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May 25, 2017 Joint Committee on Finance Paper #320

Medical Assistance Cost-to-Continue (Health Services -- Medicaid Services)

[LFB 2017-19 Budget Summary: Page 204, #2]

CURRENT LAW

The medical assistance (MA) program, also known as "Medicaid," provides health care coverage to adults and children in families with household income below certain levels, and to elderly, blind or disabled individuals who have limited resources. Certified healthcare providers provide a wide range of services to program recipients. The Department of Health Services (DHS) administers the program under a framework of state and federal law through a plan approved by the federal Centers for Medicare and Medicaid Services (CMS).

The program has two primary components -- elderly, blind and disabled (EBD) Medicaid and BadgerCare Plus. EBD Medicaid provides coverage to individuals who are elderly, blind, or disabled who meet the program's income and asset standards. Individuals may receive services provided under the state's long-term care waiver programs, such as Family Care and IRIS (Include, Respect, I Self-Direct), as well as acute care services, including physician services, prescription drugs, and inpatient and outpatient hospital services. Many individuals enrolled in EBD Medicaid also qualify for Medicare benefits. For these "dual eligible" individuals, the state's MA program pays for services not otherwise covered under Medicare, as well as Medicare's cost-sharing requirements.

BadgerCare Plus provides coverage to individuals and families that meet the program's income standards. In general, children and pregnant women in households with income up to 300% of the federal poverty level (FPL), and non-pregnant, non-disabled adults in households with income up to 100% of the FPL, qualify for Badger Care Plus. Enrollees primarily receive acute care services, such as hospital and physician services, prescription drugs, and maternity and prenatal care coverage.

As of March 2017, approximately 1.1 million individuals were enrolled in MA or MA-

related programs (excluding SeniorCare). Of that total, approximately 800,000 were enrolled in BadgerCare Plus and 225,000 were enrolled in EBD Medicaid. The 80,000 remaining enrollees participated in other MA-supported programs, including limited benefit programs such as Medicare cost-sharing assistance to individuals who do not qualify for full MA coverage and the state's family planning only services program.

MA benefits are funded from the following sources: (a) state general purpose revenue (GPR); (b) federal matching funds (FED); (c) program revenues (PR), primarily rebate revenue provided by drug manufacturers; and (d) segregated revenues (SEG), primarily from the MA trust fund.

GOVERNOR

Provide $213,493,300 ($48,108,600 GPR, $52,127,800 FED, $139,335,500 PR, and -$26,078,600 SEG) in 2017-18 and $787,820,700 ($231,282,300 GPR, $381,580,900 FED, $202,736,900 PR, and -$27,779,400 SEG) in 2018-19 to fund projected costs of MA program benefits during the 2017-19 biennium under a cost-to-continue scenario. The funding increase is based on the administration's projections of program caseload growth, changes in the use and cost of providing medical and long-term care services, changes to the state's federal medical assistance percentage (FMAP), and other funding changes over the remainder of 2016-17 and the 2017-19 biennium.

In addition, the bill would reduce funding for MA benefits by $320,300 GPR annually to reflect a transfer from the MA benefits appropriation to the state's mental health institutes to correct an error made with a gubernatorial veto included in 2015 Act 55.

The following table shows the total funding for MA benefits under the administration's cost-to-continue estimate, but also incorporating the proposed transfer to the mental health institutes budget. For the purposes of this table, the SEG funding has been adjusted to eliminate double-counted funds.

