Federal Health Care Reform
Potential Impacts on Arizona's Families, State Budget and Economy

June 2017

Health care in Arizona has experienced dramatic change since the enactment of the Affordable Care Act (ACA) in 2010. The ACA directly affected Medicaid, private insurance, state finances, patient care and employment. As Congress considers legislation to repeal and replace the ACA, another wave of change is on the horizon. In this paper, we evaluate how major provisions of current proposals in Congress could affect Arizona, including the uninsured rate, the state budget, employment and the economy overall.

AHCCCS Coverage in Arizona

The Arizona Health Care Cost Containment System (AHCCCS) is a nationally recognized Medicaid program that serves over 1.9 million low-income adults and children. AHCCCS began operating in 1982 under a Section 1115 demonstration waiver to the Social Security Act (SSA). This waiver provides Arizona with exemptions to certain provisions of the SSA, allowing the state to utilize a managed care model. Over the years, this model has driven down the cost per covered individual while simultaneously increasing access to care and broadening the choices available to patients. In 2013, AHCCCS spent nearly $2,000 less per enrollee than the national average ($5,821 versus $7,766, respectively).[1]

Who's enrolled in AHCCCS?

Of the 1.9 million enrollees in 2016, 50% were adults age 19 to 64, 44% were children, and 6% were elderly but ineligible for Medicare. Seventy-nine percent of AHCCCS enrollees live in households where at least one person works either full time (66%) or part time (13%) according to a 2015 analysis by the Kaiser Family Foundation.

Arizona has the largest difference in Medicaid enrollment between rural and urban counties in the country. Thirty-four percent of adults in Arizona's rural counties are enrolled in AHCCCS (the largest percentage in the country), whereas in Arizona's urban counties only 18% of adults are enrolled. For children, 54% in rural counties are enrolled compared to 36% in urban counties.[2] It is important to note that the total number of enrollees in Arizona's urban counties is still higher than in rural counties due to the much larger total population in urban areas.

How has enrollment changed since Medicaid expansion?

Arizona enacted Medicaid expansion under the Affordable Care Act (ACA) in January 2014. The prior eligibility limit for adults was an income of 100% of the Federal Poverty Level (FPL). Under expansion, the new limit was set at 133% of FPL (roughly $15,800 for an individual or $32,300 for a family of four in 2016). [3] The expansion came on the heels of a

Key Points

- Both bills in Congress would dramatically cut federal funds for AHCCCS.
- Nearly 400,000 Arizonans are at risk of losing AHCCCS coverage.
- Thousands more could lose tax credits to buy private insurance.
- Over 62,000 could lose jobs next year.
- Total impact to the state budget could be over $7 billion by 2026.

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[1] Medicaid and CHIP Payment and Access Commission (MACPAC), MACStats: Medicaid and CHIP Data Book, December 2016, https://www.macpac.gov/wp-content/uploads/2016/12/MACStats_DataBook_Dec2016.pdf.
[2] Georgetown University Center for Children and Families and University of North Carolina NC Rural Health Research Program, "Medicaid in Small Towns and Rural America: A Lifeline for Children, Families and Communities." Data are for fiscal year 2014-15.
[3] The ACA law text reads 133% FPL, but also calls for a new method of calculating income bringing the actual minimum to 138% PFPL. This discrepancy has created some confusion among different organizations attempting to quantify the effects of Medicaid expansion.

