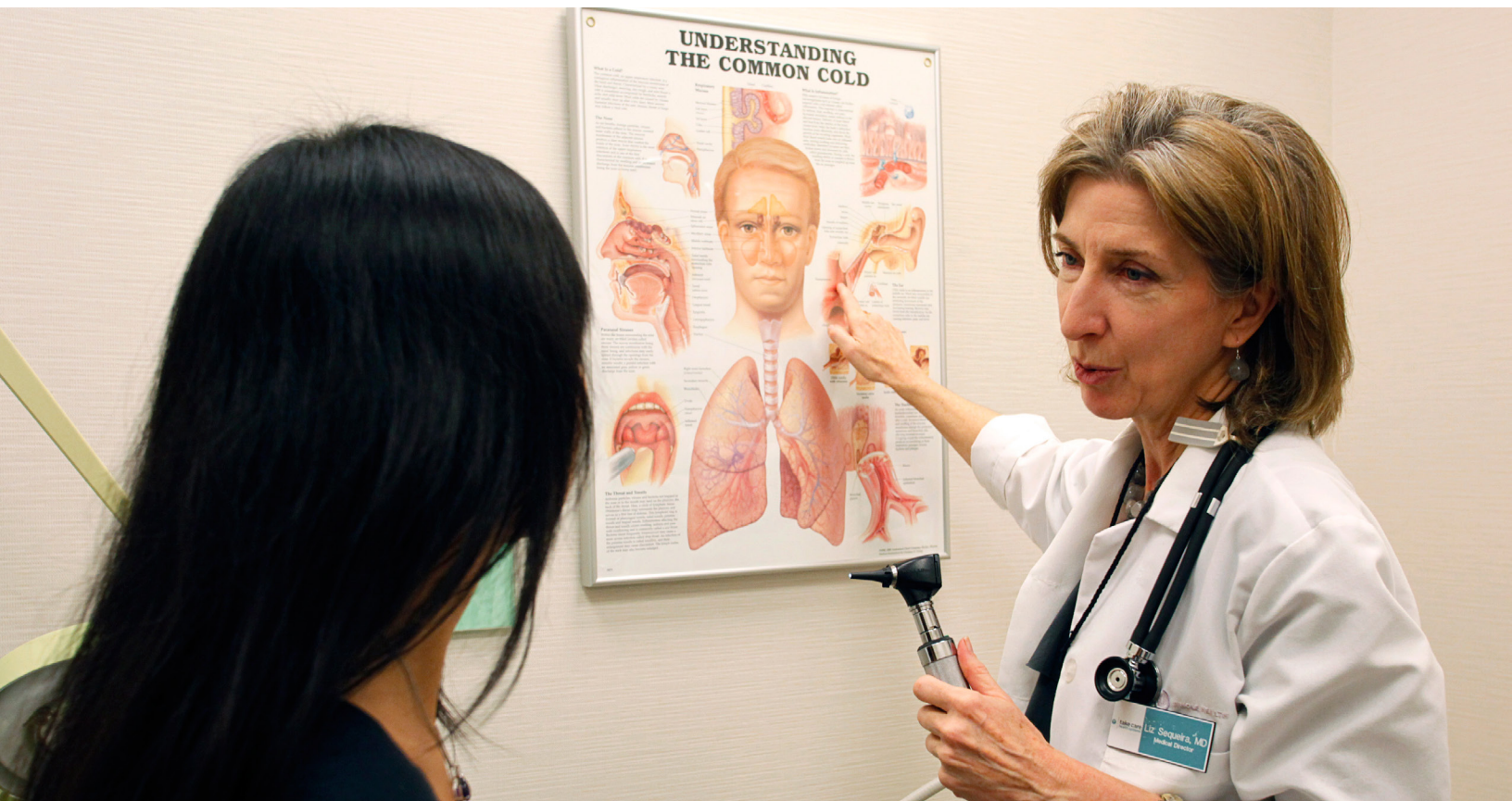


EFFECTS OF THE MEDICAID PER CAPITA CAP INCLUDED IN THE HOUSE-PASSED AMERICAN HEALTH CARE ACT

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Loren Adler

The Brookings Institution

Matthew Fiedler

The Brookings Institution

Tim Gronniger

The Brookings Institution

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Leonard D. Schaeffer Center
for Health Policy & Economics