Fund Source	2016-17 Base	2017-18	2018-19
GPR	$2,910,973,500	$2,958,761,800	$3,141,935,500
FED	5,161,878,800	5,214,006,600	5,543,459,700
PR	770,931,100	910,266,600	973,668,000
SEG	616,740,000	589,037,800	586,145,800
Total	$9,460,523,400	$9,672,072,800	$10,245,209,000

DISCUSSION POINTS

1. The bill includes funding to reflect the administration's estimate of the cost of providing MA benefits during the 2017-19 biennium under a scenario in which no changes are made to the program. [Other decision items, addressed in other LFB issue papers, adjust the MA

budget to reflect program changes, such as increases to provider reimbursement rates.] This "cost-to-continue" estimate is based on assumptions for dozens of parameters, but these assumptions generally fall into a few key categories: (a) average monthly enrollment for each of the MA eligibility groups; (b) utilization and cost of services provided on a fee for service basis; (c) managed care capitation rates; and (d) federal policy and formula changes, including changes to the federal matching percentage and Medicare premiums for dually-eligible MA members.

2. Although MA benefits are funded with four funding sources (GPR, FED, PR, and SEG), and all four are adjusted as a result of the cost-to-continue estimate, the primary focus of this paper is the estimated change to GPR-funded costs. Under the administration's cost-to-continue estimate, GPR funding would increase above the 2016-17 appropriation base by $48.1 million in 2017-18 and $231.3 million in 2018-19 for a total of $279.4 million over the biennium.

3. In a separate decision item, the bill would reduce MA benefits funding by $320,300 GPR annually to fund a transfer to the GPR appropriation for the mental health institutes. For the purposes of the calculating the change to the cost-to-continue estimate, this paper treats this reduction as part of the administration's MA budget estimate, since the reduction is not associated with any MA program changes that would reduce program costs. With the inclusion of this change, the administration's adjusted cost-to-continue estimate results in a biennial GPR change of $278.8 million. The Committee addressed the funding increase to the mental health institutes in its earlier action on LFB Issue Paper #360.

4. This paper provides a description of the principal assumptions underlying the administration's MA cost-to-continue estimate, and provides a reestimate of providing MA benefits under the cost-to-continue scenario. In some cases, changes to the administration's assumptions are warranted, based on an analysis of recent program trends. In other cases, the estimate can be updated with more recent enrollment and cost data. Under the reestimate presented in this paper, the total GPR cost over the biennium would be lower than the administration's estimate by $95.6 million over the biennium, reducing the above-base increase for MA to $183.2 million.

MA Program Enrollment

5. Table 1 below shows the actual 2015-16 monthly average enrollment by MA eligibility group, as well as the administration's enrollment projections for 2016-17 through 2018-19.

TABLE 1

Actual and Projected Monthly Average Enrollment by Group

	Actual	Administration Estimates		
	2015-16	2016-17	2017-18	2018-19
Elderly, Blind, Disabled MA				
Elderly	63,003	64,767	66,518	68,513
Disabled, Non-Elderly Adults	136,377	136,534	139,530	143,421
Disabled Children	31,833	31,087	31,552	32,172
EBD Total	231,213	232,388	237,600	244,106
BadgerCare Plus				
Parents and Caretakers	175,941	170,802	171,273	173,934
Children	469,599	467,242	468,805	472,851
Pregnant Women	21,075	20,432	20,419	20,624
Childless Adults	149,129	145,393	145,663	146,790
BadgerCare Plus Total	815,744	803,869	806,160	814,199
Other Full Benefit MA				
Foster Care/Subsidized Adoption	18,671	19,404	19,973	20,581
Well Woman	655	597	598	604
Limited Benefit Groups				
Family Planning Only	39,389	38,058	38,446	38,832
Medicare Cost Sharing Assistance	21,916	21,970	22,231	22,454
Total Enrollment	1,127,588	1,116,286	1,125,008	1,140,776
Change from Previous Year		-11,302	8,722	15,768

6. To estimate the caseload in each category, the administration used annualized growth rates for each six-month period between in January, 2017 and the end of the biennium. [Estimated growth rates for the six-month period between January, 2017 and June, 2017 do not directly affect the MA estimate for the 2017-19 biennium, but do have an indirect effect, since they set the starting point for the 2017-19 projections.] The administration's percentage growth rates are "conservative" in the sense that they are higher than recent growth trends. To illustrate, Table 2 shows, by enrollment category, the annualized percentage growth percentages for each six-month period that the administration used to develop the MA cost-to-continue estimate, compared to the actual annualized growth rate from April, 2016 to March, 2017. [The actual growth rates shown in the table are based on a best-fit slope of the monthly data in order to smooth out month-to-month variations and seasonal effects.]

