

South Carolina Hospital Association

ACA: repeal and replace



Affordable Care Act



SCHA federal agenda

- Simultaneous Replacement*
- Restore cuts and repeal DSH cuts*
- Medicaid parity*
- Quality Standards*

federal strategy

- *Senator Tim Scott (R)*

- Senate Finance Committee
- Senate HELP Committee



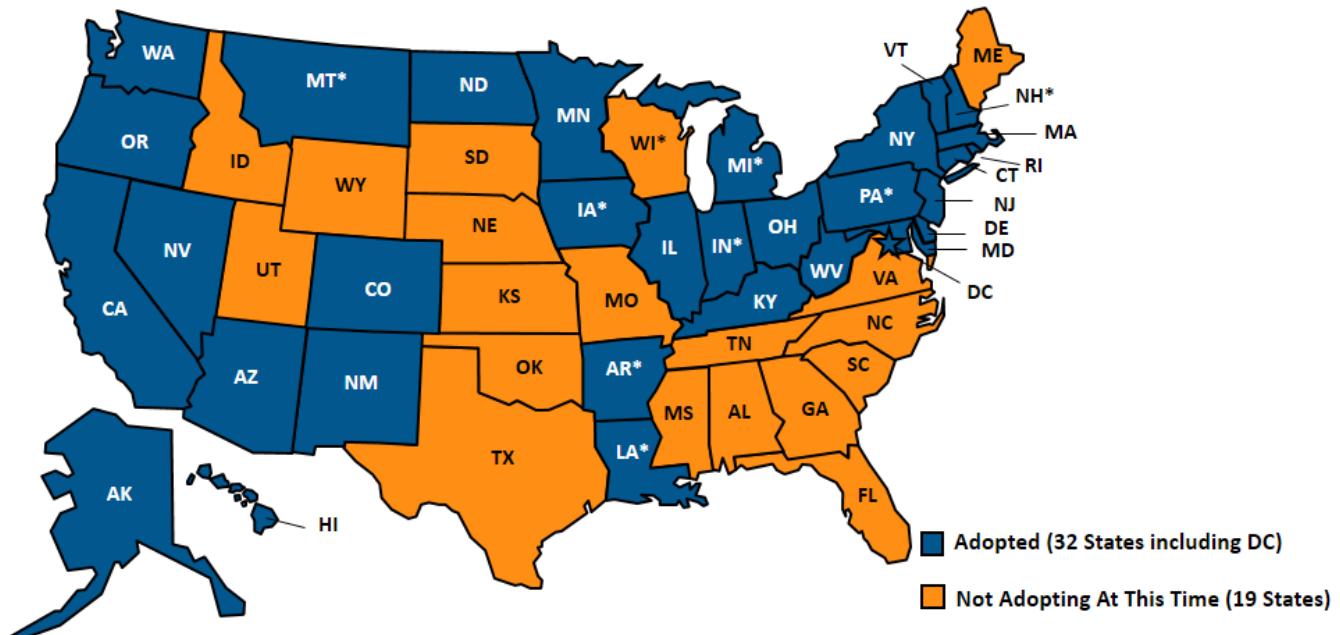
- *Congressman Tom Rice (R-SC7)*

- House Ways and Means Committee
- Close to Rep. Tom Price



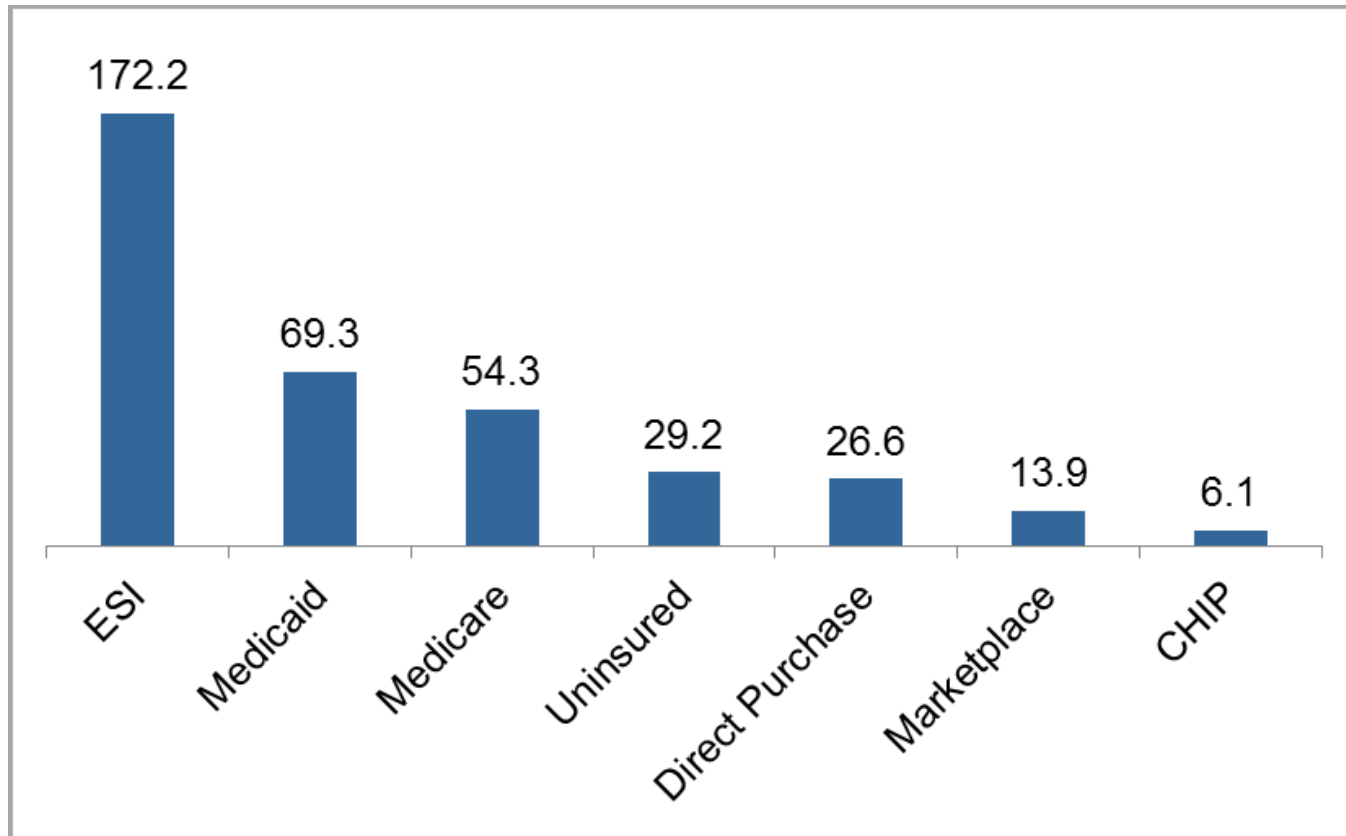
South Carolina Hospital Association

what happens to medicaid ?



medicaid today

- *Medicaid is the single largest source of health coverage in the United States*



medicaid today

- *Medicaid is the single largest federal source of funding to states*
 - 16% of state budgets
 - 56% of federal funds to states

financing structure

- *Federal dollars guaranteed to match state spending*
 - \$246 billion in total federal Medicaid funds in 2015, as a match to \$205 billion in total state funds
- *Matching rates vary by state, population, and service*

expansion

- *31 states and DC have expanded*
 - 12 states that Trump won
 - 16 have GOP governors
- *14.5 million are covered under expansion*
- *\$72.6 billion in federal funds to expansion states in 2016*
 - 100% federal funds in 2016; state share begins 2017

