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House Republican Health Bill Would Severely Harm Medicaid Managed Care Plans

By Hannah Katch

The House-passed Republican health bill would end Medicaid as we know it by converting it to a per capita cap or a block grant, thereby breaking the federal government's decades-long guarantee to pay a fixed share of states' Medicaid costs. It would also cut federal Medicaid funding and shift costs to states, forcing them to make sweeping cuts to their Medicaid programs over time. And it would slash federal funding for the Affordable Care Act's (ACA) Medicaid expansion, eventually ending it. Together, these changes would cut federal Medicaid spending by \$834 billion over ten years and reduce enrollment by 14 million people by 2026, relative to current law.¹

The bill would thus have devastating consequences for tens of millions of children, seniors, people with disabilities, and other adults who rely on Medicaid coverage. What has received less attention is that the bill would also cause significant financial harm to Medicaid managed care plans, which serve a large majority of Medicaid beneficiaries, by substantially cutting the number of their enrollees and eliminating their flexibility to improve quality and lower costs.

The bill would harm Medicaid managed care plans in three ways:

1. **Plans would lose millions of enrollees due to the Medicaid eligibility cuts stemming from the House bill.** The bill's cap on states' federal Medicaid funding would shift large and growing costs to states, requiring them to cut Medicaid eligibility over time. In addition, the bill would end the Medicaid expansion for the 11 million newly eligible people who have enrolled.
2. **Facing cost shifts, states would also cut Medicaid reimbursement rates for providers and health plans serving Medicaid beneficiaries.** Managed care plans are currently paid through "capitation payments," which must be adequate to provide covered benefits to enrollees, promote program goals such as quality of care and improved health, and encourage providers to participate in Medicaid. A Medicaid cap would undermine this payment approach, leaving plan payment rates increasingly inadequate over time. States would not only lower payment rates but also would be less able to retroactively adjust rates if care was more expensive than anticipated over the course of the year or to

¹ Congressional Budget Office, "H.R. 1628, American Health Care Act of 2017," May 24, 2017, <https://www.cbo.gov/publication/52752>.

provide higher rates for the following plan year, given the ever-growing cut in federal funding.

3. **Medicaid caps would restrict plans' flexibility to innovate.** The current capitation payment system encourages health plans to innovate — such as by investing in delivery and payment models that could improve quality and access to care while lowering costs — since plans can pocket resulting savings. The cuts in payment rates that would likely occur under a per capita cap, however, would increasingly undermine plans' ability to invest in such approaches, restricting beneficiaries' access to care and reducing plans' ability to garner savings.

House Bill Would Cut Medicaid Enrollment by 14 Million

Per capita caps or block grants would cap federal Medicaid funding and increasingly cut it over time, shifting significant costs and responsibility to states. While some health plans claim that states could somehow increase their own spending to offset the federal cuts,² that would be highly unlikely considering the sheer magnitude of the cuts under the House bill. For example, by 2026, federal Medicaid spending would be *24 percent* lower than under current law.

States would therefore have to make ever-deeper cuts to eligibility, as well as benefits and payment rates for health plans and providers, according to the Congressional Budget Office (CBO).³ Millions of children and families, seniors, and people with disabilities now enrolled in Medicaid managed care plans could become ineligible. In addition to outright eligibility cuts, states would institute other cuts that would reduce enrollment, such as imposing premiums or making it more difficult to enroll in coverage. These enrollment barriers would result in fewer eligible individuals enrolled.

Medicaid health plans would also lose millions of Medicaid expansion enrollees, as the bill would effectively eliminate the expansion. Starting January 1, 2020, the bill lowers the 90 percent federal matching rate for new enrollees to the regular matching rate — on average, 57 percent. This change would require states to pay 2.8 to 5 times more for new expansion enrollees, or current enrollees who have a break in coverage of more than one month starting in 2020 and try to reenroll. In addition, the bill allows states to freeze their expansion and deny coverage to new enrollees subject to the lower matching rate. The magnitude of the cost shift would likely lead all or most expansion states to freeze enrollment.