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Introduction

The House of Representatives recently passed legislation, known as the American Health Care Act (AHCA), that would alter how the costs of state Medicaid programs are shared between the federal government and the states. Under the current program structure, the federal government pays for a specified share of the cost of medical care for eligible individuals, while state governments pay for the remainder. The share of costs paid by the federal government varies according to a state's per capita income and the reason that individuals are eligible for Medicaid. Overall, the federal government contributed 63 percent of total Medicaid spending in 2015.¹

The AHCA would cap the total amount of federal funding that states could receive for each person they enroll, a structure commonly referred to as a “per capita cap.” The cap on federal funding, which would take effect in 2020, would be set based on states' per enrollee spending in 2016.² Thereafter, the cap would be adjusted based on changes in the Consumer Price Index for Medical Care (CPI-M), as well as changes in the share of enrollees in a set of specified eligibility categories.

To gain insight into the likely effects of this change in Medicaid's financing structure, we examine how state and federal budgets would have been affected if a similar proposal had been implemented in the recent past. In particular, we use state-level data on historical Medicaid spending published by researchers at the Kaiser Family Foundation to examine how states would have fared in 2011 had a cap with the structure specified in the AHCA been implemented in 2004 based on spending levels in 2000. We choose this time period because of the ready availability of suitable data.

WE HAVE FIVE MAIN CONCLUSIONS:

- **Implementing a Medicaid per capita cap during the 2000s would have substantially reduced federal Medicaid funding to more than half of states.** We estimate that a cap like the AHCA's, had it been implemented beginning in 2004 based on spending in 2000, would have lowered federal spending on Medicaid by \$17.8 billion in 2011, requiring an 11 percent increase in state funding to maintain their Medicaid programs in their 2011 form. The required increase in state Medicaid spending to maintain pre-cap funding levels in 2011 would have varied dramatically, with one state requiring a 77 percent increase and eight other states requiring at least a 25 percent increase, while no change would have been required in just under half of states.
- **Due to the “one-sided” nature of the AHCA's per capita cap, there would have been no winners among the states, only losers.** States receive reduced federal matching funding if their spending is above the AHCA cap in a given year, but do not receive additional federal funding relative to current law if spending is below the cap. This means that no state would have received more funding under a

¹ Office of the Actuary (OACT), Centers for Medicare & Medicaid Services. 2016 Actuarial Report On The Financial Outlook For Medicaid. Retrieved April 28, 2017 from <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2016.pdf>.

² Throughout this analysis, years refer to federal fiscal years unless otherwise specified.

per capita cap than under current law in any year. This is an underappreciated feature of a per capita cap, which greatly magnifies the federal budgetary savings from the proposal. It is also an important difference relative to true capitation or block grant proposals under which a state would receive a fixed payment for each enrolled individual or for the program overall.

