A Policy Brief: The Better Care Reconciliation Act of 2017 and Minnesota's Public Health Care Programs

July 5, 2017

This policy brief summarizes some key changes that the discussion draft of the U.S. Senate bill, the Better Care Reconciliation Act, would make to Medical Assistance, Minnesota's Medicaid program, and MinnesotaCare, Minnesota's Basic Health Program.

New Limits on Federal Funds for State Medicaid Programs

The BCRA reduces federal funding for all state Medicaid programs beginning on Jan. 1, 2020. Cuts are similar to those proposed in the American Health Care Act, the U.S. House bill[1] to replace the ACA. The bill lowers total federal Medicaid spending by $772 billion over the next 10 years, according to the Congressional Budget Office (CBO).

Under this bill:

- States will be assigned a Medicaid federal funding limit on a per capita basis for each of the population groups. Those groups are:
  - Elderly Americans (65 and older)
  - People with blindness or a disability
  - Non-disabled children, parents
  - ACA-era Medicaid expansion enrollees
  - Other adults (non-elderly, non-disabled, non-expansion adults).
- The amount of the caps in each state will be calculated based on prior spending levels for these populations for a defined "base period."[2]
- From 2020 to 2024, the caps will be trended forward using the rate in the medical component of the consumer price index (CPI). The rate for caps on seniors and people with disabilities during this time is this same rate plus one percentage point.
- Beginning in 2025, this rate will shift to the overall CPI-Urban (All Items), which generally is lower than CPI's medical care component in the House bill. This inflation rate varies year to year and can be negative depending on the economy. This is a reduction in Medicaid spending, when compared to the House bill.

What is a per capita cap?

A per capita cap limits the federal government's share of Medicaid costs by limiting the federal contribution to an average per person (per capita) amount. The cap varies by eligibility group and by year. Each group's cap is calculated for a base period and then trended forward based on a rate of inflation for each year into the future.

This changes the financing structure of the Medicaid program, in which the federal government currently covers at least half or more of the costs of the program through a state-specific matching rate formula.

[1] The American Health Care Act of 2017, H.R. 1628

[2] States may select eight consecutive fiscal quarters from Q1 FY 2014 to Q3 FY 2017 to serve as the base period. This differs from the House bill which set FY2016 as the base. Allowable and excluded expenditures in base periods will be adjusted by dividing expenditures by two.

- For states that spend over their caps, the federal government will reduce the next fiscal year's allotment of federal funding to the state by the federal share of the amount overspent.
- In addition, states will experience an additional loss in their cap if the state per capita spending for any eligibility group *exceeds* the national average by 25 percent or more in a given fiscal year. After 2019, the federal government will lower the state's per capita cap amount for that group by 0.5 to 2 percent. Conversely, the federal government will reward states spending 25 percent or more *below* the national average per capita by increasing its cap by 0.5 to 2 percent.[3] Given the comprehensive nature of our coverage, Minnesota is likely to be over the national average in terms of spending and therefore negatively impacted by this provision.
- Like the House bill, the BCRA exempts certain populations from the spending caps, maintaining the current matching rate structure of the Medicaid program for those populations.[4] The BCRA additionally exempts children with disabilities who are under the age of 19. The House bill does not exempt this group. Despite these exemptions the vast majority of Medicaid enrollees and their related costs will be subject to the per capita cap funding.

The bill provides states with the option to select a block grant funding approach instead of the per capita cap formula. However, for Minnesota, the block grant formula would likely result in less federal funding than the per capita caps because it does not account for actual growth in enrollment over time.

Changes to Federal Funding for Adults without Children on Medicaid

Under current law, states have the ability to receive enhanced federal funding if they expand Medicaid coverage to adults without dependent children with incomes up to 133 percent of the Federal Poverty Level (FPL). This is commonly referred to as the "Medicaid expansion" option.

Under the BCRA, federal financing for this population will be changed:

- Similar to the House bill, the BCRA will phase down the enhanced funding for expansion states, yet the reduction occurs more slowly through 2024.[5] The enhanced federal support for adults without children will phase down from 90 percent of the total cost in 2020, consistent with the rate set in current law, to Minnesota's regular match rate (50 percent) by 2024. In that same year (2024), the trend rate for state per capita caps will be reduced as well.
- The loss of federal funding for this population is less immediate than the phase-down of funding in the House bill, but by the end of ten years, the lost funding to the state would be equal.

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[3] Such adjustments are subject to budget neutrality requirements and will not be allowed in states where the population density is less than 15 people per square mile per Census data. This would include Alaska, Montana, Wyoming, North Dakota, and South Dakota. In FY 2020 and 2021, such adjustments will take place by aggregating all enrollee categories. For FY2022 and beyond, adjustments will occur based on the distinct enrollee categories. The bill does not adjust for differences among the states in benefit sets, eligible populations, prices in local health care markets, and whether states use managed care or fee-for-service. Differences in rate changes are made at the discretion of the federal government.

[4] Exempt populations from the caps include: Children's Health Insurance Program (CHIP) enrollees, Indian Health Services (IHS) Medicaid recipients, breast and cervical cancer-eligible individuals, partial benefit enrollees (e.g. individuals eligible for Medicare cost-sharing coverage, individuals receiving Medicaid subsidies for employer-sponsored insurance), and children with disabilities under age 19.

[5] Starting in CY2020, Minnesota FMAP would be 90 percent, as provided in current law for expansion states. After 2020, however, the Minnesota rate will phased down by five percentage points each year through 2024; then, in 2025, Minnesota will apply its regular matching rate in determining its per capita cap amounts for this population. For states expanding Medicaid after March 1, 2017 to adults without children, no enhanced FMAP will be available.