TABLE 2

Annualized Enrollment Growth Rates--
Actual Change Compared to Administration's Budget Assumptions

	Actual Change-- April, 2016 to March, 2017	Administration's Enrollment Growth Assumptions 2016-17 2nd Half	2017-18 1st Half	2017-18 2nd Half	2018-19 1st Half	2018-19 2nd Half
Elderly, Blind, Disabled*	0.1%	2.0%	2.0%	2.7%	2.7%	2.7%
BadgerCare Plus						
Children	-0.1%	0.5%	0.5%	0.8%	1.0%	1.0%
Parents	-0.3	0.5	1.0	1.0	2.0	2.0
Pregnant Women	-0.2	1.0	1.0	1.0	1.0	1.0
Childless Adults	0.0	0.5	0.5	0.5	1.0	1.0
Other Full Benefit MA						
Foster Care	0.1%	3.0%	3.0%	3.0%	3.0%	3.0%
Well Woman	-0.7	0.0	1.0	1.0	1.0	1.0
Partial Benefit MA						
Family Planning Only	-0.1%	1.0%	1.0%	1.0%	1.0%	1.0%
Medicare Cost Sharing	0.3	1.0	1.0	1.0	1.0	1.0

* EBD subgroups are combined to avoid a mismatch between the recent enrollment data used for the trend analysis and the administration's projections, which are based on slightly different groupings.

7. As shown in the first column of the table above, enrollment has been relatively flat or declined slightly over the past 12 months in most enrollment categories. If these patterns continue through the 2017-19 biennium, the administration's cost-to-continue estimate would overstate the cost of MA benefits, all else being equal.

8. Recent enrollment trends suggest that the cost-to-continue estimate should be adjusted using lower growth rate assumptions. However, recent trends are not always a good indicator of future caseload changes. If, for instance, the state or national economy falls into recession during the next two years, MA enrollment would increase at a faster rate. Consequently, although a downward adjustment to the administration's growth rate assumptions may be warranted, it would be prudent to assume a rate of growth somewhat above recent trends to allow for a contingency margin. Table 3 shows the revised growth rates for each category, along with the actual annual percentage change from April, 2016, through March, 2017.

TABLE 3

Annualized Enrollment Growth Rates--
Actual Change Compared to Revised Assumptions

	Actual Change-- April, 2016 to March, 2017	Revised Enrollment Growth Assumptions				
		2016-17	2017-18		2018-19	
		2nd Half	1st Half	2nd Half	1st Half	2nd Half
Elderly, Blind, Disabled	0.1%	1.7%	2.0%	2.0%	2.0%	2.0%
BadgerCare Plus						
Children	-0.1%	-1.0%	0.5%	0.5%	0.5%	0.5%
Parents	-0.3	-3.0	0.5	0.5	0.5	0.5
Pregnant Women	-0.2	0.5	0.5	0.5	0.5	0.5
Childless Adults	0.0	0.5	0.5	0.5	0.5	0.5
Other Full Benefit MA						
Foster Care	0.1%	3.0%	3.0%	3.0%	3.0%	3.0%
Well Woman	-0.7	0.0	1.0	1.0	1.0	1.0
Partial Benefit MA						
Family Planning Only	-0.1%	0.0%	1.0%	1.0%	1.0%	1.0%
Medicare Cost Sharing	0.3	0.0	1.0	1.0	1.0	1.0

9. The revised growth estimates shown in the table above are higher than recent trends, but generally below the administration's estimates. Generally, EBD groups are assumed to grow at an annualized growth rate of 2.0%, while BadgerCare Plus groups are assumed to grow at a rate of 0.5% on an annualized basis. Other than changes to the second half of 2016-17 to reflect the most recent enrollment data, the revised estimate maintains the administration's growth rate assumptions for the smaller enrollment groups ("Other Full Benefit MA" and "Partial Benefit MA"). Although these growth rates would be larger than recent experience, the estimates for these groups have only a minor impact on the overall cost-to-continue estimate. Overall, the revised caseload assumptions reduce GPR costs by approximately $16 million over the biennium, relative to the administration's estimate.

