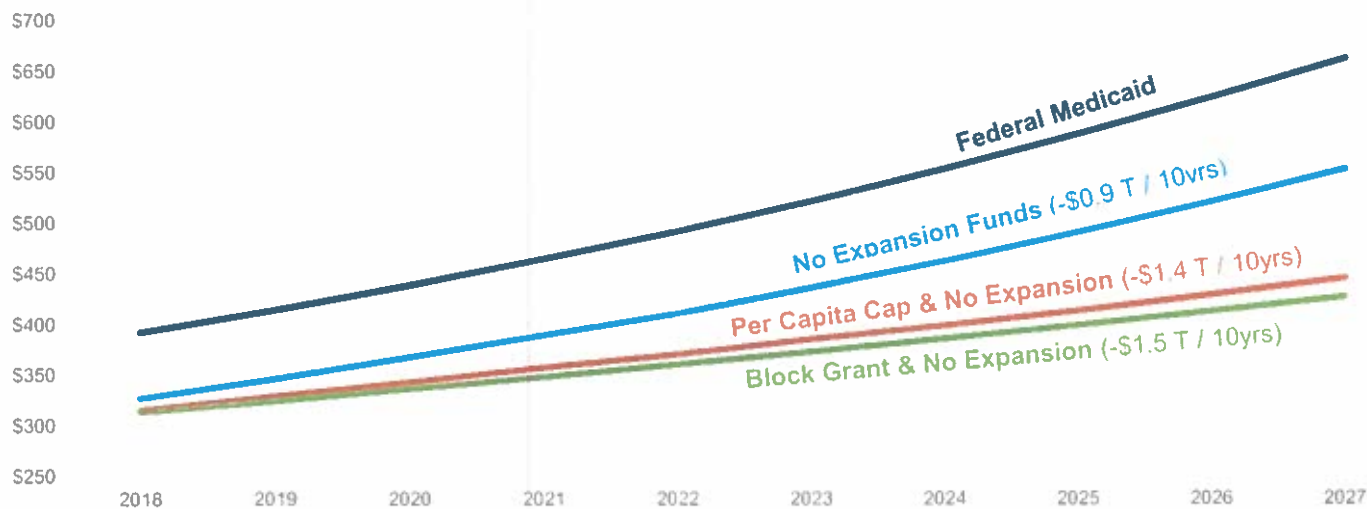
State impact depends on program, population, and healthcare characteristics



Impact on States

Repeal of Medicaid expansion funds would further increase federal savings

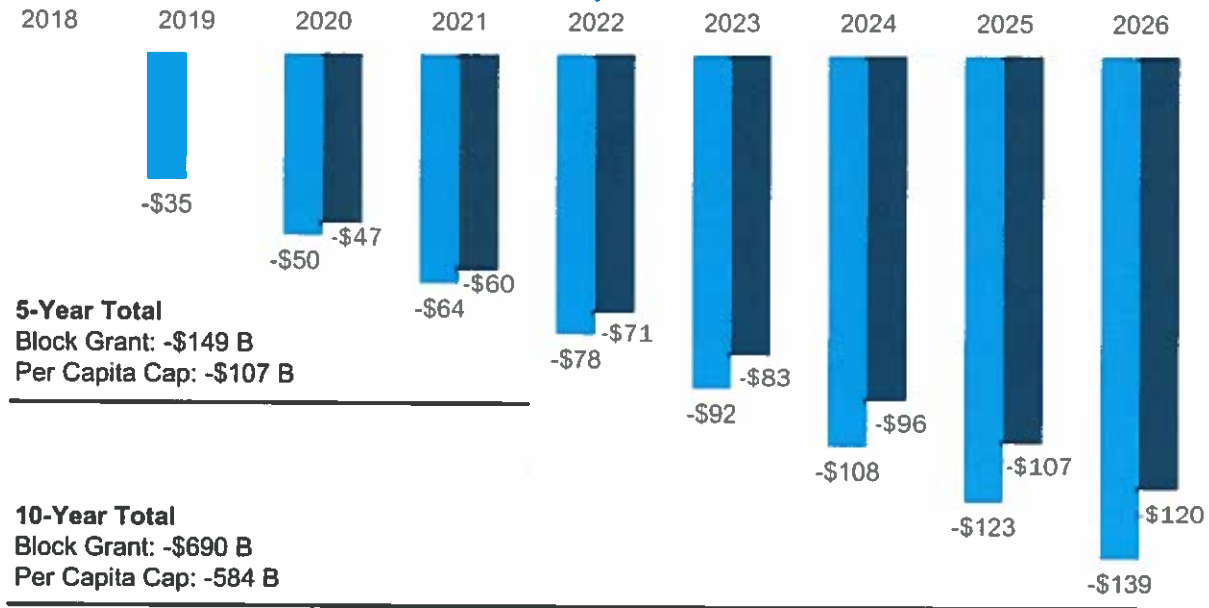
Projected Federal Medicaid Spending Assuming Repeal of Medicaid Expansion and Capped Funding Arrangement



Projections for Medicaid enrollment, Medicaid spending, CPI, and CPI-M are from CMS 2016 Medicaid Actuarial Report. No expansion assumes all federal funding for the newly eligible population is removed effective 2018. Capped funding proposals begin in 2018 with base funding tied to 2017. Projections are based on CMS assumptions for CPI and Medicaid spending growth rates.

