Preliminary analysis of the released bill suggests the Commonwealth could lose $1.1-1.9 billion per year of federal revenue for MassHealth by FY22; findings are largely consistent with CBO assumptions, which suggest ~$1.5B of reduced federal revenue in FY22

- It transfers “downside only” risk from the federal government to the states and appears not to account for longstanding safety net payments under Massachusetts’ 1115 waiver
- It gives no additional flexibility to states to manage the program; implementation details will be set by US HHS

Specific provisions in the AHCA bill*:

- **Medicaid expansion population**: eliminates $500-700M+ per year of federal revenue by 2022 for MassHealth to support coverage to the ACA Medicaid expansion population
- **Per capita caps**: transfers “downside only” risk to states through caps on per capita spending
  - By 2022, provisions could cost up to $500M of federal revenue to the Commonwealth
  - Per capita caps would grow at medical CPI-U but do not account for unpredictable high cost growth items including pharmaceutical spending
  - There are no “shared savings” if states beat the target
- **Potentially puts ~$500-$550 million of federal revenue per year of 1115 waiver funding at risk (FY20)**
  - Safety net programs and supplemental payments through the 1115 appear to not be accounted for in how per capita caps would be set**
- **Restructures and reduces federal subsidies for Connector enrollees by ~$200M by 2022**
  - Eliminates APTCs ($457M) and cost sharing reductions (CSRs) ($124M) and replaces them with age-based refundable tax credits
  - Value of new tax credits is likely to fall short of current APTCs and CSRs
  - Expected to impact ~195,000 individuals current obtaining subsidized coverage through the Connector

**The bill does not enhance states’ flexibility to manage within the new caps**

- It focuses on allowing states to reduce access to care for low income people, including seniors and children, while leaving in place federal restrictions on how states pay providers and structure programs

- The bill also eliminates $19M/year in grants to DPH (e.g., family planning, sexual assault prevention)

*Estimates reflect internal analyses; page 5 compares with CBO assumptions

**$300M of lost revenue may be addressed by technical markup
**Overview of policy and programmatic elements of AHCA (1 of 3)**

- **Phases out enhanced match for Medicaid expansion**
  - Freeze Expansion State FMAP* at CY17 level (86% for MA vs 90% by 2019 under ACA)
  - Starting 1/1/20, enhanced match available only for specific individuals enrolled as of 12/31/19 who do not lose eligibility for more than one month
  - 50% match after 1/1/20 for new expansion population enrollees and those whose eligibility lapses for more than one month

- **Restructures Medicaid financing as a per capita cap effective FFY20**
  - Federal funds capped in aggregate starting in FY20 based on per-enrollee spending targets multiplied by actual enrollment
  - Targets calculated by population group, using FY16 base data inflated by medical CPI and adjusted based on FY19 actuals
  - Includes elderly, blind and disabled, children, expansion adults, other adults
  - Limited exclusions (e.g., DSH, administrative costs, Medicare cost-sharing, and certain populations including CHIP, Medicare buy-in, individuals served by Indian Health Services)
  - Caps apply to both State Plan and Waiver (1115 and HCBS) expenditures
  - Aggregate cap allows for “savings” from one group to finance care for another
  - Targets do not account for high cost growth items such as pharmaceutical spending
  - States bear all downside risk if spending exceeds target, no “shared savings” if under target

- **The bill as written does not appear to account for DSH and other 1115 Waiver Safety Net Care Pool payments in setting per capita caps**
  - State Plan supplemental payments incorporated into per capita caps, apportioned by population
  - DSH is generally outside of per capita caps, but it is unclear how MA’s 1115 payments through our DSH waiver would be treated
  - Repeals DSH cuts starting in FY18 for non-expansion states and FY20 for expansion states
  - Non-DSH 1115 Waiver SNCP payments do not appear to be incorporated into per capita caps in calculating targets, but all 1115 waiver spending would be subject to the caps starting in FY20

*FMAP=Federal Medical Assistance Percentage, the federal matching rate for Medicaid*
Overview of policy and programmatic elements of AHCA (2 of 3)