- Under the BCRA, if Minnesota eliminates coverage for adults without children prior to 2024, the state would become permanently ineligible for enhanced federal matching funds for this group.

The bill provides new federal support for states that did not expand coverage to adults without children by creating a new safety net funding pool of $2 billion to support providers serving this population. It exempts these states from future reductions to funds made available to support local hospitals that serve low-income populations, also known as the disproportionate share hospital program (DSH).

Changes to MinnesotaCare, the State's Basic Health Plan

The BCRA maintains the state health insurance exchanges and premium subsidies established under the Affordable Care Act, but reduces the income eligibility limits for people seeking subsidies and the level of assistance they are able to receive through an exchange. However, under the BCRA, the funding formula for basic health programs will still be based on the old premium subsidies and metal levels and cost-sharing subsidies that were eliminated under the BCRA. *Therefore, the BCRA and its new subsidy structure will discontinue federal funding for MinnesotaCare in 2020, because it is currently a basic health program*.

This means an annual loss of approximately $211 million in federal funding in 2020 for Minnesota, which grows to $651 million in 2030. While the bill maintains the option for states to seek a 1332 waiver with some changes to waiver timeline and budget neutrality requirements, it is unclear that such a waiver would allow the continuation of MinnesotaCare federal funding.

The three big funding changes to Minnesota's Public Health Care Programs under BCRA

The Minnesota Department of Human Services (DHS) estimates that with the loss in federal funds under the per capita caps, elimination of MinnesotaCare funding, and loss of enhanced funding for adults without children in Medicaid:

- Over 5 years, losses in federal funding to the state would total $10.4 billion (which is $1.1 billion less than the House bill). The annual loss in 2025 would be $2.8 billion.
- Over 10 years, losses in federal funding to the state would total $31 billion (nearly equal to losses under the House bill). The annual loss in 2030 would be $5.2 billion.

For more information on the financial impacts of BCRA, see DHS' fact sheets by visiting mn.gov/dhs/aca-repeal.

Changes to Eligibility Rules for Medicaid

The BCRA makes several changes to the way eligibility is determined for Medicaid:

- **Hospital Presumptive Eligibility:** Currently, states are required to allow hospitals to presume eligibility for uninsured low-income patients receiving services, providing these individuals with temporary Medicaid coverage while they complete a full application for the program. As of Jan. 1, 2020, hospitals will no longer be able to do presumptive eligibility.
- **Retroactive Eligibility:** Currently, states are required to provide retroactive coverage up to three months prior to the month of application if the applicant was otherwise eligible for Medicaid. As of Oct. 1, 2017, Medicaid would no longer cover the three months of coverage prior to an individual's application.

- **Redeterminations of Eligibility or "Renewals":** The BCRA would allow states the option of redetermining eligibility (often referred to as renewals) for adults without children every six months or more frequently. Today, states are required to redetermine eligibility every twelve months.

Minnesota Impact of Eligibility Changes, under BCRA

The combined impact of these Medicaid eligibility changes would reduce average monthly enrollment in the state's Medicaid program. These changes would remove the costs of covering affected individuals but may leave them more likely to be uninsured during these periods. This means providers, particularly hospitals, will likely experience additional uncompensated care costs.

Other Changes that Impact Minnesota Medicaid Program and its Funding

- **Loss of funding for Community First Choice Option:** Effective Jan. 1, 2020, the bill repeals the enhanced federal funding (6 percentage points on top of the state's regular matching rate) for the 1915(k) Community First Choice option, which provides personal supports and other services to people with a need for personal assistance. Minnesota has not yet implemented the Community First Choice option but once it does, this change is estimated to reduce available federal funding for Minnesota by $63 million in 2021 and $72 million in 2022.

- **Provider tax reductions:** Today, there is a federal cap on taxes for health care providers that was intended to limit the ability of states to leverage federal funding under the current, unrestricted structure of Medicaid financing. Under BCRA, the cap for allowable provider taxes will be reduced beginning in 2021 from 6 percent of provider revenue to 5 percent in 2025. The reduction in the tax limit will further restrict the state's ability to raise revenue to make up for any of the federal funding losses under BCRA.

- **Limits to federal payments to Planned Parenthood:** The BCRA maintains the House bill's language prohibiting Planned Parenthood from receiving federal dollars for one year.

- **Federal funding for certain institutions for mental disease (IMDs)**: The bill would allow states to obtain federal matching funds for certain inpatient hospital psychiatric admissions that are fewer than 30 days (and up to 90 days in a year). However, it would require the state and counties to maintain their current (non-Medicaid) spending for state-operated mental health facilities and outpatient mental health services. In addition, this provision will be subject to overall limits on federal Medicaid funding available to states (under the per capita caps).

State Option for Work Requirements

Starting Oct. 1, 2017, states may impose work requirements for people receiving Medicaid. Work requirements may only be imposed on people who are not elderly or pregnant and who do not have a disability.

The law allows some additional exceptions including women after pregnancy, children under 19, certain caretakers of a child younger than age 6 or of a child with a disability, and certain younger married couples who are in college or an educational program directly related to gaining employment.

- **Quality Bonus Program**: From 2023 to 2026, states may receive enhanced federal funding by meeting quality targets and lower than expected aggregate spending within a fiscal year. The federal agency responsible for Medicaid will determine relevant quality measures and lower than expected aggregate spending targets. Federal funding enhancements for all states from 2023 to 2026 under this bonus program

cannot exceed $8 billion. States must spend any funds received under this program on quality improvement activities.