Insight on the Issues

Basing Per Enrollee Caps on Historical Medicaid Spending Just Does Not Work

Lynda Flowers and Ari Houser
AARP Public Policy Institute

This *Insight on the Issues* highlights why basing per enrollee caps on historical Medicaid spending will likely result in immediate cuts to state programs, will be inadequate to meet the needs of a changing demographic, and will take away the ability of many states to make changes in their Medicaid programs.

The Better Care Reconciliation Act (BCRA), released by the U.S. Senate, would dramatically change the way the federal government funds Medicaid, likely causing millions of people who currently receive coverage for health care and long-term services and supports (LTSS)—like help with bathing, dressing, eating, wound care and medication management—to lose Medicaid coverage.

No longer would the federal government match all state Medicaid expenditures for eligible enrollees. Instead, states would get a set amount of dollars, based on historical spending, per person for older adults, individuals with disabilities, expansion adults, and non-disabled children under age 19. States could choose between per enrollee caps (also known as per capita caps) and a block grant (i.e., a lump sum payment per eligibility group) for parents and all other adults.

Previous AARP Public Policy Institute reports highlight reasons why per enrollee caps are bad for seniors and people of all ages with disabilities.[1] Examples include the following:

- They would not respond to increased prices in the health care marketplace, threatening access to new lifesaving drugs and treatments.
- They would not account for a growing aging population with an increased need for LTSS.
- They threaten to place increased pressure on state budgets as federal funds fall short.
- They would place optional Medicaid services—like home- and community-based services—at risk, as states scramble to address the shortfalls.

In this *Insight on the Issues* we discuss three reasons why establishing baseline per enrollee caps based on historical Medicaid spending will lead to funding levels that fall short:

- They will likely result in immediate cuts to state programs,
- They will be inadequate to respond to demographic changes, and
- They will perpetuate historical inequities in state spending by taking away the ability of many states to change their Medicaid policies in response to changing needs.

A BASELINE BASED ON HISTORICAL SPENDING WILL LEAD TO IMMEDIATE FUNDING SHORTFALLS IN SOME STATES

To establish baseline spending, the BCRA would let states aggregate per enrollee spending by eligibility

AARP Real Possibilities
Public Policy Institute

category for any eight consecutive quarters between 2014 and the third quarter of 2017. That amount would be linked to the medical care component of the Consumer Price Index (M-CPI) through 2019 for the caps that would go into effect beginning in 2020.

The fundamental flaw with this approach to setting baseline spending is that the Centers for Medicare & Medicaid Services' Office of the Actuary projects Medicaid per enrollee spending to grow faster than the M-CPI for most years and most eligibility groups (table 1). The immediate baseline shortfall from trending 2014 spending forward would be 5.0 percent to 11.4 percent for the children, disabled, and adult eligibility groups.

This means that **as early as 2020, when the caps go into effect, some states' caps will already be below levels needed to maintain current spending under the BCRA**. Affected states would have to immediately address the shortfall by cutting provider rates, cutting services, or cutting eligibility, or they would have to identify alternative sources of revenue to cover the shortfall.

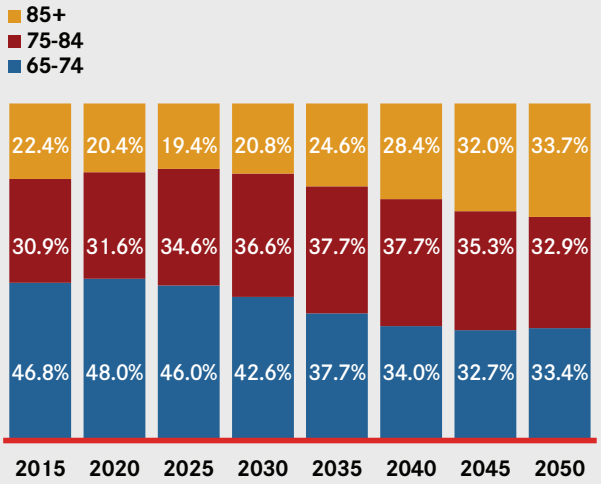
A BASELINE BASED ON HISTORICAL SPENDING WILL NOT BE SUFFICIENT FOR AN AGING POPULATION

Today, nearly half of older adults enrolled in Medicaid are between ages 65 and 74. This group—the young old—use fewer services and cost the program considerably less than the oldest old—those ages 85 and older ($11,949 v. $26,681 per year).[2] Because the young old currently make up such a large percentage of older Medicaid enrollees, they pull the average per enrollee cost down for the entire group.