temporary AHCCCS enrollment freeze that the Arizona Legislature enacted in 2011 in response to a severe state budget shortfall associated with the Great Recession. Medicaid expansion both extended eligibility to a new population (adults earning 100% to 133% FPL) and unfroze the budget-related enrollment cap for adults earning 0% to 100% FPL. According to AHCCCS data, approximately 400,000 adults have obtained coverage as a result of Medicaid expansion and restoration (317,135 in the 0-100% Proposition 204 Childless Adult population and 82,228 in the 100-133% Expansion Adult population). Of these, over 30% are over the age of 50. Approximately 80,800 are receiving mental health services and 11,563 are categorized as Seriously Mentally Ill (SMI), 29,400 are currently receiving care for cancer and 47,100 have substance abuse disorders. Arizona's KidsCare program, which provides AHCCCS coverage to children in families earning between 133% and 200% FPL, was also affected. The Arizona Legislature froze enrollment in KidsCare in 2010, also in response to the budget deficit. Many of the children who had previously been covered by KidsCare were transferred to a traditional AHCCCS program in 2014. AHCCCS then resumed enrollment in KidsCare in September 2016, largely in response to a 100% federal match. By May 2017, enrollment had grown to nearly 20,000 children.[4]

How would current proposals in Congress affect Arizona?

The American Health Care Act (AHCA), H.R. 1628, passed by the House of Representatives on May 4, 2017 would change how Medicaid is financed and the amount of future federal support for the program. The Congressional Budget Office released an analysis of the AHCA on May 24, 2017 projecting that states would receive $834 billion less in federal Medicaid funds over a 10-year period than under the current law. While the AHCA contains numerous provisions, five stand out due to their direct impact on state budgets:[5]

- **Termination of enhanced federal matching funds for states.** The AHCA ends the enhanced Federal Medical Assistance Percentages (FMAP) established in the ACA and replaces them with a per capita cap or block grant.
- **Per capita cap on Medicaid payments to states.** Each state would be annually assigned a per-enrollee spending cap for five enrollment groups—elderly, blind and disabled, children, expansion adults, and other adults—based on 2016 expenditures. The per capita cap is multiplied by the number of enrollees in each program.
- **Optional block grants for Medicaid.** States would have the option to select a block grant instead of receiving per capita payments for certain populations. States selecting this option would receive a single fixed amount annually that would not be adjusted for increases in enrollment that could occur due to population growth or economic downturns. Instead, the block grants would increase annually based on the Medical Consumer Price Index (CPI) plus an additional one percent for the elderly and disabled groups.
- **Changes criteria for tax credits.** This would occur primarily through the elimination of tax credits used to purchase insurance policies through the exchanges. Age-based tax credits would replace the current tax credits which are based on income, geography and age. These new credits would phase out for incomes ranging between $75,000 and $115,000.
- **State stability fund grants.** The law establishes a $100 billion fund over nine years for grants to states for high-risk pools, preventative services, cost sharing subsidies, mental health and substance abuse services, and maternity and newborn care, among other purposes. It also provides $15 billion over nine years for a new "Federal Invisible Risk Sharing Program" (FIRSP), to be developed by insurers and the federal government. An additional $8 billion over five years is available for states that choose community-based rating waivers, meaning that insurers could charge more for individuals with pre-existing conditions.

The Better Care Reconciliation Act (BCRA), introduced in the Senate on June 22, 2017, shares many common provisions with the AHCA, but key differences exist:

- **Slower phase down of Medicaid expansion funds.** The phase down of expansion funds would begin in 2021 and occur more slowly than in the House bill, but the final impact on Medicaid funds would be more dramatic.
- **Per capita cap or block grants for Medicaid.** The provisions are similar to the House's AHCA. The key difference is that the Senate bill would use the lower Urban CPI, which is based on a generic basket of consumer goods rather than the Medical CPI, which is based on health care related expenses.
- **Maintains existing criteria for tax credits.** Age, income, and geography would all be used to calculate tax credits for the purchase of health insurance. However, the amount available for these tax credits would be lower than in the Affordable Care Act, and the top eligible income would be 350% FPL as opposed to 400% FPL in the ACA.
- **State stability fund grants.** States would receive $50 billion over four years to stabilize their insurance markets.
- **Appropriates funds for opioid crisis.** $2 billion would be available to states to fight opioid drug abuse.

