



Health Care Reform - Capped Medicaid Funding

On May 4, 2017, the U.S. House of Representatives passed the American Health Care Act (AHCA) by a vote of 217-213 to repeal and replace the Patient Protection and Affordable Care Act (ACA). The AHCA makes significant changes to current law affecting health insurance coverage, costs, and the stability of the health insurance marketplace. The bill also proposes major modifications to how the Medicaid program is financed, by capping federal Medicaid spending beginning in federal fiscal year (FY) 2020. At that time, state Medicaid programs would be funded by the federal government using a per capita cap. States could also elect to receive federal funding through a block grant rather than a per capita cap for a 10-year period. The block grant could only be used for funding costs attributed to either the traditional adult and children populations or the adult expansion population. The provisions of the bill represent some of the more prominent ideas in health care reform. It is possible that some or all of the proposed changes may resurface in a future reform measure.

What is capped Medicaid funding?

Capped funding, either through a per capita cap or block grant, limits the amount of federal funding provided to states for administration of their Medicaid programs. In its current form, Medicaid is financed jointly between the states and federal government, where states draw down federal dollars each time the state spends money towards Medicaid. For example, Missouri's current matching rate from the federal government for FY 2017 is approximately 63 percent, or \$1.71 for every dollar the state spends on Medicaid without any ceiling on funding.ⁱ

The proposed per capita cap would provide states with a maximum amount of federal money per Medicaid beneficiary. There would be separate funding caps for each subpopulation of Medicaid enrollees – elderly, disabled, children, non-Medicaid expansion adults, and Medicaid expansion adults. If a state spends more on a beneficiary than was allotted in the cap, the state would be responsible for paying the excess. Similarly, a block grant allows the federal government to provide their share of Medicaid funding through a lump sum arrangement regardless of changes in enrollment. This mechanism places more of the onus on states if the Medicaid costs exceed the predetermined allotments, because federal payments would not be adjusted by enrollment growth.

States choosing the block grant option would not have to obey certain Medicaid requirements or offer all of the same benefits that are mandatory under per capita caps. Rules governing statewideness, free choice of provider, and standards for determining eligibility would all be relaxed under the AHCA. Block grant states would still have to provide a set list of services but would have more flexibility in administering cost-sharing requirements and developing delivery system changes.

The proposed formula in the AHCA for developing the per capita federal rate is based on 2016 expenditures and adjusted using the medical care component of the Consumer Price Index (CPI-M) to account for inflation. It also adds 1 percentage to the CPI-M to calculate the growth rate for the elderly and disabled populations. The CPI-M measures the amount consumers spend out-of-pocket on health care; however, it does not rise at the same pace of Medicaid costs. Rather, the Congressional Budget Office projects that per-beneficiary spending in Medicaid will grow at an annual rate of 4.4 percent, whereas the CPI-M will grow at a rate of 3.7 percent through 2026.ⁱⁱ Researchers estimate that this change would result in a drop in federal payments to states by about \$116 billion.ⁱⁱⁱ Although the caps may be more flexible for elderly and disabled populations, the formula for funding would likely fall below the actual costs of caring for adults, pregnant women, and children.

The formula set out in the AHCA for delivering funds through a block grant would vary depending on the year. For the first year of implementation, the state rate would be based on the per person amounts the state would have received for the targeted populations (non-expansion adults and children or expansion adults) under a per capita cap for FY 2019. Thereafter the block grant amount would be adjusted upwards for inflation. States will have the option to rollover any unused federal funds if they continue to opt for the block grant funding mechanism.

What would this mean for Missouri?

Missouri relies heavily on both federal funds and provider taxes to help pay for the state's Medicaid program, MO HealthNet. In FY 2016, the federal government paid for \$4.7 billion of the \$9.2 billion in MO HealthNet expenditures.^{iv} States impose taxes on health care services, with providers paying the bulk of the money. For instance, hospitals in Missouri are taxed at a rate of 5.95 percent of the hospitals' net revenues.^v The money generated through these taxes helps pay for the state's share of MO HealthNet expenditures and is used to draw down more federal dollars for the program. In 2015, the hospital provider taxes generated around \$1 billion in state funding, which then produced approximately \$2 billion in federal funds.^{vi}

Hospitals and other providers readily pay these taxes, which are part of Missouri law, to help leverage federal dollars for MO HealthNet. Nevertheless, the transition to a per capita cap or block grant may well affect the willingness of providers to support these taxes, as the proposed changes will limit the ability of states to generate more federal funding. If provider taxes are reduced or eliminated, the pool of money used for the state's share of Medicaid cost would decrease. As a result, per capita caps or block grants would not only decrease federal funding over time, but may also decrease the funding used for the state's share of Medicaid costs. Shifting costs in this way would require the state to either dedicate more of the general revenue toward MO HealthNet or limit services.

Policymakers should also examine possible variances in enrollment and enrollee costs. Block grants may put states in a difficult position during periods of economic downturn, because these times are often accompanied by spikes in Medicaid enrollment. If a state experiences a recession and more individuals become eligible for Medicaid benefits, the federal government's share of funding will likely fall short of covering the costs. Moreover, although the per capita cap model accounts for changes in enrollment, it does not take into consideration unanticipated costs creating higher need per beneficiary. Increased drug prices, innovative medical services, and public health crises are all conditions that may cause health care to be more expensive than expected. In these circumstances, the state will be responsible for making up the difference. This could significantly impact the state's ability to address emergencies such as the current opioid epidemic, which creates a higher need for the Medicaid population to receive substance abuse and mental health treatment.

Per capita caps and block grants are proposed as ways to slow federal spending on Medicaid and would ultimately result in less federal funding provided to states over time. Reduced assistance from the federal government would put a larger burden on Missouri to cover the expenses. Lawmakers would likely be faced with the choice of whether to scale down eligibility, cut services, or decrease payments to providers, all of which would negatively impact the nearly 970,000 low-income Missourians who rely on Medicaid services.

Endnotes available upon request.