Between 2015 and 2050, the number of adults ages 85 and older will triple, and the proportion of the older adults in Medicaid who are 85+ will increase to one-third (figure 1). These individuals use more health care and LTSS than other age groups. With increased utilization will come increased costs. In 2015, the

FIGURE 1

Projected Medicaid Age 65+ Enrollment by Age Group, 2015–2050



Source: AARP Public Policy Institute Analysis of US Census population projections and data from CMS MSIS and Kaiser Family Foundation.

TABLE 1

Growth in Medicaid Spending per Full-Year Full-Benefit Enrollee and M-CPI, 2014 to 2019

	Percentage Change from Previous Year (CMS Projection)				
	Spending per full-year full-benefit enrollee under current law				Growth rate
Year to Year Change	Children	Adults	Disabled	Aged	M-CPI
2014–2015	+8.4%	+6.2%	+4.4%	-2.1%	+2.3%
2015–2016	+2.0%	+4.6%	+3.1%	+0.9%	+2.1%
2016–2017	+3.5%	+5.0%	+4.2%	+3.4%	+3.8%
2017–2018	+4.9%	+5.3%	+4.5%	+4.5%	+4.3%
2018–2019	+4.9%	+5.3%	+4.7%	+4.3%	+4.2%
Cumulative 2014–19	+26.0%	+29.2%	+22.8%	+11.4%	+17.8%
2014–2019 Shortfall	8.2%	11.4%	5.0%	-	-

Source: AARP Public Policy Institute calculations based on US Department of Health & Human Services, Centers for Medicare & Medicaid Services (CMS), Office of the Actuary, 2016 Actuarial Report on the Financial Outlook for Medicaid, *https://www.medicaid.gov/medicaid/financing-and-reimbursement/actuarial-report/index.html.*

cost per Medicaid beneficiary age 65 and older was about 1.46 times the cost per beneficiary age 65–74. Based on current Medicaid enrollment trends and US Census population projections, the AARP Public Policy Institute projects that by 2050, the per enrollee Medicaid cost for those ages 65 and older will be about 1.63 times the cost per beneficiary age 65–74. This represents a 12 percent increase in per person spending due to the aging of the population.[3]

State per capita allotments in the Senate bill—which, in many cases, would be inadequate to begin with—will be even less able to meet the needs of an aging population. As a result, many seniors would likely face a future in which they are unable to get the services and supports they need to remain in their homes and participate in their communities.

In fact, rather than accounting for the aging of the population, the BCRA would slash the growth rate for older adults from M-CPI + 1 to CPI-U (Consumer Price Index for all urban consumers—explained below) beginning in 2025. This would cut the growth rate in half (5.2% to 2.6%) at precisely the time when the aging of the population causes additional cost growth for the "average" age 65+ Medicaid enrollee. The CPI-U, or Consumer Price Index for all urban consumers, is a measure of general inflation that examines out-of-pocket household spending on goods and services used for everyday living; it bears no relationship at all to the cost of medical care.

A BASELINE BASED ON HISTORICAL PER ENROLLEE SPENDING WILL LOCK IN HISTORICAL INEQUITIES IN STATE MEDICAID SPENDING AND FORECLOSE THE ABILITY TO ALTER CURRENT MEDICAID POLICY

Medicaid spending per enrollee varies widely by state. Because the BCRA would base per capita caps on a variable time period between 2014 and 2017, the baseline locks in current low-spending states and forecloses the possibility of these states catching up to national rates and level of service.

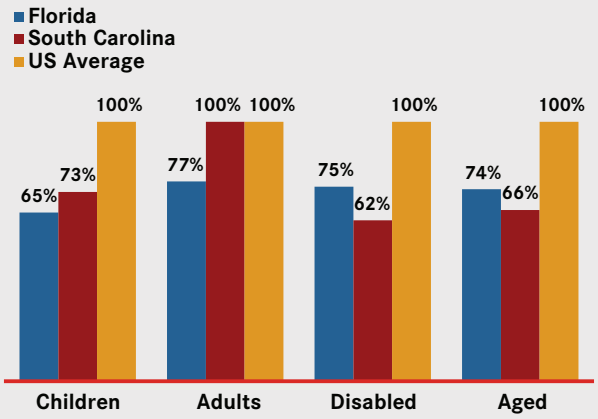
Setting a baseline based on historical per beneficiary spending could lock low-spending states into a permanent federal funding shortfall of 20 percent or more compared with the US average, making it prohibitively expensive for these states to ever offer coverage on parity with the rest of the country. Even though the BCRA includes an equity adjustment that could eventually bring very low-spending states up to 75 percent of national average spending by enrollment group, even this bump up would not help those states reach full parity.