[4] https://www.azahcccs.gov/Resources/Downloads/PopulationStatistics/2017/May/AHCCCS_Population_by_Category.pdf
[5] Because of the length and complexity of bills in Congress, not all programs are addressed in this briefing paper.

Implications for Arizona's State Budget

On June 28, 2012, the U.S. Supreme Court issued a decision on a case challenging the Affordable Care Act. The Court determined that states could not be required to expand Medicaid eligibility, effectively making expansion voluntary. Then-Governor Jan Brewer decided that expansion would be in Arizona's best interest because the costs would initially be fully covered by the federal government, phasing down to a 90% match. The Arizona Legislature passed a law allowing for Medicaid expansion, which included a hospital assessment to help fund the state's share of the expansion population. The hospital assessment, which has twice been upheld by state courts, will automatically end if ACA is repealed or the federal matching rate drops below 80%.

Because both bills being considered in Congress would effectively do away with the enhanced federal matching funds, states will have to make difficult decisions about whether to continue covering the expansion population out of their own budgets. Arizona essentially has three choices: 1) eliminate all coverage expansions, 2) maintain all coverage expansions through state funds, or 3) develop a hybrid approach.

If AHCCCS continues enrollment for Proposition 204 (voter-approved initiative from 2000 to cover adults earning up to 100% FPL) but freezes enrollment for the 80,000 adults earning between 100% and 133% FPL, the cost to the state in FY 2018 would be $30 million under both the AHCA and the BCRA. By FY 2026, the total cumulative cost will rise to $3.3 billion under the AHCA and $2.9 billion under the BCRA. These figures include the "penalty" for early expansion states like Arizona that were already covering adults up to 100% FPL before the enactment of the Affordable Care Act. On top of these costs, Arizona would face an additional $2 billion because the statutory authority for the hospital assessment is automatically repealed when the federal match drops below 80%, which it would in both bills. The impact of the reduced inflationary adjustment under the BRCA, which is based on the Urban CPI, is an estimated $2.2 billion.[6]

In FY 2016, insurance premium taxes composed 5% of total Arizona state revenue.[7] Reductions in premium tax credits will likely result in some individuals dropping insurance coverage. As a result, insurance premium tax collections would go down. As previously mentioned, income-based tax credits would be replaced by age-based tax credits in the AHCA. The BCRA would retain the criteria for tax credits but lower the amount available. The removal of the tax penalties for the individual and large employer mandates would serve as a further disincentive to purchase insurance. The AHCA does provide for the development of a new tax credit program for insurance policies bought outside of the exchanges. How this would work has yet to be defined.

What would be the downstream effects on other state programs?

At $1.75 billion, AHCCCS is the second largest expenditure in the $9.6 billion General Fund of Arizona's state budget. K-12 education is the largest expenditure at just over $4 billion. Other major expenditures are Corrections at just over $1 billion, Universities at almost $700 million, Economic Security at $530 million and Child Safety at $380 million. If federal funds for Medicaid are sharply curtailed, the State of Arizona will need to either move funds from other expenditure areas or raise taxes in order to maintain the same level of coverage. Even complete elimination of smaller state government agencies, which perform numerous federally-mandated functions such as environmental regulation, would not generate the level of funds necessary to maintain AHCCCS coverage at current levels.

Given that K-12 education is the largest single budget item, it is difficult to see a path that would not involve moving money out of the public education system. However, Governor Ducey, members of the state legislature and the business community have expended great effort in recent years to implement innovative funding measures that support our schools and teachers. Given this focus on education, it is unlikely that lawmakers or the Governor would be open to reducing funds for education in order to bolster AHCCCS. Likewise, there is little appetite for tax increases among Arizona's lawmakers or Governor Ducey. There is already an anticipated budget deficit of $92 million for the upcoming fiscal year. Given these realities, the difficulties in funding AHCCCS coverage at current levels using state funds mean that reductions in coverage are the more likely result.

