**State Health Reform Assistance Network**
Charting the Road to Coverage

A Robert Wood Johnson Foundation program

**Medicaid Capped Funding: Findings and Implications for Hawaii**
*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 Hawaii-specific data provided here offers insight into how base payment calculations and trend rates, as well as state policies and demographics, could impact Hawaii 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 millions in federal funding to Hawaii and sharply increased coverage.** If Medicaid restructuring eliminates or reduces funding for the Medicaid expansion, it would pose a significant threat to coverage in Hawaii and to the State's budget.
    - More than 108,000 individuals are covered through the Medicaid expansion adult group in Hawaii, 35% of the State's Medicaid population as of March 2016.
    - Hawaii's uninsured rate dropped by 46% from 2013 to 2015 (from 6.9% to 3.7%), an uninsured rate that is 3rd lowest among states, due in large part to the Medicaid expansion.
    - Beyond coverage, reducing or repealing federal support for expansion would have an outsized impact on Hawaii's budget. Federal funding for new adults (an estimated $540 million in 2015) accounts for 41% of all federal Medicaid funding for Hawaii.
- **Hawaii'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 Hawaii budget and other state priorities.
    - Federal Medicaid funding ($1.3 billion in 2015) makes up 54% of all federal funding in Hawaii's budget – below the average share among expansion states but still the largest source of federal funding for the State. By comparison, the next largest source of federal funds received by the State—for transportation—is 11%, followed closely by the State's federal funds received for primary and secondary education (10.7%).
- **Hawaii 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, Hawaii may be locked into low capped federal payments.
    - Hawaii spent an average of $5,506 per enrollee in federal fiscal year 2011 (12th lowest among states), well below the national average of $6,502.
    - Hawaii has relatively low spending for people with disabilities, children, and adults – $17,035 per disabled enrollee compared to $18,518 nationally (22nd lowest), $2,062 per child enrollee compared to $2,492 nationally (11th lowest), and $2,993 per adult enrollee compared to $4,141 nationally (16th lowest).
- **Between 2000-2011, Hawaii's Medicaid spending on a per capita basis for people with disabilities and the elderly grew more quickly than the national trend rates typically advanced in capped funding proposals, and faster than most other states.** If Hawaii's historical spending rates are indicative of its future spending rates, over time federal Medicaid funding under a capped funding proposal would be short of Hawaii's needs for these groups.
    - Hawaii's average per enrollee spending growth for the disabled was the highest in the nation (15.5%) and ranked 11th for the aged (6.5%).
    - With the exception of its spending children, which had the lowest average per enrollee spending growth in the nation (1.1%), Hawaii's spending growth for the disabled, elderly and adults significantly outstripped per capita GDP (2.9%), CPI (2.5%) and medical CPI (4%) during that period.

This product was prepared with support from the Robert Wood Johnson Foundation through its State Health Reform Assistance Network program.

- Hawaii already has relatively high use managed care. In contrast to other states, it is not clear how much further Hawaii could reduce per capita spending without reducing benefits or provider payment rates.

- **Hawaii 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 Hawaii's Medicaid spending was for elderly and disabled enrollees even though they accounted for only 19% of the State's Medicaid enrollment.
  - The expansion of Medicaid to low-income adults in Hawaii 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.
- **Hawaii relies on waiver payments; depending on they are treated in a capped funding approach, these federal funds may be at risk.** This is a critical issue for Hawaii to monitor.
  - Waiver payments made up nearly 5% of all Hawaii Medicaid benefit spending in 2015.

This product was prepared with support from the Robert Wood Johnson Foundation through its State Health Reform Assistance Network program.