10. The cost-to-continue reestimate presented in this paper makes no explicit assumptions with respect to any enrollment impact of proposed changes to childless adult eligibility that are included in the Department's federal childless adult waiver request, which was released to the public in draft form on April 19. The draft waiver request would impose eligibility conditions for childless adults enrolled in MA, including the payment of premiums for certain beneficiaries, drug screening, testing, and mandatory participation in treatment, and an employment and training requirement. These proposals have the potential to reduce childless adult enrollment, either due to the failure of current enrollees or new applicants to satisfy the new eligibility criteria, or due to a reduction in new applications. However, because of uncertainties regarding the impact of these provisions (either individually or in combination) and the timing of implementation, no enrollment is built into the reestimate. For a more detailed discussion of the waiver provisions, see LFB Issue Paper #324.

Utilization and Cost of Services

11. In developing the cost-to-continue estimate, the administration makes assumptions on changes in service "intensity," which is the growth in the utilization and cost of services delivered on a fee-for-service (FFS) basis. For most FFS services, the cost-to-continue estimate is based on a continuation of the same reimbursement rates as are used in the base year (since reimbursement rate increases are considered as separate decision items). For others, however, cost rate increases are built into the cost-to-continue estimate. As an example, since prescription drug reimbursement is based on pharmacies' actual acquisition costs, the intensity estimate for drugs reflects adjustments for both usage and cost. Likewise, the inpatient and outpatient hospital reimbursement rate methodology is built, in part, on changes to hospitals' costs, and so the hospital intensity estimate reflects those rate changes.

12. In general, the administration's intensity estimates were based on a trend analysis. Since the introduction of the budget, the Department has collected additional data on FFS costs, affecting the 2016-17 starting point for the 2017-19 biennial projections. These changes have been incorporated into the reestimate.

13. In addition to various adjustments to the 2016-17 starting point, DHS has made recommendations for other cost adjustments to reflect program changes that were not incorporated into the administration's original estimate. For instance, the Department recommends increases totaling $18.7 million GPR over the biennium ($45.4 million all funds) to make payments to health maintenance organizations (HMOs) for meeting new care coordination requirements that the Department has included in the HMO contract for beneficiaries whose MA eligibility stems from eligibility for supplemental security income (SSI). The Department also recommends an adjustment to estimated drug manufacturer rebate collections. Based on recent trends in collections, the Department estimates that rebates will equal 61% of gross drug costs, up from 59% used in the administration's estimate, resulting in a reduction in GPR costs of $28 million over the biennium. These changes and other similar adjustments are included in the reestimate.

14. One of the Department's recommendations deserves separate consideration. The Department recommends that additional funding be provided to cover the anticipated cost of the prescription drug nusinersen (sold under the brand name Spinraza), which was recently approved for the treatment of children diagnosed with spinal muscular atrophy (SMA). SMA is a rare genetic condition affecting muscle control that, in its most severe forms, leads to substantial physical disability and often leads to early death. SMA is diagnosed in approximately 1 out of every 10,000 births, although the disease has several classes that vary in the severity of symptoms. Although Spinraza has been shown to be effective in stopping or partially reversing the course of the disease in some SMA cases, the cost of the treatments is high. During the first year of treatment of a child with SMA, the total cost of six Spinraza injections is $750,000 (before drug rebates). Thereafter, in cases where the drug has shown effectiveness, children require three injections per year at a cost of $325,000. Based on an estimate of the number of children with SMA in Wisconsin, the Department has recommended an increase to the GPR budget for MA of $37 million over the biennium ($90 million all funds). However, there are reasons to believe that this estimate is high. Investment analysts generally have projected that Biogen, the holder of the Spinraza license, will earn around