Implications for the Uninsured Rate

Approximately 400,000 adults have obtained coverage as a result of Medicaid expansion and restoration. An additional 125,000 people have received tax credits to buy insurance on the exchange. In total, the U.S. Department of Health and Human Services calculated that the uninsured rate in Arizona has decreased by 36% since the enactment of the Affordable Care Act. [8]

AHCCCS estimates that if the state chooses to freeze coverage for both adults earning 0% to 100% FPL and those earning above 100% and up to 133% FPL, there would be 383,000 fewer adults enrolled in the program by 2023. Freezing enrollment means that no new beneficiaries could enroll in the program but that current beneficiaries could stay

[6] AHCCCS, "Summary of AHCCCS Impacts; American Health Care Act (AHCA) and Better Care Reconciliation Act (BCRA)," June 23, 2017.
[7] Author's own calculations based on Joint Legislative Budget Committee, "Historic General Fund Revenue Collections," http://www.azleg.gov/jlbc/historicalgeneral-fundrevenuecollections.pdf, page 1.
[8] Seidman Research Institute, W.P. Carey School of Business, Arizona State University, "Economic Impact on Arizona of Repeal of Funding Provisions of the Affordable Care Act," January 2017.

enrolled until they became ineligible due to a change in employment/income, a move out of state, or some other disqualifying reason. AHCCCS also estimates that if the state chooses to maintain coverage for adults earning 0% to 100% FPL at the lower FMAP but discontinue coverage for adults earning above 100% FPL and up to 133% FPL, there would be 108,000 fewer enrollees by 2023.[9]

As previously stated, 26,700 currently covered adults are receiving care for cancer and 11,563 are categorized as seriously mentally ill. The loss of coverage for these individuals could have a serious direct impact on patients and their families as well as society at large. State and federal efforts to combat the opioid addiction epidemic would be threatened. Although the BCRA does provide $2 billion to states to fight this crisis, the value of these funds is limited if those facing addition lack basic health insurance. This is especially important in Arizona where over 16,000 adults currently on AHCCCS have a diagnosis for opioid use disorder.[10]

The loss of coverage would also strain the entire health care system. Patients without health care coverage are often unable to obtain preventative services and lack access to appropriate medical specialists. They may also be unable to afford prescription medications that control chronic or acute diseases. As a result, these patients are far more likely to show up at hospital emergency departments. This causes several problems. First, the patient's health is likely to suffer from a lack of regular, ongoing care. Second, emergency departments are strained from serving patients that would be better cared for in a non-emergency setting. And third, health care costs go up because emergency departments are an expensive way to provide care for conditions that could be managed more cost-effectively in other settings.

What would happen to coverage for children?

Arizona's Children's Health Insurance Program (CHIP) program goes by the name KidsCare. The ACA made several changes to CHIP. It required a maintenance-of-effort on the part of states, meaning that states could only receive federal funds if they maintained coverage at the level that existed prior to the enactment of the ACA. Additionally, the ACA established a minimum eligibility level of 133% FPL for children of all ages. Prior to the ACA, this minimum only applied to children ages zero to five. The minimum for older children had been 100% FPL. The ACA also increased the FMAP for CHIP by 23 percentage points. In Arizona, this meant that the FMAP rose to 100%.

Under the AHCA, the minimum income eligibility for older children age 6 through 18 would revert to the prior 100% FPL. Per capita caps in funding and block grants for Medicaid would further limit the total funds available for children. Actual funding for CHIP goes through a separate bill which is up for renewal in September 2017.

What is the hidden health care tax ?