The effects are likely to be felt most acutely in Florida and South Carolina. These states have the lowest overall spending per full-year Medicaid beneficiary and low spending across all (Florida) or most (South Carolina) eligibility categories compared with the national average. In 2013—the year for which the most recent data were available—Florida's spending per full-year beneficiary was only 70 percent of the US average, and was 77 percent or lower for all four eligibility categories. South Carolina's spending per full-year beneficiary was only 68 percent of the US average, and was 73 percent or lower for three of the four eligibility categories (figure 2).

Alabama, Arizona, Georgia, Hawaii, Illinois, Nevada, and Tennessee would also be locking in low spending if FY2013 spending were used to set the caps. In each of these states, the overall spending per full-year Medicaid beneficiary was 80 percent of the US average or less,

FIGURE 2

FY2013 Total Medicaid Spending per Full-Year Full-Benefit Enrollee in Florida and South Carolina by Eligibility Group, % of US Average



Source: AARP Public Policy Institute calculations based on MACStats, Medicaid Benefit Spending per Full-Year Equivalent (FYE) Enrollee by State and Eligibility Group, FY 2013 *(December 2016), Exhibit 22, https://www.macpac.gov/publication/medicaid-benefit-spending-per-full-year-equivalent-fye-enrollee-by-state-and-eligibility-group/. For this analysis, we rely on 2013 spending per full-year-equivalent enrollee data (the most recent available) to project* possible *impacts in 2014–2017.*

TABLE 2
FY2013 Total Medicaid Spending per Full-Year Full-Benefit Enrollee by Eligibility Group for Nine States, % of US Average

State	Overall	Children	Adults	Disabled	Aged
Alabama	72%	78%	99%	55%	108%
Arizona	75%	99%	104%	82%	62%
Florida	70%	65%	77%	75%	74%
Georgia	75%	80%	110%	69%	100%
Hawaii	79%	70%	79%	72%	98%
Illinois	75%	90%	74%	100%	80%
Nevada	73%	93%	80%	100%	75%
South Carolina	68%	73%	100%	62%	66%
Tennessee	80%	90%	86%	73%	117%

Source: AARP Public Policy Institute calculations based on MACStats, Medicaid Benefit Spending per Full-Year Equivalent (FYE) Enrollee by State and Eligibility Group, FY 2013 *(December 2016), Exhibit 22, https://www.macpac.gov/publication/medicaid-benefit-spending-per-full-year-equivalent-fye-enrollee-by-state-and-eligibility-group/. For this analysis, we rely on 2013 spending per full-year-equivalent enrollee data (the most recent available) to project* possible *impacts in 2014–2017.*

with multiple enrollment categories well below the national rate (table 2).

CONCLUSION

By all measures, the per enrollee cap proposal in the BCRA falls short, beginning with the setting of the baseline. **The proposal would likely result in immediate cuts to state Medicaid programs, would be inadequate to meet the needs of a rapidly changing demographic, and is likely to take away the ability of many states to make changes to their Medicaid policies.** What we really need are Medicaid policies that allow states to adequately serve people who qualify for the program, can respond to changing societal needs and demographic changes, and provide the flexibility states need to make policy choices that meet the needs of their citizens.

1 Lynda Flowers, "Block Grant and Per Capita Caps Pose Risks for Medicaid Beneficiaries and for States," Insight on the Issues, AARP Public Policy Institute, Washington, DC, February 2017, http://www.aarp.org/content/dam/aarp/ppi/2017-01/Block%20Grants.pdf; Brendan Flinn and Ari Houser, "Capped Financing for Medicaid Does Not Account for the Growing Aging Population," Fact Sheet, AARP Public Policy Institute, Washington, DC, June 2017, http://www.aarp.org/content/dam/aarp/ppi/2017/01/Capped-financing-for-Medicaid-Does-Not-Account-For-The-Growing-Aging-Population.pdf.

2 Flinn and Houser, "Capped Financing"; Gretchen Jacobson, Tricia Neuman, and Mary Beth Musumeci, "What Could a Medicaid Per Capita Cap Mean for Low Income People on Medicare?," Issue Brief, Kaiser Family Foundation, Washington, DC, March 2017, http://files.kff.org/attachment/Issue-Brief-What-Could-a-Medicaid-Per-Capita-Cap-Mean-for-Low-Income-People-on-Medicare.

3 Flinn and Houser, "Capped Financing."

Insight on the Issues 122, June 2017

601 E Street, NW
Washington DC 20049

Follow us on Twitter @AARPpolicy
on facebook.com/AARPpolicy
www.aarp.org/ppi

For more reports from the Public Policy Institute, visit http://www.aarp.org/ppi/.

AARP Real Possibilities
Public Polic Institute