$1 billion from worldwide sales of Spinraza in 2018, increasing up to $2 billion by 2020 (the drug has been approved in the United States and Europe thus far). If these sales projections are correct, the Department's cost estimates for Wisconsin's MA program would account for approximately 4.5% of worldwide sales, an unrealistically high proportion given the population of the state and the share of children with MA coverage. The reestimate presented in this paper uses a smaller estimate, increasing MA funding by $14.3 million over the biennium to reflect anticipated Spinraza costs.

Managed Care Capitation Rates

15. Most of MA benefits are delivered through managed care organizations (MCOs), including FamilyCare MCOs and BadgerCare Plus and SSI HMOs. Under the managed care system, the MCO arranges the care for each enrolled member and pays medical claims. MA pays the MCO a monthly capitation rate for each enrolled member, plus administrative fees and supplemental payments to cover specific costs outside the capitation rate calculation. Capitation payments are established each year using service utilization data from previous years. The administration's cost-to-continue estimate generally assumes that monthly capitation rates will increase by 2.5% to 3.0% in each year. Although this rate of increase would be somewhat higher than capitation rate increases seen in recent years, the administration's assumptions are consistent with a cautious budgeting approach, allowing for the reasonable possibility of rate growth in excess of recent trends.

Federal Formula Factors

16. In addition to caseload and intensity, MA benefit costs are affected by factors related to federal formulas. These include the federal medical assistance percentage (FMAP), the state's "clawback" payment, made by states to the federal government to partially fund Medicare Part D prescription drug benefits, and Medicare premiums and cost sharing assistance for dually-eligible MA beneficiaries.

Standard Federal Matching Percentage

17. The federal medical assistance matching percentage is based on the relationship between the state's per capita income and the national average per capita income. Under the formula, a state with a per capita income equal to the national average has an FMAP of 55%, while states with a per capita income lower or higher than the average will have an FMAP that is higher or lower than 55%, respectively.

18. The administration's MA cost-to-continue estimates were based on projections of the state's FMAP for the 2017-19 biennium available at the time of the introduction of the bill. The estimate assumed a federal fiscal year 2017-18 FMAP of 58.77% and a federal fiscal year 2018-19 FMAP of 58.95%. Since the time of these estimates, the federal Bureau of Economic Analysis has published data on state and national 2016 per capita income. Incorporating this data into the FMAP calculation results in a slight increase to the federal fiscal year 2018-19 FMAP, from 58.95% to 59.02%. This change has the effect of reducing the GPR costs of MA program benefits by approximately $7.9 million and increasing FED costs by a corresponding amount.

Children's Health Insurance Program Enhanced Matching Percentage

19. The federal government provides a higher FMAP for certain services and populations. One such program deserves special mention because of its significant effect on the cost-to-continue estimate. The Children's Health Insurance Program (CHIP) provides an enhanced federal match for pregnant women and certain children, generally those in households with income above 150% of the federal poverty level (the CHIP threshold varies by the age of the child). The enhanced FMAP is calculated to reduce the state's standard share by 30%. In addition, the federal Patient Protection and Affordable Care Act (ACA) provided for an additional 23 percentage point increase to the enhanced CHIP FMAP, beginning in 2015-16 and ending in 2018-19. With that increase, the state's FMAP for services provided to CHIP-eligible enrollees is approximately 94%.

