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

Medicaid Capped Funding: Findings and Implications for Utah
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 Utah-specific data provided here offers insight into how base payment calculations and trend rates, as well as state policies and demographics, could impact Utah 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, Utah 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.
    - Utah has among the lowest eligibility levels for adults in the country (44% FPL for parents, 0% FPL for childless adults) relative to other states, which contributes to the risk of a relatively small allotment under any model using a block grant.
- **Utah 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, Utah may be locked into low capped federal payments.
    - Utah spent an average of $5,135 per enrollee in federal fiscal year 2011 (45th among states), well below the national average of $6,502.
    - Utah has relatively low spending for children, the elderly and adults: $2,260 per child enrollee compared to $2,492 nationally (21st lowest); $11,763 per aged enrollee compared to $17,522 nationally (4th lowest); and $3,326 per adult enrollee compared to $4,141 nationally (10th lowest). The State's per capita spending for the disabled was above the national average ($19,718 as compared to $18,518).
- **Utah's Medicaid spending per enrollee grew significantly more slowly for all eligibility groups than many other states between 2000-2011 but, for three of four eligibility groups, kept pace with or exceeded national trend rates typically advanced in capped funding proposals.** If Utah 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.
    - Utah's average annual per enrollee spending growth was below average across all eligibility groups: 1.6% for children (3rd lowest in nation), 2.8% for the aged (11th lowest in nation), 3.2% for the disabled (12th lowest in nation), and 4.2% for adults (8th lowest in nation).
    - With the exception of its per enrollee spending growth for children, Utah's Medicaid spending growth for the remaining eligibility groups was near GDP (2.9%), CPI (2.5%), and medical CPI (4%) during that period.
- **Utah 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 Utah to monitor.
    - DSH and UPL payments made up 5.7% of all Utah's Medicaid benefit spending in 2015.
- **Utah's 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, more than half (57%) of Utah's Medicaid spending was for elderly and disabled enrollees even though they accounted for less than a fifth (16%) of the State's Medicaid enrollment.

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- **Utah 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 growth is accommodated by a per capita cap model, it would be at risk for the higher costs attributable to an aging population.
    - Utah is the 5th fastest growing state in the country. While the country is expected to see its population grow by 8.4% by 2025, Utah is looking at a 15.9% growth rate, or an additional 442,640 people.
    - By 2025, Utah is expected to see its senior (age 65+) population – a group with high Medicaid costs – grow by 44.3%, among the fastest growth rates in the country (ranking 9th).
    - Projected growth in the elderly population will be a particular challenge in Utah in light of its relative low spending base for the elderly (3rd lowest in the nation).
- **Utah'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 Utah budget and other State priorities, such as education.
    - Federal Medicaid funding ($1.6 billion in 2015) makes up nearly half (45.4%) of all federal funding in Utah's budget – below average among non-expansion states but still the State's single largest source of federal funds. By comparison, the next largest source of federal funds—for elementary and secondary education—is 11.9% of the federal funds received by the State.

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