Because low-income people's income is more likely to fluctuate, adult Medicaid beneficiaries tend to stay on the program for only limited periods; fewer than 5 percent of those who enrolled in the expansion prior to 2020 will still be on the program by 2024, CBO estimates.⁴ As a result, the Medicaid expansion would effectively be eliminated in a few years. Health plans would thus lose millions of Medicaid enrollees.

² Yahoo Finance, "Edited Transcript of CNC earnings conference call or presentation 7-Feb-17 1:30pm GMT," February 2017, <https://finance.yahoo.com/news/edited-transcript-cnc-earnings-conference-154546249.html>.

³ Congressional Budget Office, "American Health Care Act," March 13, 2017, <https://www.cbo.gov/publication/52486>.

⁴ *Ibid.*

Medicaid Caps Would Squeeze Payments to Health Plans

States contract with Medicaid managed care plans to provide covered benefits to their enrollees and agree to pay a set amount to cover the cost of those benefits. These payments, called capitation payments, are per-enrollee payments for the care their beneficiaries will need.

“Capitation payments” may sound similar to a “per capita cap,” but the two are entirely different. Capitation payments can make Medicaid managed care plans (as well as providers) more responsible for the total cost and quality of a beneficiary’s care because the plans bear the financial risk of managing costs within their capitation payments or suffering a loss when they don’t. Federal law requires states to pay health plans a capitation rate that is “actuarially sound,” meaning that it is estimated to cover the cost of all health plan services defined in the contract between the state and the health plan. Federal standards also require Medicaid health plan capitation rates to be sufficient to promote program goals such as quality of care, improved health, and health care delivery innovation. Further, the rates must be high enough to encourage providers to participate in Medicaid.⁵

States usually agree in advance to increase capitation payment rates if health care costs are significantly more than expected, and states can add payments for unforeseen circumstances, such as when an expensive new treatment is released. States also raise or lower capitation payments at the end of the year and adjust them in future years based on expected medical and long-term care costs to keep capitation rates adequate.

In sharp contrast, the House bill’s per capita cap is designed to *significantly reduce* federal Medicaid funding to states, relative to current law, and would ultimately provide far less funding than necessary to pay for the services Medicaid beneficiaries need. States would have no choice but to make large and growing Medicaid cuts, including cuts to reimbursement rates to managed care plans and health care providers. States also would likely seek further changes in Medicaid law to allow them to pay capitation rates to managed care plans that are *not* actuarially sound. If they received that authority, managed care plans could quickly see their rates reduced well below the level sufficient to pay for all needed services for Medicaid beneficiaries, likely causing plans to stint on care or inappropriately limit access to care.⁶ That, in turn, would likely make it more difficult each year for managed care plans to maintain a sufficient provider network for their enrollees, further reducing access to needed care.

In addition, a Medicaid per capita cap would leave states responsible for 100 percent of all costs in excess of the cap. For example, if costs end up higher than anticipated and states exceed their federal funding cap — due to, for instance, a disease outbreak, or the development of new, expensive drugs — states would get no additional federal Medicaid funding and would have to bear those higher costs alone. States would likely pass these costs along to health plans, providers, and beneficiaries. In addition, states would be on the hook for the effects of demographic changes like the aging of the population. Over time, the average age of seniors will rise as the baby-boom

⁵ Federal Register, Department of Health and Human Services, “Medicaid and Children’s Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability,” RIN 0938-AS25, May 2016.

⁶ American Academy of Actuaries, Letter to Speaker Ryan and Leader Pelosi, March 22, 2017, www.actuary.org/files/publications/AHCA_comment_letter_032217.pdf.

generation moves from “young-old” to “old-old” age. Seniors aged 85 and older have Medicaid spending that is 2.5 times higher than seniors aged 65-74, but the cap would not adjust for these higher costs.

Also under a per capita cap, states likely would no longer be able to retroactively adjust capitation rates if care was more expensive than anticipated over the course of the year. Nor could they likely provide higher rates for the following plan year, given the ever-growing cut in federal funding. Managed care plans would either have to absorb these higher costs or deny needed care to their members.

