State Health Reform Assistance Network
Charting the Road to Coverage

A Robert Wood Johnson Foundation program

Medicaid Capped Funding: Findings and Implications for Nebraska

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 Nebraska-specific data provided here offers insight into how base payment calculations and trend rates, as well as state policies and demographics, could impact Nebraska 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

- **Under a capped funding model, Nebraska could be disadvantaged relative to states that receive federal funding for the ACA Medicaid expansion.** Expansion states and states with higher eligibility levels could see higher funding allowances than non-expansion states with respect to any block grant proposal.
    - The 31 expansion states received nearly $73 billion in additional federal funding in 2016.
    - Nebraska has among the lowest eligibility levels for adults in the country (58% FPL for parents, 0% FPL for childless adults), which contributes to the risk of a relatively small allotment under any model using a block grant.
- **Nebraska has low per capita Medicaid spending levels relative to other states in the U.S., 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, Nebraska may be locked into low capped federal payments.
    - Nebraska spent an average of $5,777 per enrollee in federal fiscal year 2011 (34th among states), below the national average of $6,502.
    - Nebraska has relatively low spending across all eligibility groups – $2,041 per child enrollee compared to $2,492 nationally (10th lowest), $14,997 per aged enrollee compared to $17,522 nationally (13th lowest $17,449 per disabled enrollee compared to $18,518 nationally (24th lowest), and $4,015 per adult enrollee compared to $4,141 nationally (22nd lowest).
    - These low 2011 spending levels reflect a decade of low spending growth. Nebraska's per enrollee spending growth was among the lowest in the nation from 2000 - 2011: 3.3% for children (12th lowest in nation), 2.2% for the disabled (6th lowest in nation), and -.5% for the aged (3rd lowest in nation). Nebraska's Medicaid spending growth for these groups largely fell below per capita GDP (2.9%), CPI (2.5%), and medical CPI (4%) during that period.
- **Nebraska 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, two-thirds (67%) of Nebraska's Medicaid spending was for elderly and disabled enrollees even though they accounted for approximately a quarter (24%) of the State's Medicaid enrollment.
- **Nebraska'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 Nebraska budget and other State priorities, such as education.
    - Federal Medicaid funding (more than $1 billion in 2015) makes up approximately one third (33.1%) of all federal funding in Nebraska's budget – below average among non-expansion states but still the State's largest source of federal funds. By comparison, the next largest source of federal funds—for higher education—is 11.6% of the federal funds received by the State.

This product was prepared with support from the Robert Wood Johnson Foundation through its State Health Reform Assistance Network program.