- **States that had a low level of spending per enrollee in the base year were much more likely to see funding reductions under this proposal.** More than 85 percent of estimated federal spending reductions would have occurred in states with below-median per enrollee costs in 2000. This reflects the fact that states with relatively low spending in 2000 tended to experience faster cost growth in subsequent years. This type of “mean reversion” is a common feature of health care spending trends that is likely to recur in the future. If the goal of a per capita cap is to encourage more efficient health care provision, this feature is challenging to justify. The states seeing the largest cuts in federal funding are likely to be those with less opportunity to reduce spending without harming beneficiaries.
- **States would have seen much larger Medicaid funding reductions if spending had grown even moderately faster, and the risk is asymmetric.** If Medicaid per enrollee spending had grown just one percentage point faster annually from 2000 through 2011, the reduction in federal funding due to a per capita cap would have been \$33.9 billion, nearly double the base scenario’s \$17.8 billion. The reduction in federal funding would have been smaller if spending had grown more slowly, but the magnitude of the risk to states is asymmetric due to the one-sided nature of the cap; since states can never receive more funding than under current law, they bear the full risk of higher spending growth, but capture only part of the benefit of lower spending growth. Medical inflation fails to capture many of the factors that affect overall health care spending trends, most importantly trends in health care utilization. Therefore, a spending cap based on medical inflation, like the AHCA’s, leaves states at risk of facing cuts that are significantly larger than expected if utilization increases due to demographic changes, changes in residents’ health status, public health emergencies, changes in medical practice patterns, or the arrival of new medical technologies.
- **A per capita cap would have generated large funding reductions even if the target growth rates under the AHCA were set to match national spending trends exactly because the caps still would not have accounted for state-specific trends.** Even if the spending targets for each beneficiary category had exactly matched actual cost growth for that beneficiary category nationwide, a per capita cap would still have generated reductions in federal funding for state Medicaid programs of \$15.3 billion in 2011, just 14 percent smaller than the base scenario’s \$17.8 billion. This result occurs because spending growth varied widely across states, so states seeing above average growth would still have experienced significant cuts in this scenario, while because of the “one-sided” nature of the cap, states seeing below average growth would still have been largely unaffected by the cap.

It is important to note that this analysis is not a forecast of how a per capita cap would affect state Medicaid programs in the future since future spending trends will differ from those observed over this historical period. This exercise nevertheless provides important insights into the range of potential impacts and how those impacts are likely to vary across states.

It is also important to note that this paper does not attempt to quantify the effects of the other changes the AHCA would make to Medicaid, most notably phasing out the Affordable Care Act's (ACA) expansion of Medicaid eligibility to non-elderly individuals with incomes below 138 percent of the federal poverty line. Nor does this analysis examine the effects of the AHCA's Medicaid proposal on the number of people with insurance coverage or the characteristics of that coverage. The Congressional Budget Office's (CBO) most recent analysis of the AHCA estimated that the combined effect of the AHCA's various proposals would be to reduce the number of people with Medicaid coverage by 14 million by calendar year 2026, with a portion of that coverage loss attributable to the AHCA's per capita cap proposal.³

Background on the Per Capita Cap Proposal in the House Health Care Bill

STRUCTURE OF THE HOUSE PER CAPITA CAP PROPOSAL

Under the existing Medicaid program, the federal government pays for a specified share of the cost of medical care for eligible individuals, while the state pays for the remainder. For traditional Medicaid populations, the federal government's share varies based on state income from 50 percent in high-income states like Massachusetts and New York to almost 75 percent in Mississippi, the lowest-income state, in fiscal year 2017. Certain other categories of beneficiaries, including adults who became eligible for Medicaid under the ACA and children eligible via the Children's Health Insurance Program, are eligible for higher matching rates. Under current law, there is no limit on the total amount of Medicaid spending eligible to receive federal support.

Section 121 of the AHCA would cap the total amount of Medicaid spending eligible for federal funding starting in 2020.⁴ To compute its cap, the state would count the number of enrollees in five beneficiary categories: aged enrollees, people with disabilities, children, adults who became eligible for Medicaid due to the ACA's Medicaid expansion, and other adults. For each beneficiary category, the state would then multiply the number of enrollees by a per capita target dollar amount for that type of enrollee. The state's overall cap is the sum of the resulting dollar amounts for the five beneficiary categories. Importantly, states would be subject only to this aggregate cap on Medicaid spending, not separate caps for each category of Medicaid beneficiary.

This type of cap is commonly referred to as a "per capita cap" because the level of the aggregate spending cap is proportional to the state's enrollment. Figure 1 illustrates how the spending cap would be calculated for a fictional state.

3 Congressional Budget Office. (2017). Congressional Budget Office Cost Estimate of the Direct Spending and Revenue Effects of H.R. 1628, the American Health Care Act. [Letter]. Retrieved April 28, 2017 from <https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/hr1628.pdf>.