ACA repeal

- *Efforts to repeal the ACA include a repeal or rollback of Medicaid expansion with delayed date*
- *Expanded states have these funds “baked” into their state budgets*

american health care act

- *Originally allowed non-expansion states to expand until 2020; an amendment took that opportunity away*
- *AHCA included “grandfather” provision for enhanced federal funds for expansion enrollees until they cycle off*
- *\$10 billion over 5 years available for non-expansion states in AHCA*

american health care act

- *Non-expansion states would have DSH cuts repealed in 2018*
- *Expansion states would get DSH cuts in 2018-19 and would have the cuts repealed in 2020*

new proposals

- *New proposals to replace ACA need to appeal to far right conservatives*
 - State waivers for essential health benefits
 - State waivers for community rating
- *Federal funds for high-risk pools*

medicaid proposals

- *Capped Federal Funding*
 - Block Grants
 - Per Capita Caps
- *Most recent plans would give states the option of a per capita allotment calculation or a block grant allotment*

capped funding models

- *Both capped funding plans would:*
 - Limit federal spending
 - Shift risk to states for growth
 - Increase flexibility for states in design of program
 - Lock in existing disparity between states

block grants

- *States receive no more than a set amount of federal funds annually*
 - Amounts typically allocated by reference to a base year
 - In AHCA, tied to CPI-M
 - States may or may not have a state spending requirement to receive funds
 - Generally gives states more flexibility to set eligibility, benefits, and other features

per capita caps

- *States receive fixed amount of federal funds per Medicaid enrollee*
 - Per capita amount set based on state's per enrollee spending in base year (2016) tied to CPI-M or CPI-M +1% for elderly and disabled
 - Caps vary based on eligibility category
 - Elderly, Blind and Disabled, Children, Adults, Expansion Adults
 - State match required

per capita calculation

- *Step 1: develop base average per capita cost for each category*

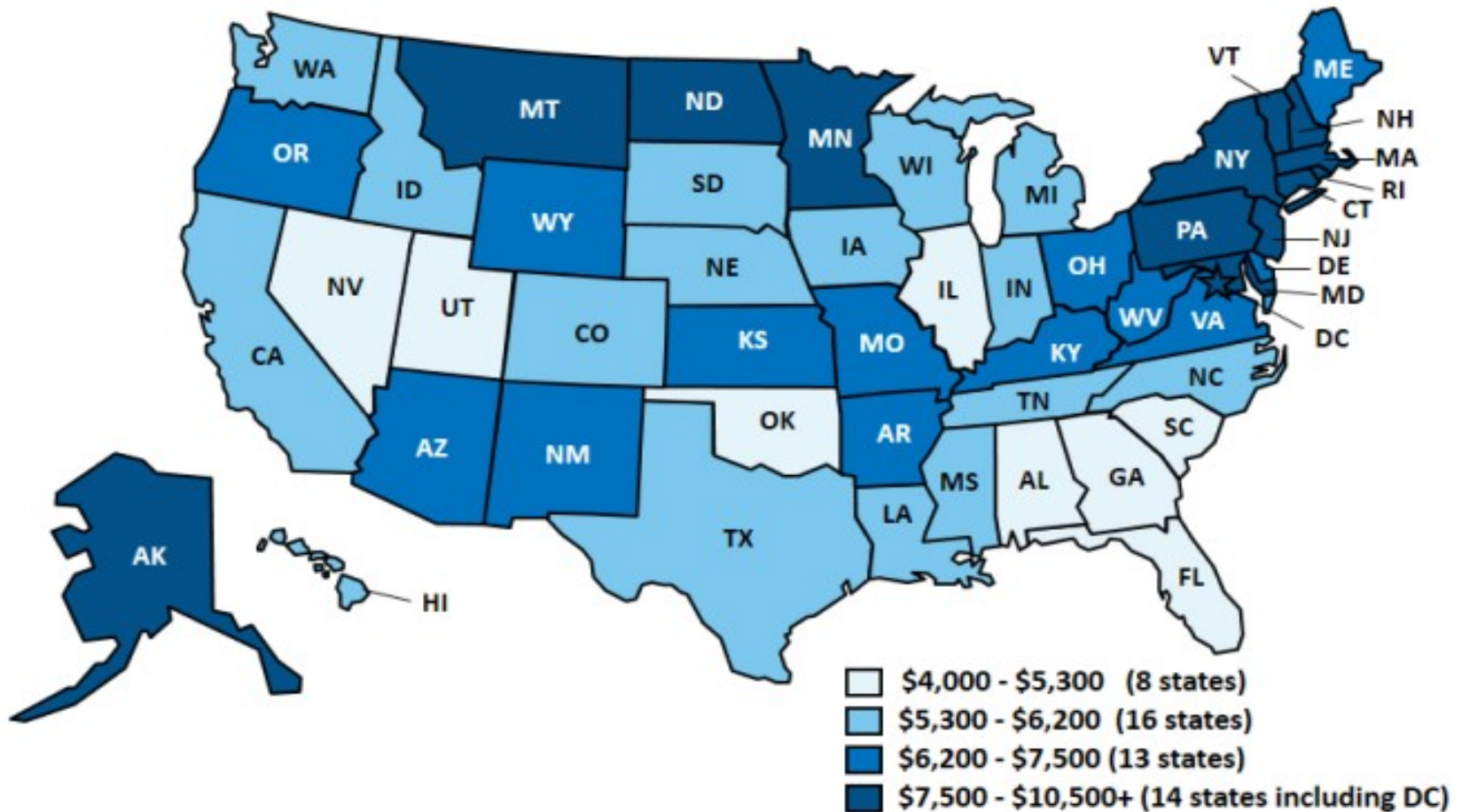
$$\begin{array}{ccccc} \text{Total Cost of} & & \text{Number of} & & \text{Average Per} \\ \text{Beneficiaries in a} & \frac{\text{Category}^*}{\text{Beneficiaries in a}} & \text{Beneficiaries in a} & = & \text{Capita Payment} \\ \text{Category}^* & & \text{Category} & & \text{Per Person to} \\ & & & & \text{State} \end{array}$$

