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Fitch: Medicaid Changes in ACA Repeal Bill Pose Risks for States and Hospitals.

Fitch Ratings-New York-07 March 2017: The congressional bill released yesterday by House Republicans to repeal and replace the Affordable Care Act (ACA) includes significant changes to Medicaid that expose states to new fiscal and policy risks, says Fitch Ratings. States generally maintain significant flexibility to deal with fiscal challenges, including shifts in federal funding, while maintaining fundamental credit quality. As Medicaid represents approximately one-third of state budgets, the fundamental changes proposed could challenge that flexibility. Implications for lower levels of government including school districts, cities, counties, and public higher education institutions that rely on state support could be more significant given their generally more constrained budgetary flexibility. Hospital and skilled nursing home providers would be at risk of reduced coverage eligibility, reduced reimbursement for services provided or both.

First, the House Republican American Health Care Act (AHA) proposes ending Medicaid's entitlement structure and moving states to a per capita cap system on Jan. 1, 2020. The per capita cap structure proposed in AHA is intended to slow the growth in federal Medicaid spending by limiting increases in federal spending to a measure of medical inflation and shifting risk for higher costs to states, providers and enrollees. The Kaiser Commission on Medicaid and the Uninsured estimates that the March 2016 House Budget Resolution (which included the option of per capita caps or block grants for Medicaid) would reduce federal spending on traditional Medicaid by $1 trillion (or 26%) over 10 years. The Congressional Budget Office (CBO) has not yet released its official estimates of AHA's effect on the federal budget.

Reducing federal Medicaid funding anywhere near 26% over 10 years would require states to make significant budgetary changes. Without CBO estimates of the full magnitude of the AHA's proposed reductions in federal spending, it is difficult to assess how effectively states could prepare for these changes. Effects for each state will also vary, depending on their per capita spending levels for Medicaid in the fiscal 2016 base year under AHA. House Republicans and the President have previously indicated states could utilize unspecified new flexibility to offset the reduced funding. Fitch notes that current law already offers states discretion to implement Medicaid within federal statutes and rules, and also creates a waiver process for additional flexibility. Currently, every state has at least one waiver in place. And during the last two recessions, the states implemented a wide range of changes in Medicaid operations and financing (with and without waivers), including a pronounced shift to managed care. As such, it is unclear that any additional flexibility provided by the federal government would be sufficient to offset the funding cuts.

Second, the AHA ends new enrollment in the Medicaid expansion and the enhanced federal match that 31 states and the District of Columbia have opted into, on Dec. 31, 2019. Under AHA, states that expand before that date will continue to receive the enhanced federal funding envisioned under current law for the newly eligible population under the expansion. But the enhanced funding would only apply to those individuals who were enrolled prior to Dec. 31, 2019. Over time, the newly eligible population would roll off, as would the associated enhanced federal funding. The federal Department of Health and Human Services (HHS) estimated 9.1 million people received insurance

coverage under state Medicaid expansions in federal fiscal year 2015. With the enhanced matching rate (100% in 2015 and phasing down to 90% by 2020 under current law), HHS estimates the states received $58.1 billion in federal funding to provide that coverage in 2015.

Under AHA, expansion states would not risk immediately losing the billions in federal funding for the newly eligible. But they will be faced with a unique policy predicament of denying Medicaid access to individuals who would otherwise qualify beginning in 2020, or taking on significant costs they had anticipated would be borne largely by the federal government.

The 19 non-expansion states, and health care providers operating within them, could see short-term benefits under AHA. The bill establishes a $2 billion annual pool of federal funding available from 2018 to 2021 to states that do not expand to offset their payments to Medicaid providers, presumably because of higher uncompensated care levels. Similarly, AHA limits planned reductions in Medicaid's disproportionate share (DSH) funding provided to states for safety-net providers to $3 billion annually instead of $8 billion under current law. Under AHA, non-expansion states are exempt from even these more limited DSH cuts. All states, and the District of Columbia, would be subject to the more long-term and consequential implications of the AHA's per capita cap system for Medicaid financing described above.

The AHA released yesterday is the first public draft of major legislation that will likely be the subject of intensive lobbying efforts and potentially significant revisions. Beyond the Medicaid provisions noted above, the legislation also includes wide-ranging changes to other aspects of the healthcare industry that could directly or indirectly affect state and local governments including public health funding, the individual marketplace, and related tax provisions. But the House Republican leadership has laid out an aggressive timeline with the first committee hearings scheduled for Wednesday. The bill appears broadly in line with the President's healthcare goals outlined in his recent address to Congress and he released a brief statement indicating his support for the AHA.

Fitch will continue to closely monitor legislative developments around the AHA, which could have implications for states' credit quality as well as for related public finance entities and healthcare providers. Medicaid changes that significantly reduce federal funding will cause states to consider a broad mix of revenue increases or spending cuts to maintain long-term fiscal balance. Local governments, school districts and higher education institutions could face fiscal stress in adjusting to reduced state support. In a time of already muted revenue growth, spending cuts could affect K-12 and higher education the most, as those are the other largest areas of state spending outside of Medicaid. Similarly, changes that result in rising uninsured and uncompensated care levels and reduced reimbursement to hospitals, health systems and long term care providers would be a negative credit development and likely pressure healthcare provider performance over the longer term.

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