ALLIANCE FOR A
HEALTHY KANSAS

Impact on Kansas of the Per Capita Cap in the Better Care Reconciliation Act of 2017

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The Senate leadership's "repeal and replace" bill, known as the Better Care Reconciliation Act of 2017 (BCRA) makes a number of sweeping changes to the Medicaid program, most significantly the elimination of expansion funding and the imposition of a cap on federal funding. Specifically, the bill would preclude nonexpansion states like Kansas from accessing the enhanced funding for Medicaid to expand coverage in the future and it would phase out the enhanced funding for expansion states after a three-year period beginning in 2021. For all states, the bill would establish a cap on federal Medicaid funding for nearly all beneficiaries and services, and make a number of other changes to Medicaid.[i] Notably, this fundamental change in the way Medicaid is financed goes well beyond repealing and replacing the Affordable Care Act; the legal commitment that the federal government share the cost of Medicaid with states is longstanding and did not come about as a result of the ACA.

The Congressional Budget Office (CBO) has estimated that the coverage provisions of the July 20th version of the bill will reduce federal Medicaid expenditures by $756 billion between federal fiscal year (FY) 2017 and FY 2026. While important for evaluating the overall size of the Medicaid cuts and the likely impact on coverage and the federal budget, the CBO estimate is not designed to provide state-specific information. This analysis provides an estimate of the impact on Kansas of the per capita cap on Medicaid, based on work by Manatt Health using the Manatt Medicaid Financing Model.[ii] It is important to note that other provisions of the bill, such as the partial elimination of retroactive coverage, will lead to additional federal funding losses for Kansas, and that this analysis does not calculate the potential loss of federal funds for Kansas from losing access to the enhanced federal funds if it were to pursue expansion in the future.[iii]

Additional detail is provided throughout on the following key findings:

- **The Senate bill imposes substantial cuts on Kansas that grow markedly over time.** Kansas would lose close to a billion dollars in federal funding ($917 million) between 2020 and 2026 as a result of the per capita cap.

- **Per capita cap cuts more than double by the end of the next decade.** Kansas cuts jump from an estimated $127 million in FY 2024 to $261 million in FY 2026. The reductions will continue to grow past the 2026 window examined by CBO and this analysis.

- **Offsetting federal cuts could be unsustainable for the State.** To offset the per capita cap cuts, Kansas would need to increase its state spending by $917 million between 2020-2026, as the numbers above show, and the year-by-year state spending obligation would grow over time.

- **The per capita cap will put health care at risk for all Medicaid populations.** If Kansas distributes federal spending reductions proportionately across all eligibility groups, cuts from FY 2020-2026 would total $222 million for seniors, $298 million for people with disabilities, $249 million for children, and $146 million for low-income adults.

- **Kansas – rather than the federal government – bears the risk under a per capita cap.** To date, the risk of higher-than-expected health care costs has been split between states and the federal

government. In the future, however, Kansas alone would be responsible for any costs in excess of the allowable trend rates, which are themselves volatile and difficult to predict.

Key Findings

1. The per capita cap will result in large federal funding reductions for Kansas

The per capita cap in BCRA would eliminate the federal government's guarantee to share the cost of all qualifying Medicaid expenditures, replacing it with a cap on federal Medicaid spending. Between FY 2020 and FY 2026, the cap could reduce federal spending on the Kansas Medicaid program by an estimated $917 million.

2. The cuts grow over time, more than doubling by the end of the next decade.

The Senate bill "backloads" the cuts by substituting the Consumer Price Index (CPI) for the medical component of CPI and the medical CPI plus one percentage point in the cap formula beginning in FY 2025. As shown in Table 1, cuts attributable to the cap increase from an estimated $127 million in FY 2024 to $261 million in FY 2026, more than doubling within two years. This out-year change means that the Medicaid cuts grow markedly over time and much of their impact is not picked up in the CBO analysis or these estimates, which end with FY 2026.

Table 1: Federal Per Capita Cap Cuts to Kansas Under the BCRA, FY 2020 - FY 2026 (millions)

Federal Per Capita Cap Cuts in Kansas, FY 2020-2026							
2020	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**	**2020-2026**
-$65	-$76	-$90	-$106	-$127	-$191	-$261	-$917

Source: Manatt Medicaid Financing Model

3. Offsetting federal cuts could be unsustainable for Kansas.

Kansas could avoid cutting back on Medicaid coverage, long term care services, and provider payments rates as a result of the federal cuts if it replaced the lost federal dollars with new state spending. To do this, Kansas would have to spend an additional $917 million of its own funds on the program between FY 2020 and FY 2026 (Table 2). Given Kansas's structural budget issues, it is highly unlikely that the state would be able to backfill for the federal cuts.