4 Calculations related to the per capita cap would exclude certain narrow categories of beneficiaries and spending. In particular, children receiving Medicaid coverage that is funded through the Children's Health Insurance Program, individuals receiving partial Medicaid benefits, as well as certain other small categories of beneficiaries would not be included. Similarly, spending associated with excluded enrollees, as well as Medicaid Disproportionate Share Hospital payments, payments for Medicare premiums and cost sharing, and certain payments to safety net providers would also be excluded from these calculations.

Figure 1. Calculation of the AHCA Spending Cap for a Fictional State

Beneficiary Category	Enrollment	x	Per Capita Target Amount	=	Contribution to Cap
Aged	125,000		\$20,000		\$2.5 billion
People with disabilities	200,000		\$30,000		\$6.0 billion
Children	600,000		\$4,000		\$2.4 billion
Adults made eligible by ACA	250,000		\$6,000		\$1.5 billion
Other adults	300,000		\$6,500		\$2.0 billion
Spending Cap for State = Sum of Five Category Subtotals					= \$14.4 billion

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The two most important determinants of the cap’s stringency—and, thus, of its overall effects—are how the per capita target dollar amounts for the five beneficiary categories would be set initially and how they would be updated over time. The AHCA would set the initial target amounts for each state to match the level of per capita Medicaid spending in the state in 2016.⁵ Through 2019, those target amounts would grow at the same rate as the Consumer Price Index for Medical Care for All Urban Consumers (CPI-M). For subsequent years, the target amounts for aged enrollees and people with disabilities would grow at the rate of the CPI-M plus 1 percentage point, while the other target amounts would continue to grow at the rate of the CPI-M.

HOW THE PER CAPITA CAP PROPOSAL WOULD AFFECT STATES’ BUDGETS AND MEDICAID PROGRAMS

The effect of the proposal would be to reduce federal support to states whose Medicaid spending exceeded the cap, as illustrated in Figure 2 for the same fictional state examined in Figure 1. For example, if the state spent \$15.4 billion on its Medicaid program, the federal government would no longer pay its usual share of the final \$1 billion in costs, so the state would now be required to cover the full amount of these costs.⁶ For a state in which the federal government pays 60 percent of Medicaid costs, the lost funding would be \$600 million. The proposal thus generates fiscal savings for the federal government and corresponding fiscal costs for states.

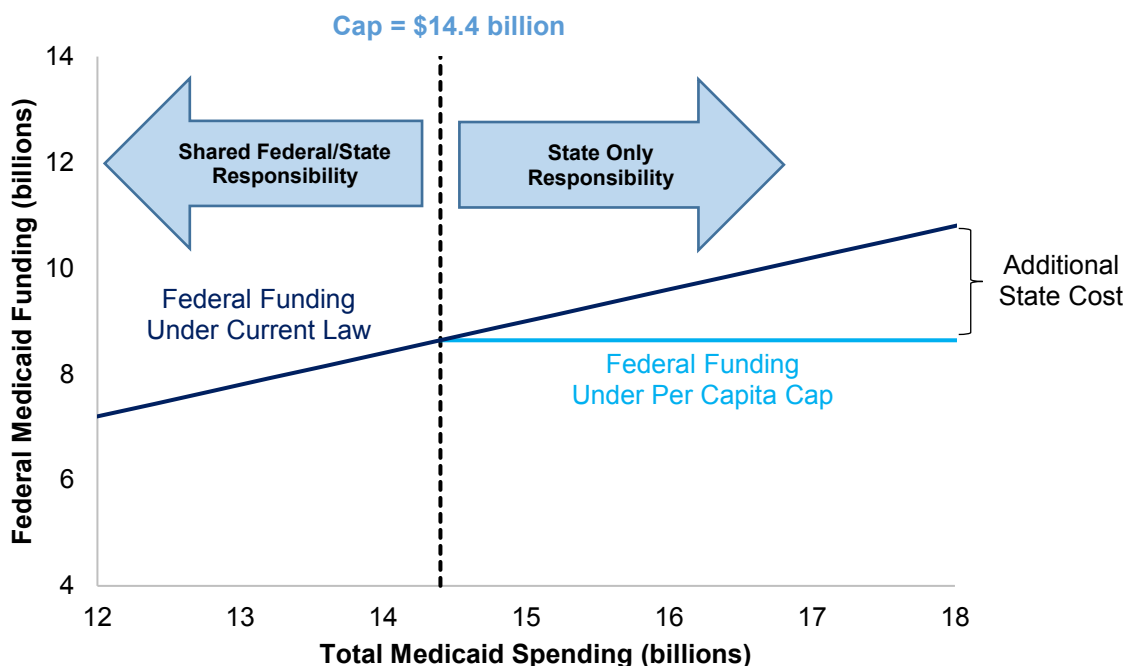
In considering how the per capita cap will affect states’ finances, it is important to note that the per capita cap proposal is a “one-sided bet” in favor of the federal government. States who exceed their cap would