- **Changes certain Medicaid eligibility and benefits requirements**
  - Requires eligibility redeterminations every 6 months for expansion population beginning 10/1/17
  - Repeals Essential Health Benefits requirement for expansion population beginning in 1/1/20 (e.g., does not require addiction services)
  - Repeals hospital presumptive eligibility and limits presumptive eligibility
  - Reduces mandatory eligibility for kids ages 6-18 from 138% FPL to 100% FPL effective 1/1/20 (though states may cover children 100-138% through CHIP)
  - Ends the requirement that otherwise eligible applicants who report they are citizens or have a qualifying immigration status be covered for up to 90 days while they produce citizenship or immigration documents, effective six months after enactment
  - Requires states to use federal minimum for home equity in asset test (for elders, individuals living in nursing facilities and HCBS waiver participants)
  - Reduces retroactive eligibility from 3 months to the month in which an individual applies (Note: MA currently has a waiver to provide 10 days retroactive eligibility for most members under age 65)
  - Changes treatment of lottery winnings and inheritances in income calculation for eligibility

- **Other State Funding**
  - Increases funding for non expansion states while reducing funds for public health and family planning
    - Creates new pool of $10B safety net funding for non-expansion states ($2B/year for 5 years)
    - Repeals Prevention and Public Health Fund effective 10/1/19
    - Bans federal funding for Planned Parenthood for one year upon enactment
    - Provides $422M in additional funding for Community Health Centers in FY17 only
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Overview of policy and programmatic elements of AHCA (3 of 3)

- **Net reduction in federal funding to support health coverage for subsidized populations via Connector**
  - Bill would repeal advance premium tax credits (APTCs) and cost sharing reductions (CSRs). These changes would affect ~195,000 individuals currently in subsidized coverage through the Connector.
  - Though the bill would replace a portion of the lost premium tax credits and potentially offer a pool of funds to reduce enrollee costs, these measures appear to fall far short of current funding levels.

- **New Premium Tax Credits are likely to have regressive impacts**
  - Structure of new premium tax credits – linked to age rather than income or cost of insurance - is likely to disproportionately increase premium costs to older and poorer Massachusetts residents currently enrolled in the Health Connector.
  - Consumer confusion and market disruption are likely, given bill would require annual changes to tax credit rules until 2020.

- **Risks to Medicaid expansion funding would have cascading effects into Health Connector, HIX platform, and commercial market**
  - Given the Health Connector and MassHealth’s close policy & programmatic partnership and shared eligibility and enrollment platforms, the bill’s substantial changes to Medicaid, including per capita caps in 2020, could pose impacts to the Health Connector’s enrollment, finances, policy and operations as well as the broader commercial market (of which the Health Connector’s enrollees – both subsidized and unsubsidized – are a part).
**ACHA will result in $1.1 – $1.9 billion+ annual reduction in federal revenue**

<table>
<thead>
<tr>
<th>Actual FY16 Spending</th>
<th>Federal revenue at risk under AHCA by FY22</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>FFY16 gross spending</td>
</tr>
<tr>
<td>Expansion population</td>
<td>$2.1B</td>
</tr>
<tr>
<td>Other population (eg, FFS/MCO, state plan supps)</td>
<td>$16.2B</td>
</tr>
<tr>
<td>1115 waiver payments</td>
<td>$1.2B</td>
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<tr>
<td></td>
<td>$19.6B</td>
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<tr>
<td>Total MassHealth impact</td>
<td>$19.6B</td>
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<tr>
<td>Connector impact**</td>
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<tr>
<td>DPH impact</td>
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</tr>
<tr>
<td><strong>Total combined impact</strong></td>
<td><strong>$20.2B</strong></td>
</tr>
</tbody>
</table>

*Assumes MA can resume making regular DSH payments if the per capita cap structure would limit current 1115 waiver payments funded by DSH allotment. Another $330M of federal revenue would be at risk if the Secretary of HHS does not allow MA to make such a change.

** Excludes ConnectorCare wrap, captured in MassHealth 1115 waiver impact above.
**Preliminary estimate: ACHA revenue losses would increase from 2020 to 2022**

<table>
<thead>
<tr>
<th>CBO-extrapolated estimates ($M)</th>
<th>Internal estimates ($M)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2020</strong></td>
<td><strong>2021</strong></td>
</tr>
<tr>
<td>Expansion population</td>
<td>460</td>
</tr>
<tr>
<td>Other population (eg, FFS/MCO, state plan supps)</td>
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<tr>
<td>1115 waiver payments</td>
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<tr>
<td>Total MassHealth impact</td>
<td>760</td>
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<tr>
<td>Connector impact**</td>
<td>200</td>
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<tr>
<td>DPH impact</td>
<td>19</td>
</tr>
<tr>
<td><strong>Total combined impact</strong> ($B, rounded)</td>
<td><strong>1.0</strong></td>
</tr>
</tbody>
</table>

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