- *Step 2: determine total cap amount*

$$\begin{array}{ccccc} \text{Average Per} & & \text{Number of} & & \text{Total Cap} \\ \text{Capita Payment} & \times & \text{Beneficiaries in a} & = & \text{Allocation} \\ \text{Per Person to} & & \text{Beneficiaries in a} & & \text{Adjusted for} \\ \text{State in Base Year} & & \text{Category in Start Year} & & \text{Growth} \end{array}$$

* Total Cost for Beneficiaries is defined as Medical Assistance Expenditures as Reported for Medical Assistance Service Categories in CMS-64 Reporting

per capita spending



Source: Rudowitz, R., Garfield, R., and Young, K., "Overview of Medicaid Per Capita Cap Proposals," Kaiser Family Foundation, June 2016. Available at: <http://kff.org/report-section/overview-of-medicaid-per-capita-cap-proposals-issue-brief/>

capped funding constraints

- *Neither block grants nor per capita caps account for things outside a state's control*
 - Public Health Crisis (Zika, Opioids, etc.)
 - Breakthrough drugs (HepC)
 - Natural disasters (Flood, Hurricanes, etc.)
- *Block grants do not account for economic downturns, resulting in higher enrollment*

new flexibility

- *Capped funding usually brings increased state flexibility*
 - Potential for changes in mandatory populations
 - Potential restrictions on eligibility and enrollment
 - Increase flexibility for premiums and copays
 - Potential new uses for funds

considerations for states

- *States would need to decide whether to commit more of their own resources to Medicaid or reduce spending*
 - Cutting reimbursement to health care providers
 - Eliminate optional services
 - Restricting eligibility
- *States may not spend state dollars beyond federal match*

considerations for hospitals

- *Costs may limit enrollment, benefits, and rates*
- *Fewer covered lives may lead to increased uncompensated care*
- *Increased churn rates for Medicaid enrollees make it difficult to manage population health*
- *Fewer dollars and more flexibility...*

questions?

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