⁵ The legislation uses a somewhat convoluted procedure to calculate these amounts, possibly because the drafters expected that it would not be possible to disaggregate state Medicaid spending by beneficiary category using the data available for 2016. In detail, the legislation directs CMS to calculate: (1) a single per capita amount for *all* beneficiaries for 2016; and (2) per capita spending for each of the five beneficiary categories for 2019. The initial targets for the five beneficiary categories are then set to match the overall *level* of per capita spending in 2016 and the *relative* spending across the five beneficiary categories in 2019. Because we have data on spending for each beneficiary category for 2000, we simply use these amounts directly, rather than implementing the more complex procedure envisioned in the legislation.

⁶ More precisely, the proposal would continue to make initial federal payments for spending in excess of the cap, but would require states to repay these amounts in the subsequent fiscal year.

lose the full amount of federal funding associated with spending above the cap and thus bear the full cost of their program at the margin. By contrast, nothing would change for states whose spending was below the cap; they would face the same funding structure as under current law and thus receive no additional federal funds. Because of this structure, states can lose funding under this proposal, but cannot gain funding.

Figure 2. Fictional Example of State and Federal Spending



Note: Scenario assumes federal share of 60 percent. Enrollment held constant as spending varies.

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This “one-sided bet” feature is an important respect in which the AHCA’s per capita cap differs from a true capitation arrangement that would provide states with a fixed amount of money for each beneficiary.⁷ For states in which total spending came in below the cap or capitation amount, a capitation arrangement would be considerably more generous than a per capita cap. This is because states in this circumstance would continue to receive the full capitation amount; by contrast, under a per capita cap, a state that spends less than the cap receives correspondingly less in federal funding just as it would under current law. Only for states that exceed the cap or capitation amount would a capitation arrangement and a per capita cap have the same effects. A per capita cap similarly differs from true block grant arrangements in which a state would receive a fixed amount of money overall.

Beyond the fiscal consequences of this proposal, a crucial question is how states that expect their spending to come in above the cap will change the structure of their Medicaid programs. States could,

⁷ While a capitation arrangement would have fiscal advantages for states relative to a per capita cap and corresponding fiscal disadvantages for the federal government, switching to capitation structure would also have important health policy consequences. As discussed below, a per capita cap will likely drive states who expect to spend more than the cap under current law to cut their Medicaid programs because states will now face the full cost of the program at the margin. Under a capitation arrangement, all states, not just states with spending above the cap, would experience this change in incentives.

in principle, respond by raising additional revenue or cutting other programs and using these funds to replace the lost federal funds, thereby avoiding changes to their Medicaid programs. Analysts at the Kaiser Family Foundation have produced scenarios illustrating the changes states would have to make in other parts of their budgets in order to accommodate increases in Medicaid obligations of various sizes.⁸

While some states might find some other sources of funds, it is highly unlikely that this would be states' primary response, for two reasons. First, the per capita cap greatly reduces the effective return to an additional dollar of state Medicaid spending since each dollar of state spending would no longer be matched by additional federal funding. This loss would be substantial. For a state with a federal share of 60 percent, the amount of federal funding the state would receive for each additional dollar it spends would fall from \$1.50 to zero. Second, Medicaid constitutes a significant fraction of states' overall general fund budgets—16 percent on average during states' 2015 fiscal years—so any change that tightens states' overall fiscal constraints, as this proposal would, would likely cause some reduction in states' Medicaid spending.⁹