20. Unlike most Medicaid expenditures, the amount of federal funds available to each state for CHIP-funded services is capped by annual federal allotments. Since CHIP was created in 1997, Congress has periodically reauthorized the program, providing a multi-year extension to the CHIP allotments. The last such act, passed in 2015, extended allotments through federal fiscal year 2017. If Congress does not act to provide allotments in federal fiscal year 2018 and beyond, states will eventually exhaust remaining 2017 allotments. If that happens, any program expenditures for CHIP-eligible enrollees would then be subject to federal matching at the standard FMAP, rather than the enhanced FMAP.

21. The federal Medicaid and CHIP Payment and Access Commission (MACPAC), which advises Congress on Medicaid issues, estimates that without Congressional action some states will begin to exhaust their allotments by the end of calendar year 2017. MACPAC projects that Wisconsin will exhaust its CHIP allotments in April, 2018.

22. The administration's cost-to-continue estimate is based on the assumption that Wisconsin will continue to have sufficient CHIP allotments to take advantage of the enhanced CHIP FMAP through the end of the 2017-19 biennium. Based on the MACPAC projections, this would require Congress to provide additional allotments beginning in federal fiscal year 2018. The reestimate presented in this paper retains this assumption, while noting that this is a decision to be made by policymakers, and so is not subject to fiscal analysis.

23. If Congress does not authorize additional CHIP allotments, the impact on the GPR costs of providing MA benefits to CHIP enrollees would be substantial. If, for instance, MA benefits for these enrollees were subject to the standard FMAP, rather than the enhanced FMAP in state fiscal year 2018-19, GPR costs would increase by an estimated $113 million in that year.

24. Another possibility is that CHIP allotments are reauthorized, but that the 23 percentage point increase to the enhanced CHIP FMAP is repealed for federal fiscal year 2018-19. In this event, MA expenditures for children eligible under CHIP would be matched at a rate of approximately 71% instead of 94% for the final nine months of the 2017-19 biennium, increasing estimated GPR expenditures by approximately $55 million in 2018-19.

Clawback Payments

25. Since 2006, state Medicaid programs have been required to make a payment each year to fund a portion of the costs of the federal Medicare Part D program, in recognition that Part D results in state Medicaid program savings on drugs for dually-eligible enrollees. The amount of this "clawback" payment is based on a formula that is intended to equal 75% of each state's estimated savings. Year-to-year payments change based on the number of dually-eligible MA beneficiaries, the change in per capita drug spending under Part D, and the state's FMAP.

26. The administration's estimate of clawback payments was based on the assumption that per capita drug spending would increase by 12% annually in calendar years 2018 and 2019. However, the federal Medicare and Medicaid Services (CMS) has recently projected that Part D per capita drug expenditures will increase by just 1.2% in 2018. Because the Part D per capita increase is an element of the clawback formula, the cost-to-continue estimate presented in this paper revises the estimate of 2018 clawback payments to reflect the CMS projections. For 2019, the reestimate assumes an 8% growth in per capita drug costs, which is the approximate increase assumed for that year by the Medicare Trustees for the purposes of Medicare Part D budget projections. These revisions result in a reduction of clawback payments of $36 million GPR over the biennium.

Medicare Premiums and Cost Sharing for Dually-Eligible Enrollees

27. MA pays the Medicare Part A and Part B premiums and, in some cases, deductibles and coinsurance for enrollees who are dually-eligible for Medicaid and Medicare. The administration's cost-to-continue estimate assumes growth in these costs based on recent trends. The largest component of the administration's estimated increase is due to a projected 13% annual increase to the Medicare Part B premium in calendar years 2018 and 2019. However, the 2016 Medicare Trustee's report projects that Part B premiums will be significantly lower in those years than the administration's estimates. Revising the Part B premiums to be more in line with the Medicare Trustee's projections reduces the GPR-funded portion of the cost-to-continue estimate by $22 million over the biennium.

Summary and Discussion of Revised Cost-to-Continue Estimate

28. The revisions to the cost-to-continue estimate assumptions discussed in this paper, as well as various technical corrections, result in, relative to the bill, a reduction of $95.6 million to the GPR funding for MA benefits over the biennium and a total reduction of $132.6 million in the MA benefits budget from all sources. Relative to the MA base, GPR funding for MA would increase by $183.1 million GPR over the biennium and by $866.4 million from all fund sources.

