State Health Reform Assistance Network
Charting the Road to Coverage

A Robert Wood Johnson Foundation program

Medicaid Capped Funding: Findings and Implications for Indiana

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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 Indiana-specific data provided here offers insight into how base payment calculations and trend rates, as well as state policies and demographics, could impact Indiana 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 over a billion in federal funding to Indiana in 2015 and sharply increased coverage.** If Medicaid restructuring eliminates or reduces federal funding for the Medicaid expansion, it would pose a significant threat to coverage in Indiana and to the State's budget.
    - Nearly 382,000 individuals are covered through the Medicaid expansion adult group in Indiana, 30% of the State's Medicaid population as of March 2016.
    - Indiana's uninsured rate dropped by 30% from 2013 to 2015 (from 14% to 9.8%), due in large part to the Medicaid expansion.
    - Beyond coverage, reducing or repealing federal support for expansion would have an outsized impact on Indiana's budget. Federal funding for new adults (an estimated $1.2 billion in 2015) accounts for 18.5% of all federal Medicaid funding for Indiana.
    - Even if it could absorb the fiscal hit of a reduction in federal support for expansion, Indiana is one of at least nine states that is required by state law to reduce or eliminate Medicaid eligibility and/or benefits for the expansion population if the Medicaid matching rate is reduced.
- **Indiana'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 Indiana budget and other State priorities, such as education.
    - Federal Medicaid funding ($6.6 billion in 2015) makes up more than half (62.8%) of all federal funding in Indiana's budget – the 8th highest share among expansion states. By comparison, the next largest source of federal funds—for primary and secondary education—is just over 9% of the federal funds received by the State.
- **Indiana has low per capita Medicaid spending levels relative to other states, putting it at risk of being "locked in" to a low capped payment.** Since nearly all capped funding proposals start with a state's historic spending, Indiana may be locked into low capped federal payments.
    - Indiana spent an average of $5,600 per enrollee in federal fiscal year 2011 (38th among states), well below the national average of $6,502.
    - Indiana has relatively low spending for children and adults: $1,858 per child compared to a national average of $2,492 (3rd lowest) and $3,198 per adult compared to a national average of $4,141 (8th lowest).
- **Between 2000-2011, Indiana's Medicaid spending on a per capita basis grew more slowly than many other states but still more rapidly than or on par with the national trend rates typically advanced in capped funding proposals.** If Indiana 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.
    - Indiana's average annual per enrollee spending growth from 2000-2011 was: 4.3% for the aged (24th in the nation), 3.9% for the disabled (33rd in the nation), 3.9% for children (35th in the nation), and 5.5% for adults (37th in the nation).
    - Indiana's Medicaid spending growth kept pace with or outstripped per capita GDP (2.9%), CPI (2.5%), and medical CPI (4%) during that period.

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- **Indiana 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 Indiana to monitor.
    - DSH and UPL payments made up 9.9% of all Indiana Medicaid benefit spending in 2015.
- **Indiana 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, close to two-thirds (66%) of Indiana's Medicaid spending was for elderly and disabled enrollees even though they accounted for approximately a quarter (23%) of the State's Medicaid enrollment.
    - The expansion of Medicaid to low-income adults in Indiana 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.

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