Reductions in state Medicaid programs would likely take a variety of forms. States could respond by reducing per person costs, such as by narrowing the package of benefits covered under their Medicaid programs or reducing the rates their programs pay to medical providers. In other cases, states would likely elect to reduce program enrollment, particularly for eligibility groups for which the per capita targets fell behind the actual cost of providing medical services and for high cost enrollees within any particular eligibility group. It is beyond the scope of this analysis to forecast precisely how states will respond, but the Congressional Budget Office concluded that states would take a combination of approaches, including reducing the number of people covered through Medicaid.¹⁰

Impacts of AHCA's Per Capita Cap in 2011 if Implemented in 2004

METHODOLOGY FOR HISTORICAL EXERCISE

To illustrate the potential effects of a per capita cap on states' Medicaid programs, we consider what would have happened had a per capita cap like the one included in the AHCA been implemented in 2004 (rather than 2020 as under the AHCA). Under this alternative timeline, the base period for determining the per capita target amounts for each state and beneficiary category would have been 2000. Those target amounts would then have been inflated by the CPI-M through 2003 and then by either the CPI-M or CPI-M plus 1 percentage point, as applicable for the beneficiary category, thereafter. We examine the effects of the policy in 2011. Our approach is broadly similar to an approach taken in a prior analysis

8 See Valentine, A., Rudowitz, R., Boyd, D., & Dadayan, L. (2017). Implications of Reduced Federal Medicaid Funds: How Could States Fill the Funding Gap? Kaiser Family Foundation. <http://kff.org/medicaid/issue-brief/implications-of-reduced-federal-medicaid-funds-how-could-states-fill-the-funding-gap/> for a discussion of how States could achieve such reductions.

9 Medicaid and CHIP Payment and Access Commission (MACPAC). (2017). Medicaid's share of state budgets. Retrieved April 28, 2017 from <https://www.macpac.gov/subtopic/medicaids-share-of-state-budgets/>.

10 Congressional Budget Office. (2017). Congressional Budget Office Cost Estimate for the American Health Care Act. Retrieved April 28, 2017 from <https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/americanhealthcareact.pdf>.

released by the Kaiser Family Foundation.¹¹ Researchers at the Urban Institute have used a related methodology to project the effects of a per capita cap over the coming decade.¹²

We choose this time period because of the ready availability of appropriate data from a recent Kaiser Family Foundation (KFF) study of Medicaid spending trends using states' reports to CMS.¹³ That analysis reported per capita Medicaid spending for full-benefit enrollees by state and eligibility category in 2011.¹⁴ Per capita spending for each state and eligibility category in 2000 is then derived based on average annual growth rates from 2000-2011 by category, also reported by KFF.¹⁵ We obtain data on Medicaid enrollment by eligibility category in 2011 from a separate KFF publication.¹⁶ The available data do not allow us to estimate impacts in each individual year, but do allow us to estimate effects in 2011. We exclude New Mexico from the analysis because data are missing for some beneficiary categories.

We focus on two budgetary outcomes for states in 2011:

- First, we calculate the amount by which total (federal and state combined) spending on each *state's* Medicaid program would have exceeded its cap, both in dollar terms and as a percentage of total Medicaid spending. These estimates reflect how much each state would need to reduce its overall spending on medical services (while holding enrollment fixed) if it wished to conform its spending to the cap.
- Second, we calculate the reduction in federal funding for the state's Medicaid program relative to current law, both in dollar terms and as a percentage of the *state's* spending on its Medicaid program, at the baseline level of Medicaid spending.¹⁷ These estimates reflect how much funding each state would need to find elsewhere in its budget if it wished to continue operating its program as it would have under current law.

11 Garfield, R., Rudowitz, R., & Young, K. (2017). Data Note: What if Per Enrollee Medicaid Spending Growth Had Been Limited to CPI-M from 2001-2011? Kaiser Family Foundation. <http://kff.org/medicaid/issue-brief/data-note-what-if-per-enrollee-medicaid-spending-growth-had-been-limited-to-cpi-m-from-2001-2011/>.