Table 2: Increase in State Spending Required to Offset the Per Capita Cap Cut Under the BCRA, FY 2020 - FY 2026 (millions)

State	State Spending Under Current Law	Increase in State Spending If States Offset Per Capita Cap Cuts	
		$	%
Kansas	**$13,756**	**$917**	**6.7%**

Source: Manatt Medicaid Financing Model

4. The per capita cap will put health care at risk for all Medicaid populations.

Unless the state offsets the federal cuts with an increase in spending from its own resources, it will need to reduce rates paid to providers, cut benefits, increase cost sharing or undertake a combination of these strategies to keep its overall spending below the cap (any spending above the cap would be solely at state expense). How Kansas might implement the cuts will be left to the state to decide, but if the federal spending reductions were distributed proportionately (according to spending) across all eligibility groups served in the Kansas Medicaid program, they would total $222 million for seniors, $298 million for people with disabilities, $249 million for children, and $146 million for low-income adults between FY 2020 and 2026 (Table 3).

Note that this only counts the federal spending reductions; if Kansas contributed state dollars only up to the level required to draw down the full amount of available federal dollars these spending reductions for children, seniors, people with disabilities and others enrolled in the Kansas Medicaid program would increase to $1.7 billion between FY 2020 and 2026

Table 3: Federal Per Capita Cap Cuts Under the BCRA by Eligibility Group, FY 2020 - FY 2026 (millions)

State	Federal Cuts from Per Capita Cap Assuming States Apply Cuts in Proportion to Spending by Eligibility Group				
	Aged	Disabled	Children	Adults	Total
Kansas	**-$222**	**-$298**	**-$249**	**-$146**	**-$917**

Source: Manatt Medicaid Financing Model

5. Under the bill, Kansas bears the risk of unanticipated, but not unlikely, health care cost growth as well as the risk that the caps turn out to be lower than projected.

In these estimates, we assume that Medicaid spending under current law will grow in Kansas at rates projected by the Centers for Medicare & Medicaid Services (CMS) Office of the Actuary, and that medical CPI will grow at an average annual rate of 3.7 percent and CPI at an average annual rate of 2.4 percent, as projected by CBO. In practice, future health care spending pressures and trends are difficult

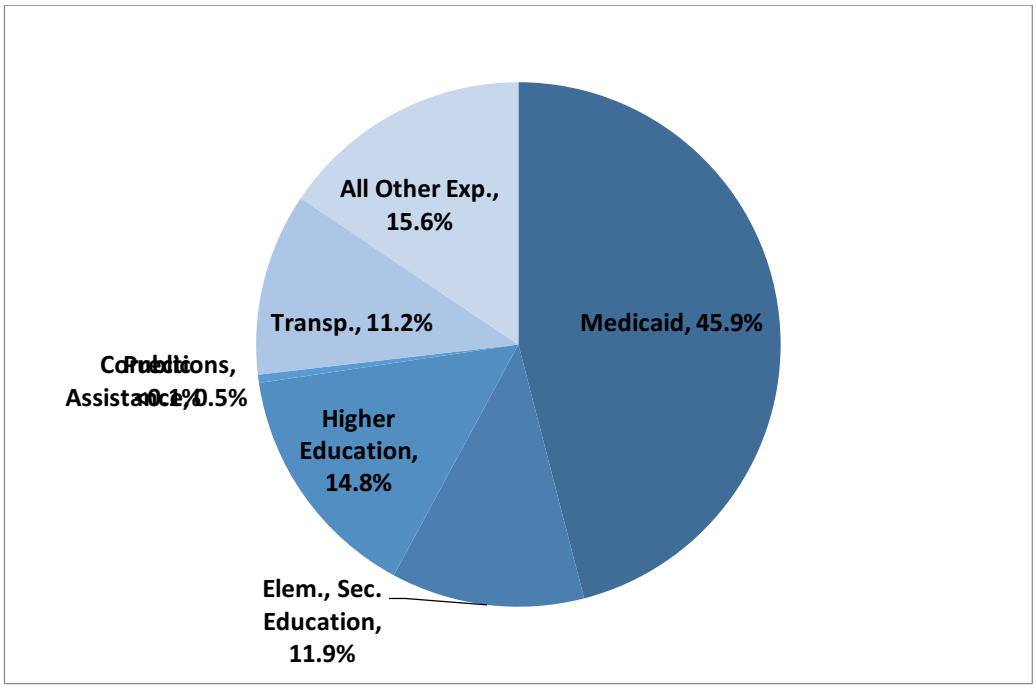
to predict. Currently, the risk of higher-than-projected spending is split between states and the federal government, regardless of whether it was due to a health crisis such as the opioid epidemic, breakthrough treatments and drugs, an aging population or other factors.