A federal law known as the Emergency Medical Treatment and Active Labor Act (EMTALA) requires hospitals to evaluate and stabilize all patients who come through their doors regardless of ability to pay. When patients who do not have health insurance and are unable to self-pay come to emergency rooms, hospitals classify the services they provide as "uncompensated care." Hospitals simply absorb a portion of this uncompensated care. Since the enactment of the ACA in Arizona, uncompensated care has dropped by $541 million – from roughly 8% to 2.7% of total hospital expenses.[11]

If legislation similar to the AHCA or BCRA is enacted and the state does not continue covering adults earning up to 133% FPL, hospitals would be unable to absorb the entire increase in uncompensated care. Historically, when the level of uncompensated care rises too high, hospitals pass along these costs to private insurance companies. When hospitals negotiate rates with private insurers, they account for uncompensated care in their costs. The insurance companies then pass these increased costs along to their policy holders. This cost shift is often referred to as the "hidden health care tax" because it is a cost that must be paid by employers and individuals as a result of the government's underpayments for Medicaid.

[9] AHCCCS, "Summary of AHCA Impacts," as presented in issued letter to Sen. Flake by Arizona Association of Health Plans and Health System Alliance of Arizona on March 20, 2017.
[10] AHCCCS, "Summary of AHCCCS Impacts: American Health Care Act (House) and Better Care Reconciliation Act (Senate), June 23, 2017.
[11] Arizona Hospital and Healthcare Association, Memo, December 2016 Hospital and Financial Results, March 1, 2017.

How would the private insurance market change?

Several provisions in the AHCA and BCRA would impact the premiums paid by purchasers of private insurance. One of these is the allowable age rating ratio. Under the Affordable Care Act (ACA), older individuals could only be charged a premium three times higher than younger individuals. Under the AHCA and the BCRA, the ratio would expand to 5-to-1. Another significant change is the way that tax credits are calculated. Under the ACA, tax credits vary based on three factors: age, region and income. Under AHCA, age is the only variable. However, the BCRA retains the three criteria of the ACA but at lower levels.

The National Academy for State Health Policy conducted an analysis for each state using data from the Kaiser Family Foundation.[12] Under the ACA, the average net consumer premium for all ages in Arizona in 2020 is estimated to be $2,480 annually after accounting for tax credits (based on an individual income of $30,000). Under the provisions of the AHCA, significant differences would exist by county. Maricopa County, which has a competitive insurance market, would experience the lowest increases in relative terms. However, the estimated increases are still large in absolute terms. A 27-year old would pay an average net consumer premium of $3,480 per year while a 60-year old would pay $16,450. This stands in contrast to the estimates for Yavapai County where a 27-year old would pay $5,980 and a 60-year old would pay $26,090.

Implications for Arizona's Economy

The loss of Medicaid expansion funds and the reductions in premium tax credits would have a significant effect on Arizona's health care industry. But the effects would not stop there. Hospitals, medical labs, doctor's offices and assisted living facilities would reduce purchases from suppliers and cancel construction contracts. Suppliers to the health care industry cover a wide range of products and services such as janitorial services, accounting, uniforms, office supplies, transportation, electricity, telecommunications, food service, construction, real estate and many more. All of these sectors would feel the downstream effects of funding reductions for health care.

The Seidman Research Institute at the W.P Carey School of Business at Arizona State University conducted a study in January 2017 to determine the economic impact of the repeal of the funding provisions of the ACA.[13] The study looks at four sub-sectors within the health care industry – hospitals, ambulatory health care (medical offices and labs), nursing and residential facilities and social assistance services. Together these sub-sectors represent 12.6% of all employment in the state of Arizona.

The study models two scenarios, both for the upcoming fiscal year of 2018 and for a ten-year period of 2017 through 2027. The first scenario assumes that all state and federal funding related to the ACA are lost. The second scenario assumes that only federal funding is lost.

Under **scenario 1**, in 2018 there is a loss of 62,659 jobs. Of these, 29,461 are in the health care industry and 33,198 are in other industries. By 2027, the cumulative job loss is 717,701, of which 325,381 are in health care and 392,320 are in other industries. Gross state product is reduced by $5 billion in 2018 and a cumulative total of $60 billion by 2027. Personal income goes down by $3.5 billion in 2018 and a cumulative total of $46 billion by 2027.

