State Health Reform Assistance Network
Charting the Road to Coverage

A Robert Wood Johnson Foundation program

Medicaid Capped Funding: Findings and Implications for Colorado

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On March 24, 2017, the House of Representatives determined not to move ahead with the American Health Care Act (AHCA), its proposal to repeal and replace the Affordable Care Act (ACA). The AHCA included provisions that would have capped federal Medicaid funds through per capita caps and block grants, and reduced or eliminated federal funding for the expansion of Medicaid to low-income adults. While the AHCA failed to advance, these Medicaid proposals are likely to remain a priority for Congressional leadership. To assist states in evaluating how they might fare under a capped funding model, Manatt Health analyzed state-specific data for all 50 states and the District of Columbia. The Colorado-specific data provided here offers insight into how base payment calculations and trend rates, as well as state policies and demographics, could impact Colorado under capped funding proposals. The data are drawn from a tool kit prepared by Manatt Health for the Robert Wood Johnson Foundation's State Health Reform Assistance Network.[1]

Medicaid capped funding proposals are designed to provide the federal government with greater budget certainty and to reduce federal spending, and thereby reduce federal Medicaid funding for states, especially in the out years. In several recent proposals, including the AHCA, the size of the cap for each state is set based on its historical spending in Medicaid, trended forward by an annual, national "trend rate," rather than a state-specific trend. As a result, under a capped financing formula, federal Medicaid funding to states would no longer respond automatically to increases in state-specific health care expenditure growth, break-through therapies, public health crises, or, depending on the design of the cap, increases in enrollment due to growing populations, changing demographics, economic downturns or other factors. States might have additional flexibility to reduce eligibility, benefits or provider payment rates, but ultimately they bear the risk of costs exceeding the cap.

Data Considerations

This memo relies on the most recent publicly available data, and in some instances, it references 2011 data. While a state might have more recent data on its own program spending, 2011 is the most recent year for which per enrollee spending and historical growth rates are publicly available by eligibility group for all states. The lack of more recent 50-state data is challenging, but the comparison across states is helpful. In any event, faced with the lack of more recent 50-state data, Congress will likely need to rely on older and aggregated data in setting capped funding levels.

[1] http://statenetwork.org/resource/data-points-to-consider-when-assessing-proposals-to-cap-federal-medicaid-funding-a-toolkit-for-states/

Key Data Findings

- **Expansion brought billions in federal funding to Colorado and sharply increased coverage.** If Medicaid restructuring eliminates or reduces funding for the Medicaid expansion, it would pose a significant threat to coverage in Colorado and to the State's budget.
    - Nearly 426,000 individuals are covered through the Medicaid expansion adult group in Colorado, 32% of the State's Medicaid population as of March 2016.
    - Colorado's uninsured rate dropped by 42% from 2013 to 2015 (from 13.8% to 8%), due in large part to the Medicaid expansion.
    - Beyond coverage, reducing or repealing federal support for expansion would have an outsized impact on Colorado's budget. Federal funding for new adults (an estimated $1.4 billion in 2015) accounts for 31% of all federal Medicaid funding for Colorado.
- **Colorado's State budget relies heavily on federal Medicaid funding.** Medicaid represents the single largest source of federal funding for the State. A loss of federal Medicaid funding could shift costs to the State, posing a threat to the Colorado budget and other State priorities, such as education.
    - Federal Medicaid funding ($4.5 billion in 2015) makes up more than half (52.3%) of all federal funding in Colorado's budget – below the average share (59.3%) among expansion states but still the largest source of federal funding for the State. By comparison, the next largest source of federal funds—for transportation—is 10% of the federal funds received by the State.
- **Colorado has low per capita Medicaid spending levels relative to other states, putting it at risk of being "locked in" to a relatively low capped payment.** Since nearly all capped funding proposals start with a state's historic spending, Colorado may be locked into low capped federal payments.
    - Colorado spent an average of $5,730 per enrollee in federal fiscal year 2011 (35th among states), well below the national average of $6,502.
    - Colorado has relatively low spending for children and adults – $2,241 per child compared to $2,492 nationally (32nd in nation) and $3,469 per adult compared to $4,141 nationally (41st in nation). Colorado spends modestly above the national average for the aged (23rd in nation) and disabled (19th in nation).
- **Colorado's Medicaid spending per enrollee grew more slowly than many other states between 2000-2011 but was on par or above the national trend rates typically advanced in capped funding proposals in three of its four eligibility groups.** If Colorado decides that it needs to adjust its spending, for example, to ensure access to care, it is unlikely to have additional federal funding to rely on under capped funding.
    - Colorado's average annual per enrollee spending growth from 2000-2011 was average or below average across eligibility groups: 1.7% for children (4th lowest in the nation), 3.8% for the disabled (18th lowest in the nation), 3.9% for the aged (24th lowest in the nation), and 4.5% for adults (11th in the nation).
    - Colorado's spending growth for three of its four eligibility groups either kept pace with or exceeded per capita GDP (2.9%), CPI (2.5%) and medical CPI (4%).

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- **Colorado relies on DSH and UPL payments; depending on how they are treated in a capped funding approach, these federal funds may be at risk.** This is a critical issue for Colorado to monitor.
    - DSH and UPL payments made up 18% of all Colorado Medicaid benefit spending in 2015 – the 6th highest share in the nation.
- **Colorado Medicaid spending is disproportionately for seniors and people with disabilities.** As a result, capped funding is likely to disproportionately impact these populations.
    - In FY 2011, nearly two-thirds (63%) of Colorado's Medicaid spending was for elderly and disabled enrollees even though they accounted for only 20% of the State's Medicaid enrollment.
    - The expansion of Medicaid to low-income adults in the Colorado undoubtedly has shifted the distribution of spending across eligibility groups, but there is little doubt that when updated data become available, they will indicate that spending on the elderly and disabled remains substantial.
- **Colorado is a fast growing state, which puts it at particularly high risk under capped funding.** A capped funding formula that does not take enrollment into account would leave the state at higher risk than other states. Even if enrollment growth is accommodated by a per capita cap model, it would be at risk for the higher costs attributable to an aging population.
    - Colorado is the 14th fastest growing state in the country. While the country is expected to see its population grow by 8.4% by 2025, Colorado is looking at a 9.4% growth rate, or an additional 473,310 people.
    - By 2025, Colorado is expected to see its senior (age 65+) population – a group with high Medicaid costs – grow by 39%.

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