Under a per capita cap, however, Kansas would bear the full risk for any spending in excess of the allowable trend rates. In addition, these trend rates are themselves volatile and difficult to predict.[iv] For example, if medical CPI happens to come in at 3.2 percent – rather than the 3.7 percent currently projected by CBO – total federal spending reductions from the per capita cap for all states would increase from an estimated $154.2 billion to $230.8 billion from FY 2020 to 2026. Conversely, if medical CPI is higher than expected, it would create a more generous cap for states, reducing the size of cuts. For example, if medical CPI were 4.2 percent – rather than the 3.7 percent projected by CBO – the size of total federal cuts attributable to the per capita cap would drop to $75.4 billion.[v]

6. Medicaid is a Critical Source of Federal Funding for Kansas

Medicaid is by far the largest source of federal funding to Kansas, accounting for nearly half of all federal funds (46%) coming into the state and more than the combined federal funding for higher education, elementary and secondary education, transportation, public assistance *and* corrections (Figure 1). As such, reductions in federal Medicaid funding could have a large impact on the state's budget. In addition, given the volatility of health care costs and the per capita cap trend rates, BCRA would introduce considerable uncertainty into the state budget process, limiting the ability of lawmakers to effectively allocate resources not only to Medicaid but to other state priorities as well.

Figure 1: Federal Funding to Kansas by Program Area, SFY 2015



Source: "Data Points to Consider When Assessing Proposals to Cap Federal Medicaid Funding: A Toolkit for States" *Manatt Health* for the *Robert Wood Johnson State Health Reform Assistance Network*. 13 Feb. 2017. Available at:

http://www.statenetwork.org/resource/data-points-to-consider-when-assessing-proposals-to-cap-federal-medicaid-funding-a-toolkit-for-states/

Endnotes

[i] On June 22, Senate leadership released their proposed substitute for the House-passed AHCA, the Better Care Reconciliation Act of 2017 as a discussion draft. On June 26, they updated the discussion draft but the changes did not modify the Medicaid portions of the bill. While other versions were released on July 13 and July 20 the modifications did not change the specifics of the per capita cap or the expansion-related provisions.

[ii] This memo is based on a 50-state analysis of the impact of the BCRA prepared by Jocelyn Guyer, April Grady, and Kevin McAvey of Manatt Health. A description of the cap and the expansion changes and the methodology for estimating the state impacts of these provisions are found in the appendices to this analysis.
[ii] With moderate take-up, the Urban Institute estimates that 146,000 people would gain coverage if Kansas expanded. In a separate report, Urban finds that expansion would bring an estimated $10.3 billion in federal dollars to the Kansas Medicaid program during 2017-2026, with a state contribution of $1.5 billion prior to any offsetting state savings. State offsets would include shifting Medicaid costs from regular to enhanced match (e.g., for certain people who would otherwise qualify under pregnancy, disability, breast and cervical cancer, or other pathways), as well as reducing state-only spending (e.g., for behavioral health, inmates' hospital costs, etc.) by moving some of those costs to Medicaid where a federal match is available.

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[iv] The July 13 version of the Senate substitute includes $45 billion from 2018-2026 for state grants to support substance use disorder treatment, an increase from $2 billion in the June 22 version, and $252 million to support research. Independent analyses suggest that this amount falls far short of what would be necessary to adequately address the opioid crisis and would not address the overall health care needs of those impacted. The July 13 version also includes a provision that would allow certain expenditures to be excluded from the cap if a public health emergency was declared in that state. The exclusion would be limited to expenditures directly related to the emergency as determined by the Secretary and, for all states, it could not exceed $5 billion over the five-year life of this special exclusion. This capped, time limited exclusion that is subject to HHS discretion is no replacement for the automatic adjustment in federal funding that the current Medicaid program assures states that experience higher costs due to a public health crisis.

[v] The 3.2 percent and 4.2 percent medical CPI scenarios both assume a trend rate of 2.4 percent when the bill moves to a CPI trend rate in FY 2025; 2.4 percent is the CPI trend rate as projected by CBO. Even if medical CPI growth is closer to 4.2 percent than the 3.7 percent assumed for the state-by-state estimates presented in this analysis, a plausible scenario is that states will aim to keep their spending somewhat below their anticipated cap to create a "buffer" against the risk of a federal clawback. If so, even if medical CPI were to reach 4.2 percent, the magnitude of the cuts could be closer to the levels estimated using 3.7 percent.