Under **scenario 2**, in 2018 there is a loss of 57,781 jobs. Of these, 27,335 are in the health care industry and 30,446 are in other industries. By 2027, the cumulative job loss is 663,217 of which are 301,417 in the health care industry and 361,800 are in other industries. Gross state product is reduced by $4.6 billion in 2018 and a cumulative total of $55.9 billion by 2027. Personal income goes down by $3.2 billion in 2018 and a cumulative total of $42.7 billion by 2027.

Arizona has focused on growing the biosciences industry for the past 15 years. Hospitals, research and medical labs, pharmaceuticals and medical devices, which collectively employed 106,282 Arizonans in 2015, account for the majority of biosciences employment. Losses in health care jobs will hamper continued efforts to develop Arizona's biosciences industry.

Importantly, the economic impacts of the loss of Medicaid expansion funds and premium tax credits would not be distributed evenly throughout the state. The Phoenix metro area has the largest number of health care workers at 267,840, which comprises 11.8% of all employment. Among metro areas, Tucson has the largest percentage of its workforce employed in healthcare at 16.0%. Flagstaff and Lake Havasu City/Kingman also have a high percentage of the workforce employed in healthcare at 15.8% and 15.5%, respectively. Six out of fifteen counties have more than 15% of the workforce in healthcare. Rural Apache county stands out with healthcare employment at 23.9%. Those areas with the highest health care employment stand to take the biggest economic hit from the anticipated job losses.

The Path Forward

Moderate Republicans have a different set of concerns than their more conservative colleagues. Three big issues that do not currently have consensus among Republican lawmakers include:

- The depth of the cuts to Medicaid and the speed of the phase down of federal matching funds;
- Which measure of the Consumer Price Index to use for

[12] National Academy for State Health Policy, "State Chart Book: Comparison of Predicted Premium Differences by Counties under the Affordable Care Act and the American Health Care Act," June 8, 2017.
[13] Seidman Research Institute, W.P. Carey School of Business, Arizona State University, January 2017 http://azchildren.org/wp-content/uploads/2017/02/ASU-Economic-Impact-Study-2-6-17.pdf

calculating block grants to states (urban vs. medical); and

- Calculation used for premium tax credits (age only vs. a combination of age, geography and income).

No Democrats are expected to vote for the Senate bill. Due to the narrow majority Republican's hold, Majority Leader Mitch McConnell can only afford to lose two Republican votes. This is a tall order given the wide range of opinions held by members of the Republican Caucus and the initial opposition from four leading conservative Republican Senators.

If the Senate is able to pass a bill, it must still be reconciled with the AHCA as passed in the House. A conference committee would be tasked with resolving differences. If the conference committee is successful, the House and Senate would then need to pass identical versions of the bill for it to reach President Trump's desk.

Conclusion

Health care in America faces serious challenges. If we are to maintain the best quality of care in the world without inflicting severe financial damage to our federal and state budgets, we must consider real reforms that bring down systemic costs. Simply cutting off funding for Medicaid and reducing subsidies for premium tax credits is not the answer. Areas that could make a meaningful difference in health outcomes and the cost of care include: 1) a focus on wellness, preventative care, and the management of chronic conditions, 2) better care coordination among providers rather than the current disjointed system, 3) fundamental changes in the way providers are paid (through incentives to keep patients healthy and out of emergency departments, 4) better integration of physical and behavioral health, 5) targeted efforts to reduce opioid abuse, 5) true flexibility for states to design cost-effective Medicaid programs, and 6) straight-forward subsidies for the most expensive patients who are "uninsurable" under traditional insurance policies. The reforms currently being offered in Congress will have the effect of straining Arizona's budget, pushing more people into the ranks of the uninsured and decreasing employment in health care and related industries. Rather than going down this path, let's seize the opportunity to enact real solutions that will improve the quality of and access to care while reducing budgetary impacts.

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