State Health Reform Assistance Network
Charting the Road to Coverage

A Robert Wood Johnson Foundation program

Medicaid Capped Funding: Findings and Implications for Connecticut

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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 Connecticut-specific data provided here offers insight into how base payment calculations and trend rates, as well as state policies and demographics, could impact Connecticut 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 $1.3 billion in federal funding to Connecticut in 2015, and helped drive the uninsurance rate to one of the lowest in the U.S.** If Medicaid restructuring eliminates or reduces funding for the Medicaid expansion, it would pose a significant threat to coverage in Connecticut and to the State's budget.
    - Nearly 208,000 individuals are covered through the Medicaid expansion adult group in Connecticut, 24% of the State's Medicaid population as of March 2016.
    - Connecticut's uninsured rate dropped by nearly 35% from 2013 to 2015 (from 9.2% to 6%), due in large part to the Medicaid expansion.
    - Beyond coverage, reducing or repealing federal support for expansion would have an outsized impact on Connecticut's budget. Federal funding for new adults (an estimated $1.3 billion in 2015) accounts for 29% of all federal Medicaid funding for Connecticut.
- **Connecticut'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 Connecticut budget and other State priorities, such as education.
    - Federal Medicaid funding ($4.5 billion in 2015) makes up more than half (59%) of all federal funding in Connecticut's budget, which is on par with the average share (59.3%) among expansion states. By comparison, the next largest source of federal funds in Connecticut—for transportation—is just over 12% of the federal funds received by the State.
- **Connecticut has among the highest 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, Connecticut may be expected to move the state's per capita expenditures toward the median over time.
    - Connecticut ranked 8th among states in total per capita Medicaid spending per enrollee. In fiscal year 2011, average spending was $8,122 per enrollee, well above the national average of $6,502.
    - Connecticut has relatively high spending across all eligibility categories: $31,004 per disabled individual compared to a national average of $18,518 (2nd highest); $30,560 per elderly enrollee compared to a national average of $17,522 (3rd highest); $3,158 per child compared to a national average of $2,492 (9th highest); and $4,538 per adult compared to a national average of $4,141 nationally (18th highest).
- **Connecticut's Medicaid spending per enrollee grew more slowly for all eligibility groups than many other states between 2000-2011 but was on par or above the national trend rates typically advanced in capped funding proposals.** If Connecticut 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.
    - Connecticut's average annual per enrollee spending growth was relatively low across all eligibility groups: 2.9% for the aged (12th lowest in nation); 3.5% for disabled (15th lowest in nation); 3.9% for children (16th lowest in nation); and 6.1% for adults (17th lowest in nation).

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- Connecticut's spending growth matched or outstripped per capita GDP (2.9%) and CPI (2.5%), but fell below medical CPI (4%) for all but the adult group (6.1%) during that period.

- **Connecticut 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 Connecticut to monitor.
    - DSH and UPL payments made up 3% of all Connecticut Medicaid benefit spending in 2015.
- **Connecticut 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 61% of Connecticut's Medicaid spending was for elderly and disabled enrollees even though they accounted for just under a quarter (24%) of the State's Medicaid enrollment.
    - The expansion of Medicaid to low-income adults in Connecticut 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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