Modeling the Impacts of the American Health Care Act on Massachusetts

MAY 2017

IMPACTS OF H.R. 1628: AMERICAN HEALTH CARE ACT OF 2017 (AHCA) ON HEALTH CARE COVERAGE & COSTS IN MASSACHUSETTS

IMMEDIATE IMPACTS TO THE MASSHEALTH EXPANSION POPULATION: 2017–2021

The AHCA reduces the enhanced federal match rate for the Affordable Care Act (ACA) expansion population, setting it at 80% beginning in 2017 rather than it increasing to 93% in 2019 as mandated in the ACA. Beginning in 2020, there is no enhanced match for the expansion population, and it will be reduced from 80% to 50%. These changes results in $2.2B fewer federal dollars flowing to MassHealth between 2017 and 2021. To maintain current MassHealth eligibility and benefits, the state would have to spend an additional $1.9B over the same period.

FULLY IMPLEMENTED AHCA COVERAGE & COST IMPACTS: 2022 AND BEYOND

Changes in Public Coverage (2022):

If the state continues to cover the ACA expansion population at the lower federal match rate, does not make any cuts to eligibility or benefits, and eliminates the ConnectorCare program, full implementation of the AHCA will result in:

- Approximately **90,000 residents losing coverage**.
  - More than half of those have income between 138–300% FPL (between $33,948/year and $73,800/year for a family of four).
  - Many of those have coverage through ConnectorCare today or have income between 300–400% FPL and are currently eligible for the ACA's advance premium tax credits (APTCs) that vary with income and available premiums; AHCA would replace these with flat age-related tax credits which would be lower for many people.

If the state cannot cover the budget shortfall to maintain MassHealth eligibility and benefits for the expansion population, enrollment cuts would be necessary:

- Meaning that the 355,000 people in the Medicaid expansion population, in addition to the 90,000 above, would result in up to **445,000 residents losing coverage**.

Changes in Private Coverage (2022):

- Approximately **38,000 more residents would enroll in employer-sponsored insurance**.
  - Many of these individuals may have been eligible for APTCs and/or ConnectorCare under the ACA because their employer offer of coverage was deemed "unaffordable." Under the AHCA, according to HIPSM–MA, they now opt to take up their employer offer even though it may create a heavy financial burden to do so.

Changes in Government Spending:

- A ***decrease*** **of $1.4B in 2022** in federal Medicaid spending in Massachusetts.
  - This includes changes in federal spending on MassHealth and the loss of subsidies for ConnectorCare enrollees authorized under the 1115 waiver.
- An ***increase*** **of $1.1B in 2022** in state funding to maintain current MassHealth enrollment and benefits.
  - This accounts for the state no longer paying for enhanced subsidies for ConnectorCare enrollees.
- Over ten years (2017–2026), this equates to a **$9.6B reduction** in the level of federal Medicaid spending in Massachusetts.

Changes in Private Spending:

- Under the AHCA, health care spending by employers would increase by $296M in 2022, increasing from $24.8B to $25.1B (1.2%).
- Health care spending by non-elderly households would increase by $253M in 2022, from $13.5B to $13.8B (1.9%).

FOUNDATION MASSACHUSETTS

Massachusetts Coalition for Coverage and Care

URBAN INSTITUTE

THE HEALTH INSURANCE POLICY SIMULATION MODEL

The Urban Institute's Health Insurance Policy Simulation Model, or HIPSM, is a detailed microsimulation model of the health care system. It estimates the cost and coverage effects of proposed health care policy options. This national model, created in 2007, has been used to analyze some of the most important health policy debates of our time, including an earlier version that was used in 2005–2006 to model reforms in Massachusetts when policy makers were drafting Chapter 58, our landmark health care law. In addition, HIPSM was cited in the majority Supreme Court decision in *King v. Burwell*.

To evaluate how the health care system would be affected by policy changes, HIPSM simulates the decisions of employers to offer and families or individuals to enroll in health insurance coverage. The model is designed to show the effect of policy on government and private health care spending, health insurance premiums in employer and nongroup health insurance risk pools, rates of employer offers of coverage, and health insurance coverage.

HIPSM uses data from several national datasets including the American Community Survey, the Medical Expenditure Panel Survey, and the Statistics of U.S. Businesses.

HIPSM–MA

The Blue Cross Blue Shield of Massachusetts Foundation, on behalf of the Massachusetts Coalition for Coverage and Care, funded a state-level analysis (HIPSM–MA), using cost and coverage data from MassHealth (the state's Medicaid program), the Massachusetts Health Connector Authority, and the Center for Health Information and Analysis. This is the first analysis of this magnitude done for any individual state.

ABOUT THE URBAN INSTITUTE

The nonprofit Urban Institute is dedicated to elevating the debate on social and economic policy. For nearly five decades, Urban scholars have conducted research and offered evidence-based solutions that improve lives and strengthen communities across a rapidly urbanizing world. Their objective research helps expand opportunities for all, reduce hardship among the most vulnerable, and strengthen the effectiveness of the public sector.

The following assumptions were used to calibrate the HIPSM–MA analysis:

1. **Individual Mandate and Benefits:** The state would maintain its individual mandate, associated penalties, and related Minimum Creditable Coverage requirements. The state would not request a waiver of Essential Health Benefits.
2. **Employer Mandate:** An employer mandate would not be in place.
3. **Insurance Rating Rules:** The state would not request a waiver to permit insurers to develop rates based on medical experience and would maintain its existing modified community rating and 2:1 age band rating.
4. **Medicaid Expansion:** The model includes two scenarios:
   a. The state continues to cover the ACA expansion population at the lower federal match rate, does not make any cuts to eligibility or benefits, and eliminates the ConnectorCare program.
   b. The state would not allocate funds to cover the federal funding shortfall and would end coverage for the ACA expansion population.
5. **Per Capita Caps:** With the exception of assumption 4b above, the state would not modify Medicaid eligibility or benefits. The trend rates used to project MassHealth spending are those included in the state's 1115 waiver agreement. To the extent the state is able to perform better than these trends (e.g., as a result of its delivery system reform efforts) the funding gap could be mitigated.
6. **Work Requirements:** The state would not impose work requirements for Medicaid members.
7. **The Children's Health Insurance Program (CHIP):** Congress would reauthorize CHIP by September 30, 2017.
8. **ConnectorCare:** The program would be eliminated and the only financial assistance available to people not eligible for Medicaid would be the new AHCA age-related tax credits.
9. **1115 Waiver Non-Disproportionate Share (DSH) and Delivery System Reform Incentive Program (DSRIP):** The model does not analyze these funds. HIPSM is based on individual and employer behaviors and associated health care spending and does not account for spending not tied to individuals. If those expenditures were accounted for, the shortfall in state funding would likely increase.
10. **Patient and State Stability Fund:** The state would not allocate matching funds in order to access the Patient and State Stability Fund.