Finally, managed care plans would likely see higher average claim costs due to the end of the expansion and the per capita cap. That’s because the House bill would create strong incentives for Medicaid beneficiaries with greater health needs to remain enrolled to avoid being barred from reenrolling when states freeze their expansion to new enrollment; this could lead expansion enrollees to be less healthy, on average, driving up average per-enrollee costs, as the American Academy of Actuaries warns.⁷ Claims costs would rise even as states were reducing capitation rates. Similarly, state Medicaid cuts that involve premiums or otherwise make it harder for eligible to enroll would likely deter those who are relatively healthy and have lower health care costs from enrolling, thereby driving up claims costs.⁸

Medicaid Caps Would Restrict Plans’ Flexibility to Innovate

Today, health plans can succeed financially (and make a profit, among for-profit health plans) by innovating to reduce health care costs among their enrollees. By shifting beneficiaries toward primary care that can prevent future health conditions and prevent unnecessary use of costly services such as the emergency department, plans can save money out of their capitation rate. Ideally, this arrangement benefits all sides: the state pays the health plan an adequate rate for all covered services a beneficiary would likely need, and the health plan offers coordinated care that keeps the beneficiary healthy and pockets any savings.

A per capita cap, however, would likely result in lower and lower managed care rates as explained above. With less funding to cover beneficiaries’ essential services, plans would have fewer resources to make upfront investments in innovative ways of delivering care that can improve health care access and quality and lower costs over the long run. Moreover, with substantially fewer Medicaid enrollees overall, managed care plans would also have less incentive and less economies of scale to do so.

Supporters of the per capita cap frequently claim that it would give states flexibility to better customize their Medicaid programs to serve enrollees’ needs. In reality, caps would have the opposite effect: funding cuts would likely reduce flexibility and raise costs over time by hindering financially strapped plans from investing in care coordination and delivery system innovation.

⁷ American Academy of Actuaries, *op cit.*

⁸ *Ibid*; see also Jessica Schubel and Judith Solomon, “States Can Improve Health Outcomes and Lower Costs in Medicaid Using Existing Flexibility,” Center on Budget and Policy Priorities, April 9, 2015, <http://www.cbpp.org/research/health/states-can-improve-health-outcomes-and-lower-costs-in-medicaid-using-existing>.

Medicaid Cuts Would Stymie Innovation

Hennepin Health, a nationally renowned health program in Minnesota, may have to close if Congress cuts coverage for its members, who primarily gained Medicaid eligibility under the ACA Medicaid expansion. “[T]he financial model for Hennepin Health could be completely undermined,” the organization warns. “It’s a huge threat.”

Minnesota began expanding Medicaid soon after the ACA’s enactment. Hennepin County, which comprises Minneapolis and its surrounding suburbs, pioneered a new way to care for hard-to-reach Medicaid beneficiaries in 2011, focusing on Hennepin’s newly eligible adults with chronic conditions who frequently used the emergency department. A Medicaid health plan, the county health department, a public hospital, and a health center partnered to create an accountable care organization, Hennepin Health, to care for the county’s highest-need patients. And Hennepin Health works: emergency department visits dropped nearly 10 percent and primary care visits rose, as did the share of members receiving recommended care. Hennepin Health members receiving stable housing were 35 percent less likely to visit the emergency room and 16 percent less likely to be admitted to the hospital.^a

States like Minnesota have the flexibility to design innovative ways to deliver care because of the reliable funding that Medicaid provides. Hennepin Health required significant upfront funding to expand its workforce, invest in IT systems, and pay providers. Cuts to Medicaid would jeopardize home-grown innovation across the country.

^a Martha Hostetter, Sarah Klein, and Douglas McCarthy, “Hennepin Health: A Care Delivery Paradigm for New Medicaid Beneficiaries,” The Commonwealth Fund, October 2016.

Health Plans, Investors, and Analysts Have Strong Concerns with Republican Health Bill