29. Table 4 shows the MA benefits funding by fund source under the reestimate, as well as the change to the funding provided by the bill. The SEG funding has been adjusted to eliminate double-counted funds to give a more accurate representation of total MA benefits funding under the cost-to-continue scenario. These changes reflect the difference between the revised cost-to-continue estimate and the administration's cost-to-continue estimate as modified by a separate decision item that would reduce MA benefits by $320,300 GPR annually in order to offset an increase to the GPR appropriation for the mental health institutes.

TABLE 4

Reestimated MA Cost-to-Continue Funding

	Reestimate Funding		Change to Bill		
	2017-18	2018-19	2017-18	2018-19	Biennium
GPR	$2,932,345,300	$3,072,781,400	-$26,416,500	-$69,154,100	-$95,570,600
FED	5,176,912,800	5,476,025,700	-37,093,800	-67,434,000	-104,527,800
PR	940,257,200	1,013,131,900	29,990,600	39,463,900	69,454,500
SEG*	588,126,400	585,118,500	-911,400	-1,027,300	-1,938,700
Total	$9,637,641,700	$10,147,057,500	-$34,431,100	-$98,151,500	-$132,582,600

* SEG amounts are adjusted to remove double-counted funds. For technical reasons related to this adjustment, the amounts shown in the "Change to Bill" columns differ from the change to unadjusted an appropriation that is reflected in the final estimate (fiscal estimate box).

30. With limited exceptions, the medical assistance program is required by state and federal law to pay for the cost of all medically necessary services for program enrollees. If the amount of funding provided in the biennial budget is insufficient to fund these costs, the Department's options to administratively reduce costs are somewhat limited. In the event of a budget shortfall in MA, the Committee or the full Legislature may be required to act, either by increasing the MA appropriations or making statutory program changes to reduce costs. For this reason, there are risks associated with underestimating the MA budget. In order to provide some context for understanding these risks, the following points discuss some of the uncertainties involved in developing the budget estimates.

31. Some of risks to the revised cost-to-continue estimate have already been discussed above. Chief among these is the potential that a change to the state or national economy would result in job losses and a reduction in household income. Depending upon the timing of an economic downturn, the resulting increase in MA enrollment could cause benefit expenditures to exceed the reestimated budget.

32. Another significant risk is potential changes in federal policy as it relates to Medicaid or broader healthcare policy. A potential decision to not renew CHIP allocations was already mentioned, but other changes to federal policy could also affect the state's MA spending. Discussions in Congress on the potential repeal of the Affordable Care Act are ongoing. The elimination of or reduction to income-based premium tax credits for the purchase of health insurance could reduce opportunities to obtain coverage for households near the poverty line, which may push some, who would otherwise purchase commercial insurance with these subsidies, to seek or retain MA coverage.

33. As noted with the discussion of the prescription drug Spinraza, the cost of new drugs or new medical technology can increase the cost of health coverage in ways that are not anticipated. The cost-to-continue estimate includes an "intensity" adjustment to account for increasing usage or costs, but these adjustments are generally based on past trends, which may not fully account for

future costs.

34. While conditions may change in ways that increase MA costs above budget estimates, changing conditions can also lower costs below those estimates, as illustrated by the 2015-17 biennium MA budget. According to the Department's most recent estimates, GPR costs for MA benefits during the 2015-17 biennium will be lower than the amount budgeted by $330 million. There are multiple factors behind this reduction, which amounts to 5.8% of the biennial GPR budget for the program. Nursing home and home health utilization, for instance, have been lower than expected. In addition, prescription drug spending has been lower than expected, but despite a lower gross cost, drug manufacturer rebates have exceeded budget estimates. Finally, while the 2015-17 budget estimates were based on increasing enrollment in BadgerCare Plus (consistent with the trends at the time), the caseload has remain unchanged or declined for many of the enrollment categories.

