State Health Reform Assistance Network
Charting the Road to Coverage

A Robert Wood Johnson Foundation program

Medicaid Capped Funding: Findings and Implications for Nevada

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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 Nevada-specific data provided here offers insight into how base payment calculations and trend rates, as well as state policies and demographics, could impact Nevada 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 nearly $1 billion in federal funding to Nevada and sharply increased coverage.** If Medicaid restructuring eliminates or reduces funding for the Medicaid expansion, it would pose a significant threat to coverage in Nevada and to the State's budget.
    - Nearly 204,000 individuals are covered through the Medicaid expansion adult group in Nevada, 34% of the State's Medicaid population as of March 2016.
    - Nevada's uninsured rate dropped by nearly 40% from 2013 to 2015 (from 20.5% to 12.3%), due in large part to Medicaid expansion.
    - Beyond coverage, reducing or repealing federal support for expansion would have an outsized impact on Nevada's budget. Federal funding for new adults (an estimated $948 million in 2015) accounts for 40% of all federal Medicaid funding for Nevada.
- **Nevada has the lowest total per capita Medicaid spending level relative to other states, putting it at risk of being "locked in" to a particularly low capped payment.** Since nearly all capped funding proposals start with a state's historic spending, Nevada may be locked into very low capped federal payments.
    - Nevada spent an average of $4,010 per enrollee in federal fiscal year 2011 (lowest among states), well below the national average of $6,502.
    - Nevada has relatively low spending across all eligibility groups – $15,706 per disabled enrollee compared to $18,518 nationally (14th lowest), $13,226 per aged enrollee compared to $17,522 nationally (7th lowest), $1,940 per child enrollee compared to $2,492 nationally (5th lowest), and $2, 367 per adult enrollee compared to $4,141 nationally (3rd lowest).
- **Nevada'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 Nevada budget and other state priorities.
    - Federal Medicaid funding (nearly $2.4 billion in 2015) makes up 59% of all federal funding in Nevada's budget—an average share among expansion states but still the single largest source of federal funding for the State. By comparison, the next largest source of federal funds—for transportation—is 8% of the federal funds received by the State.
- **Nevada's spending per enrollee generally grew more slowly than many other states between 2000-2011 but kept pace with or exceeded the national trend rates typically advanced in capped funding proposals.** If Nevada 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.
    - Nevada's average annual per enrollee spending growth for children and adults were among the lowest across states from 2000 – 2011: 3.1% for children (10th lowes) and 3.6% for adults (7th lowest); its per enrollee spending growth for the disabled (4.6%) and elderly (4.2%) were slightly higher than the national average.
    - Nevada's spending growth on all groups outstripped both per capita GDP (2.9%) and CPI (2.5%), and for the elderly and disabled, also outstripped medical CPI (4%) during that period.

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- **Nevada 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 Nevada to monitor.
    - DSH and UPL payments made up 10.4% of all Nevada Medicaid benefit spending in 2015 – on par with the national average.
- **Nevada 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, over half (56%) of Nevada's Medicaid spending was for elderly and disabled enrollees even though they accounted for only 21% of the State's Medicaid enrollment.
    - The expansion of Medicaid to low-income adults in Nevada 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.
- **Nevada is one of the fastest growing states in the country, 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 is accommodated by a per capita cap model, it would be at risk for the higher costs attributable to an aging population given its low spending base.
    - Nevada is the 2nd fastest growing state in the country. While the country is expected to see its population grow by 8.4% by 2025, Nevada is looking at a 26% growth rate, or an additional 805,000 people.
    - By 2025, Nevada is expected to see its senior (age 65+) population – a group with high Medicaid costs – grow by 56%, among the fastest growth rates in the country (ranking 2nd). Nevada's Medicaid enrollment of aged individuals from 2011 – 2011 likewise grew quickly – at an average annual rate of 5.1%, compared to the national average of 2.3%, the 5th fastest growth rate for this Medicaid population in the nation.
    - Projected population growth will be a particular challenge in Nevada in light of its extremely low per capita spending base across all eligibility groups (lowest in the nation).

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