- The credit rating agency Moody’s recently alerted investors to the dangers that the House Republican bill poses to managed care plans.⁹ The bill would be “credit negative” for U.S. corporate health care companies, Moody’s announced, due to its lowering of federal Medicaid spending and increase in the uninsured rate. While repealing several ACA taxes on the health industry would modestly benefit these sectors, Moody’s estimates the benefit would be more than offset by the declines in the number of insured patients and in Medicaid funding.
- In a March 2017 letter to House Speaker Paul Ryan and Minority Leader Nancy Pelosi, the American Academy of Actuaries wrote, “Basing per capita caps on state-specific historical costs ... would penalize states with the most efficient programs, because states with historically less-efficient programs would presumably have greater opportunities for savings to avoid state budget overruns.” The letter further explained, “If [the per capita cap growth rate] does not keep pace with total health care cost changes, it will likely be difficult for states to sustain or improve their current programs. Efforts to close budget gaps including eligibility and benefit changes may reduce Medicaid spending but they will not reduce total spending; the cost of care will be transferred to providers, insurers, employers, and to the individuals who seek needed care.”¹⁰

⁹ Moody’s Investment Service, “Announcement: Moody’s: Proposed American Health Care Act would be credit negative for most healthcare companies,” March 17, 2017, https://www.moody.com/research/Moodys-Proposed-American-Health-Care-Act-would-be-credit-negative--PR_363716.

¹⁰ American Academy of Actuaries, *op cit*.

- The Association for Community Affiliated Plans (ACAP), which represents many non-profit Medicaid managed care plans, publicly opposed the bill, stating “President Trump and Congress have before them an abundance of opportunities to improve the American health care system. The American Health Care Act [AHCA] is not one of them. . . . ACAP calls on the Senate to disregard the AHCA and begin this effort anew with a clean sheet of paper.”¹¹ Medicaid Health Plans of America, representing largely for-profit managed care plans, also opposed the bill.
- Medical directors of two regional health plans recently warned that innovative Medicaid programs could be eliminated under the House bill’s Medicaid cuts. UCare in Minnesota works with community organizations to improve access to care for seniors and people with disabilities with Medicaid coverage, such as by investing in a mobile dental clinic. Medicaid funding cuts would “drastically impact those types of programs and lead to a decrease in the health of our community, and probably [an] increase in the overall cost of healthcare,” according to Lisa Mattson, the plan’s associate medical director.¹²

Similarly, Geisinger in Pennsylvania recently launched an ambulatory clinic to provide substance use disorder treatment. Dr. Perry Meadows, the plan’s medical director of government programs, said “Quite honestly, if Medicaid [expansion] disappears, this program will disappear.” He said that without Medicaid coverage for substance use disorder treatment, “we’re going to be losing lives.”¹³

- The former CEO of Molina Healthcare, a large health plan that covers people in Medicaid and the individual market, stated recently about the House plan, “What it’s really going to do is transfer the responsibility for funding Medicaid from the federal government and put more of a burden on the states. . . . [I]f health care costs go up, where’s the money going to come from? Are they going to raise taxes? Or are they going to take it away from education which will hurt public schools?” When asked about the effect on his business, he said, “I am worried about the long-term consequences to the safety net. Medicaid is the safety net. And when you damage that, people are going to fall through.”¹⁴
- America’s Health Insurance Plans, the national association covering many commercial health plans, wrote in a March 8 letter to the House regarding the Republican health bill, “As a core principle, we believe that Medicaid funding should be adequate to meet the healthcare needs of beneficiaries. We are concerned that key components of the proposed new funding formulas starting in 2020 — such as the base year selection and annual increases tied to the

¹¹ Association for Community Affiliated Plans, “Statement of ACAP in Opposition to the American Health Care Act,” March 21, 2017, <http://www.communityplans.net/policy/statement-of-acap-in-opposition-to-the-american-health-care-act/>.

¹² Shelby Livingston, “Not-for-profit health insurers warn Medicaid cuts would endanger essential care-management programs,” *Modern Healthcare*, June 12, 2017, <http://www.modernhealthcare.com/article/20170612/NEWS/170619984>.

¹³ *Ibid.*

¹⁴ Morning Edition, “Molina Healthcare CEO Expresses Doubts About GOP’s Health Plan,” March 10, 2017, <http://www.npr.org/2017/03/10/519593216/molina-healthcare-ceo-expresses-doubts-about-gops-health-plan>.

consumer price index for medical care — could result in unnecessary disruptions in the coverage and care beneficiaries depend on.”¹⁵

¹⁵ Marilyn Tavenner, AHIP Letter Regarding American Health Care Act, March 8, 2017, <https://www.ahip.org/ahip-letter-regarding-american-health-care-act/>.