35. While there are risks associated with underestimating MA benefit costs, an overestimate represents a lost opportunity to allocate state funds to other purposes. The administration's cost-to-continue estimate for the 2017-19 biennium can be characterized as a conservative estimate that, in many respects, builds in a budget margin in the event of an economic recession or other major contingencies. The cost-to-continue estimate presented in this paper uses updated data and revised assumptions, resulting in a lower MA budget (Alternative 1). Consistent with the 2017-19 biennium general fund revenue estimates produced by this office, the reestimate does not account for a possible economic recession, but still retains an overall cautious approach that allows for the possibility that MA costs will increase above recent trends.

36. The Committee could decide to mitigate the risks associated with an economic recession or other factors that increase GPR-funded MA costs by transferring an amount from the general fund to the medical assistance trust fund (MATF), to create a reserve. In the event that GPR funding is not sufficient to pay all MA benefits costs in the biennium, the Department could submit a request under s. 13.10 of the statutes to increase the MATF SEG appropriation, allowing the Department to spend the reserve for MA benefit costs. Any amounts of this reserve not used in the 2017-19 biennium would remain in the MATF and be available for future MA costs. Although the Committee could provide any amount for this purpose, one option would be to transfer $55,000,000, which is the estimated amount of the additional cost that the state would incur if the 23 percentage point increase to the CHIP FMAP were eliminated in federal fiscal year 2018-19 (Alternative 2). Alternatively, the Committee could transfer one-half of this amount ($27,500,000), to provide a smaller contingency reserve under the assumption that the underlying estimate provides a sufficient margin to allow the MA benefits budget to absorb some of the additional GPR cost that would be associated with a decision to eliminate the 23 percentage point increase to the CHIP FMAP (Alternative 3).

ALTERNATIVES

1. Reduce funding for MA benefits by $35,436,400 (-$26,416,500 GPR, -$37,093,800 FED, $29,990,600 PR, and -$1,916,700 SEG) in 2017-18 and $98,794,800 (-$69,154,100 GPR, -$67,434,000 FED, $39,463,900 PR, and -$1,670,600 SEG) in 2018-19 to reflect a

reestimate of MA benefits costs under a cost-to-continue scenario. [Adoption of this reestimate would have the effect of deleting the bill's proposed $320,300 annual GPR reduction to the MA benefits appropriation associated with the mental health institutes funding provision.]

ALT 1	Change to Base	Change to Bill
GPR	$183,179,700	- $95,570,600
FED	329,180,900	- 104,527,800
PR	411,526,900	69,454,500
SEG	- 57,445,300	- 3,587,300
Total	$866,442,200	- $134,231,200

2. Adopt the appropriation changes in Alternative 1. In addition, transfer $55,000,000 from the general fund to the medical assistance trust fund to provide a reserve for addressing any potential shortfalls in GPR funding for MA benefits.

ALT 2	Change to Base	Change to Bill
GPR	$183,179,700	- $95,570,600
FED	329,180,900	- 104,527,800
PR	411,526,900	69,454,500
SEG	- 57,445,300	- 3,587,300
Total	$866,442,200	- $134,231,200
GPR-Transfer	$55,000,000	$55,000,000
SEG-Revenue	$55,000,000	$55,000,000

3. Adopt the appropriation changes in Alternative 1. In addition, transfer $27,500,000 from the general fund to the medical assistance trust fund to provide one-half of the reserve amount as Alternative 2.

ALT 3	Change to Base	Change to Bill
GPR	$183,179,700	- $95,570,600
FED	329,180,900	- 104,527,800
PR	411,526,900	69,454,500
SEG	- 57,445,300	- 3,587,300
Total	$866,442,200	- $134,231,200
GPR-Transfer	$27,500,000	$27,500,000
SEG-Revenue	$27,500,000	$27,500,000

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