State Health Reform Assistance Network
Charting the Road to Coverage
A Robert Wood Johnson Foundation program

Medicaid Capped Funding: Findings and Implications for Pennsylvania

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 Pennsylvania-specific data provided here offers insight into how base payment calculations and trend rates, as well as state policies and demographics, could impact Pennsylvania 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 $2.5 billion in federal funding to Pennsylvania and sharply increased coverage.** If Medicaid restructuring eliminates or reduces funding for the Medicaid expansion, it would pose a significant threat to coverage in Pennsylvania and to the State's budget.
    - Over 700,000 individuals are covered through the Medicaid expansion adult group in Pennsylvania, about 26% of the State's Medicaid population as of March 2016.
    - Pennsylvania's uninsured rate dropped by nearly 35% from 2013 to 2015 (from 9.6% to 6.3%), due in large part to the Medicaid expansion.
    - Beyond coverage, reducing or repealing federal support for expansion would have an outsized impact on Pennsylvania's budget. Federal funding for new adults (an estimated $2.5 billion in 2015) accounts for 17% of all federal Medicaid funding for Pennsylvania.
- **Pennsylvania'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 Pennsylvania budget and other State priorities, such as education.
    - Federal Medicaid funding ($14.3 billion in 2015) makes up 61% of all federal funding in Pennsylvania'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 about 10% of the federal funds received by the State.
- **Pennsylvania has high per capita Medicaid spending levels relative to other states.** Although nearly all capped funding proposals start with a state's historic spending, under some proposals, Pennsylvania may be expected to move the state's per capita expenditures toward the median over time.
    - Pennsylvania ranked 7th among states in total per capita Medicaid spending per enrollee. In fiscal year 2011, average spending was $8,508, well above the national average of $6,502.
    - Pennsylvania has relatively high spending for children, the aged, and adults: $3,194 for children compared to a national average of $2,492 (8th highest); $21,372 per aged individual compared to $17,522 nationally (16th highest), and $4,631 per adult compared to $4,141 nationally (17th highest). Pennsylvania's per capita spending for the disabled was $16,441 compared to a national average of $18,518.
- **Between 2000-2011, Pennsylvania's Medicaid spending on a per capita basis grew much more rapidly than the national trend rates typically advanced in capped funding proposals for three of four eligibility groups, and faster than most other states.** If Pennsylvania's historical spending rates are indicative of its future spending rates, over time federal Medicaid funding under a capped funding proposal would fall short of the State's needs.
    - Pennsylvania's average annual per enrollee spending growth was slightly above average for children and among the highest in the nation for the disabled and adults from 2000 - 2011: 5.4% for children (25th in nation), 5.7% for disabled (9th in nation) and 10.9% for adults (5th in nation).
    - Pennsylvania's Medicaid spending growth on all of these groups significantly outstripped per capita GDP (2.9%), CPI (2.5%), and medical CPI (4%) during that period.

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- **Pennsylvania 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 Pennsylvania to monitor.
    - DSH and UPL payments made up 7.8% of all Medicaid benefit spending in 2015.
- **Pennsylvania 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 three quarters (73%) of Pennsylvania's Medicaid spending was for elderly and disabled enrollees, even though they accounted for approximately one third (35%) of the State's Medicaid enrollment.
    - The expansion of Medicaid to low-income adults in Pennsylvania 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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