State Health Reform Assistance Network
Charting the Road to Coverage

A Robert Wood Johnson Foundation program

Medicaid Capped Funding: Findings and Implications for Minnesota

April 5, 2017

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 Minnesota-specific data provided here offers insight into how base payment calculations and trend rates, as well as state policies and demographics, could impact Minnesota 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 more than a billion dollars in federal funding to Minnesota and helped drive the uninsurance rate to among the lowest in the nation.** If Medicaid restructuring eliminates or reduces funding for the Medicaid expansion, it would pose a significant threat to coverage in Minnesota and to the State's budget.
    - More than 187,000 individuals are covered through the Medicaid expansion adult group in Minnesota, nearly 17% of the State's Medicaid population as of March 2016.
    - Minnesota's uninsured rate dropped by 46% from 2013 to 2015 (from 8.3% to 4.5%)—ranking 5th lowest among states, due in large part to the Medicaid expansion.
    - Beyond coverage, reducing or repealing federal support for expansion would have an outsize impact on Minnesota's budget. Federal funding for new adults (an estimated $1.7 billion in 2015) accounts for 27% of all federal Medicaid funding for Minnesota.
- **Minnesota'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 Minnesota budget and other state priorities, such as education.
    - Federal Medicaid funding (nearly $6.1 billion in 2015) makes up 60% of all federal funding in Minnesota's budget – slightly above the average share among expansion states. By comparison, the next largest source of federal funds—for primary and secondary education—is nearly 8% of the federal funds received by the State.
- **Minnesota has among the highest per capita Medicaid spending level relative to other states.** Although nearly all capped funding proposals start with a state's historic spending, under some proposals, Minnesota may be expected to move the state's per capita expenditures toward the median over time.
    - Minnesota ranked 9th among states in total per capita Medicaid spending per enrollee. In fiscal year 2011, average spending was $8,057 per enrollee, well above the national average of $6,502.
    - The State has relatively high spending for children, the disabled and the aged: $3,461 per child compared to a national average of $2,492 (6th highest); $26,890 per disabled individual compared to a national average of $18,518 (6th highest); and $25,030 per elderly enrollee compared to a national average of $17,522 (11th highest). Minnesota's spending for adults was relatively low: $3,863 per adult enrollee compared to a national average of $4,141 (35th in nation).
- **Minnesota's Medicaid spending on a per capita basis grew more slowly than many other states between 2000-2011 but still more rapidly than or on par with the national trend rates typically advanced in capped funding proposals.** If Minnesota 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.
    - Minnesota's average annual per enrollee spending growth from 2000 – 2011 was: 3.0% for the aged (38th in nation), 3.9% for the disabled (31st in nation), 6.5% for children (13th in nation), and 6.3% for adults (34th in nation).
    - Minnesota's Medicaid spending growth on these groups outstripped per capita GDP (2.9%) and CPI (2.5%) from 2000-20111. Minnesota's Medicaid spending growth on children and adults also outstripped medical CPI (4%) during that period.

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- **Minnesota 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 (64%) of Minnesota's Medicaid spending was for elderly and disabled enrollees, though they accounted for only 22% of the State's Medicaid enrollment.
    - Minnesota is also experiencing rapid growth in enrollment of both disabled individuals and the elderly. From 2000-2011, average annual enrollment growth for disabled individuals was 4.9% (13th highest) and 3.9% (9th highest) for the aged.
    - The expansion of Medicaid to low-income adults in Minnesota 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.
- **Minnesota relies on DSH, UPL and waiver 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 Minnesota to monitor.
    - DSH, UPL, and waiver payments made up 1.4% of all Medicaid benefit spending in 2015.

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