Cuts to federal spending grow most in later years

Federal Medicaid Spending Under a Block Grant vs. Per Capita Cap



■ Block Grants ■ Per Capita Caps

Congressional Budget Office, Options for Reducing the Deficit: 2017 to 2026, "Impose Caps on Federal Spending for Medicaid."

Key findings about capped funding proposals

Amount of Federal Savings Depends on Specifics of the Proposal

Growth Rates Are Critical for Long-Term Budget Impact

Cuts to Federal Spending Grow Most in Later Years

Repeal of Medicaid Expansion Funds Would Increase Federal Savings

Impact on States May Be Uneven Depending on Program Characteristics

Key Findings on Medicaid Capped Funding

Most recent House proposal would repeal Medicaid expansion and implement a per capita allotment

Repeal Medicaid Expansion Funds

- Repeal enhanced funding for Medicaid expansion
- Transition period for states that expanded to continue receiving enhanced federal funds
- Non-expansion states receive funds for safety-net providers during transition

Implement Per Capita Allotment

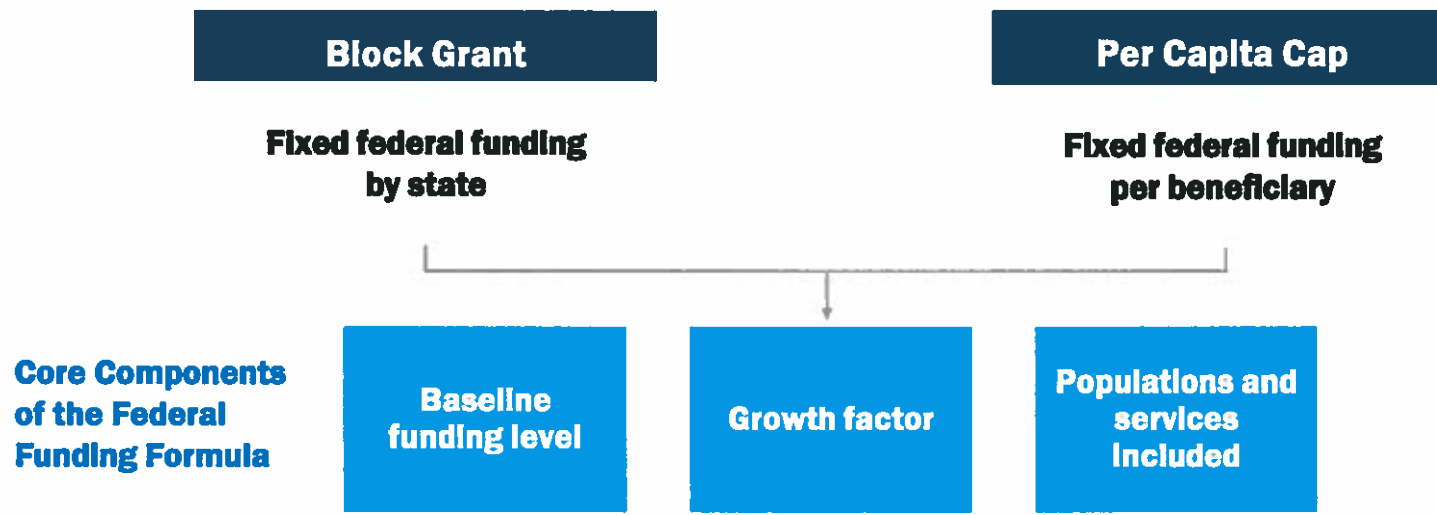
- Per capita allotment for each eligibility group
- Custom state caps based on average spending will grow with inflation
- States must continue to provide matching funds
- DSH and admin costs excluded from caps

Optional Block Grant

- States have option to accept block grant instead of per capita allotment
- Mandatory benefits must be provided to aged and disabled
- Medicaid expansion enrollees not included in initial block amounts

Caps on federal Medicaid funding could include block grants or per capita caps

- Today, federal funding of Medicaid is open-ended—the federal government contributes a fixed share of each state’s actual spending
- Medicaid reform proposals would set federal spending to a target



Federal policymakers are considering changes to Medicaid

**Repeal Medicaid
Expansion Funding**

**Eliminate enhanced federal funding for
optional Medicaid expansion**

**Cap Federal Spending
and Cost Growth**

**Limit spending through Medicaid block
grants at the state or per capita level**

**Offer More Flexibility
to States**

**Grant states additional flexibilities to
design and administer Medicaid
programs**

Medicaid is a growing portion of state & federal budgets; covers low-income, high-need populations

Spending

\$576B

Total Annual Spending (2016)

\$363B

Federal Spending

\$213B

State Spending

16%

of All Health Spending

29%

of Total State Spending

Coverage

72M (1 in 5)

People Covered

16.4M

New Enrollees Since January 2014

30%

of Disabled Adults Covered

1 in 2

Births Paid for by Medicaid

51%

of Spending for Long Term Services
and Supports paid by Medicaid

Current Context for Medicaid Reform

Agenda

- **Current Context for Medicaid Reform**
- **Key Findings**
- **Impact on States**
- **Key Takeaways**

Medicaid Funding Reforms: Impact on States

Caroline F. Pearson

Avalere Health | An Inovalon Company
February 2017



GUESTS

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Panel 1

- **Caroline Pearson, Senior Vice President, Avalere Health**
- **Erica Hutchins Coe, Partner, McKinsey & Company**

Panel 2

- **Secretary Tom Price, U.S. Department of Health and Human Services**

#WeTheStates



SPECIAL SESSION

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HEALTH CARE REFORM**