12 Holahan, J., Buettgens, M., Pan, C., & Blumberg, L.J. (2017). The Impact of Per Capita Caps on Federal and State Medicaid Spending. Urban Institute. http://www.urban.org/sites/default/files/publication/89061/2001186-the_impact-of-per-capita-caps-on-federal-spending-and-state-medicaid-spending.pdf.

13 Kaiser Family Foundation. (2017). Data Note: Variation in Per Enrollee Medicaid Spending Across States. <http://kff.org/medicaid/issue-brief/data-note-variation-in-per-enrollee-medicaid-spending-across-states/>.

14 Kaiser Family Foundation. Medicaid Spending Per Full-Benefit Enrollee. <http://kff.org/medicaid/state-indicator/medicaid-spending-per-full-benefit-enrollee/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

15 Kaiser Family Foundation. Average Growth in Annual Medicaid Spending from FY2000 to FY2011 for Full-Benefit Enrollees. <http://kff.org/medicaid/state-indicator/average-growth-in-annual-medicaid-spending-from-fy2000-to-fy2011-for-full-benefit-enrollees/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>. The KFF growth rate estimates for aged enrollees exclude spending on prescription drugs in order to avoid distortions from the creation of Medicare Part D in 2006. For our purposes, focusing on spending growth excluding prescription drugs likely provides a more accurate picture of how a per capita cap would actually have affected state Medicaid programs since the per capita cap would likely have been adjusted for the creation of Part D. Indeed, the actual Part D legislation included a provision that "clawed back" a portion of what states would save on certain dual eligible beneficiaries due to the creation of Part D. For additional detail, see Schneider, A. (2004). The "Clawback:" State Financing of Medicare Drug Coverage. Kaiser Family Foundation. <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/the-clawback-state-financing-of-medicare-drug-coverage.pdf>.

16 See Kaiser Family Foundation. Distribution of Full-Benefit Medicaid Enrollees by Enrollment Group. <http://kff.org/medicaid/state-indicator/distribution-of-full-benefit-medicaid-enrollees-by-enrollment-group/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

17 When calculating changes in federal funding for 2011, we use federal medical assistance percentage (FMAP) that would have applied in the absence of the provisions of the American Recovery and Reinvestment Act and subsequent fiscal measures that temporarily increased FMAPs. These rates were only in effect for the final quarter of 2011. See Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2010 through September 30, 2011. 74 FR 62315. (November 27, 2009). Retrieved April 28, 2017 from <https://aspe.hhs.gov/system/files/pdf/106651/fmap11.pdf>.

In what follows, we present state-level estimates, but do not report each state's identity. Understanding how the impacts of a per capita cap would vary across states is important to understanding a per capita cap's overall effects. However, future state-specific spending trends will differ from those observed over the historical period we examine, so how a specific state would have fared under a per capita cap historically is not likely to be a reliable forecast of how that particular state would fare in the future.

Differences in patterns of spending growth between the historical period and future periods, of course, could also affect the overall national impact of a per capita cap. In particular, if the national average difference between per enrollee Medicaid spending growth and growth of the CPI-M were larger in the future, then the overall impacts of a per capita cap would tend to be larger. Conversely, if the difference were smaller in the future, then the overall impact of a per capita cap would tend to be smaller. We explore this source of uncertainty in a later section of our analysis.

