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

Medicaid Capped Funding: Findings and Implications for South Carolina
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 South Carolina-specific data provided here offers insight into how base payment calculations and trend rates, as well as state policies and demographics, could impact South Carolina 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

- **South Carolina has among the lowest per capita Medicaid spending levels 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, South Carolina may be locked into low capped federal payments.
    - South Carolina spent an average of $5,188 per enrollee in federal fiscal year 2011 (8th lowest among states), well below the national average of $6,502.
    - South Carolina has relatively very low spending in nearly all eligibility groups –$12,830 per disabled enrollee compared to $18,518 nationally (3rd lowest), $12,256 per aged enrollee compared to $17,522 nationally (5th lowest), and $2,008 per child enrollee compared to $2,492 nationally (7th lowest).
- **Under a capped funding model, South Carolina 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.
    - South Carolina has relatively low eligibility levels for adults compared to other states (62% 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.
- **Between 2000-2011, South Carolina's Medicaid spending on a per capita basis grew more rapidly than the national trend rates typically advanced in capped funding proposals.** If South Carolina'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 South Carolina's needs.
    - South Carolina's average annual per enrollee spending growth was higher than the national average for the aged (4.7% vs. 3.7% nationwide; ranked 22nd highest) and adults (8.8% vs. 5.6% nationwide; ranked 12th highest).
    - South Carolina's Medicaid spending growth for children, adults, and the aged outstripped per capita GDP (2.9%), CPI (2.5%), and medical CPI (4%) during that period.
- **South Carolina 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 South Carolina to monitor.
    - DSH, UPL and waiver payments made up 12.5% of all South Carolina Medicaid benefit spending in 2015 – well above the national average.
- **South Carolina 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 (62%) of South Carolina's Medicaid spending was for elderly and disabled enrollees even though they accounted for just over a quarter (26%) of the State's Medicaid enrollment.

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- **South Carolina has a higher uninsured rate than the U.S. average – leaving South Carolina with a bigger "hole" to address if and when the State is looking to cover additional residents.** Capped funding proposals to date do not take into account the size of each state's remaining uninsured population.
    - As of 2015, the uninsured rate in South Carolina was 10.7% – the 15th highest in the nation.
    - While the current Medicaid structure preserves South Carolina's option to expand its Medicaid coverage, a capped model may eliminate or reduce federal financial support for any such expansion.
- **South Carolina's State budget relies heavily on federal Medicaid funding.** Medicaid represents the single largest share of South Carolina's State funding. A loss of federal Medicaid funding could shift costs to the State, posing a threat to the South Carolina budget and other State priorities, such as education.
    - Federal Medicaid funding ($4.3 billion in 2015) makes up more than half (56.5%) of all federal funding in South Carolina's budget – the 4th highest share among non-expansion states. By comparison, the next largest source of federal funds—for elementary and secondary education—is just over 11% of the federal funds received by the State.

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