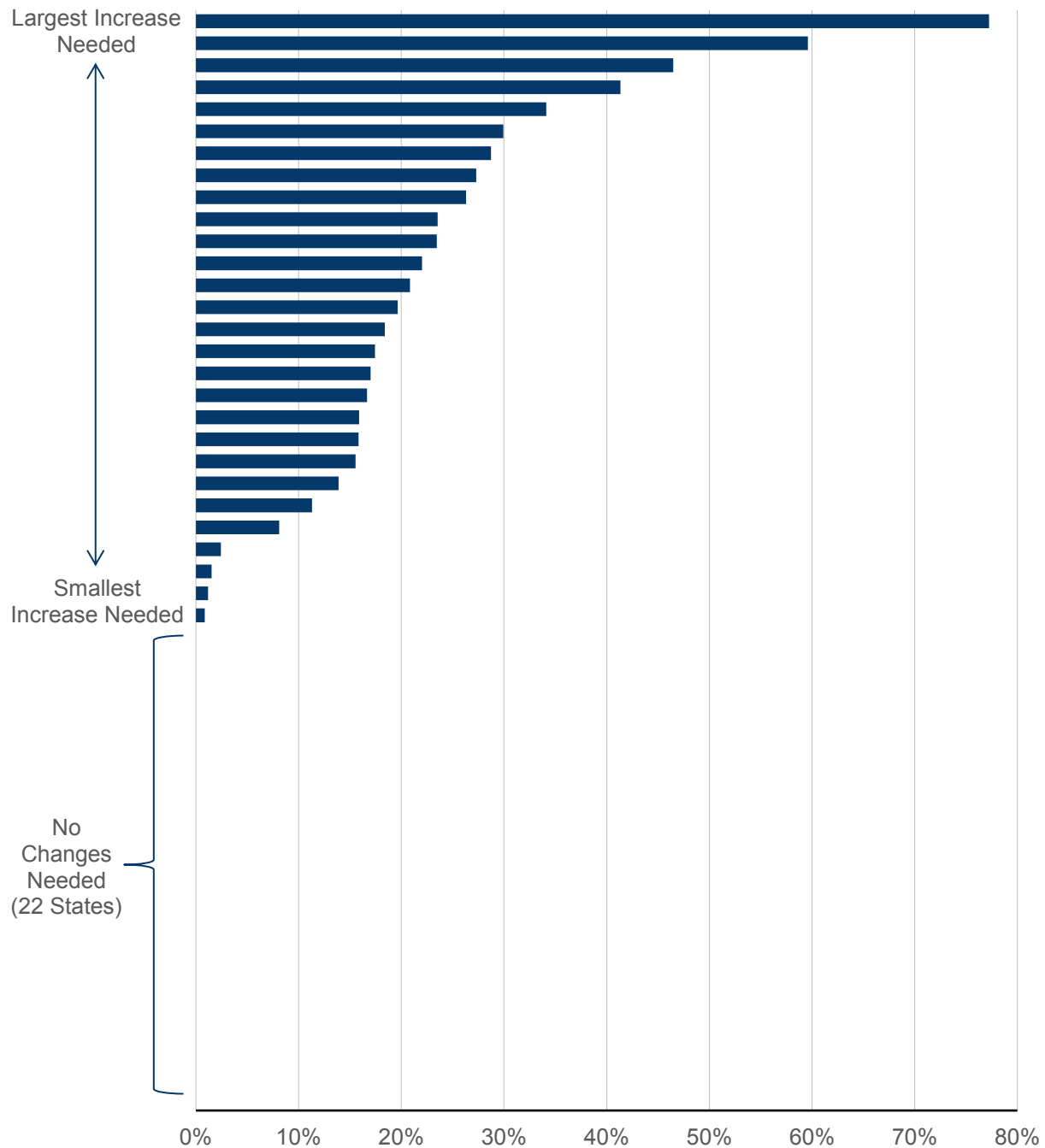
AGGREGATE AND STATE-BY-STATE RESULTS

We estimate that just over half of states would have exceeded the AHCA's cap in 2011, with total excess spending of \$30.1 billion, representing 8.5 percent of total Medicaid spending. This would have reduced federal funding for the affected states' Medicaid programs by \$17.8 billion, representing 11 percent of total state Medicaid spending.

As explained in the previous section, due to the "one-sided" nature of a per capita cap, no state would have received more federal funding under the per capita cap than it would have received under current law. Moreover, because state spending growth varies from year to year and the cap is applied on an annual basis, many of these states would have experienced a funding cut in at least one of the intervening years, although we are not able to identify which states due to a lack of data for the years between 2000 and 2011.

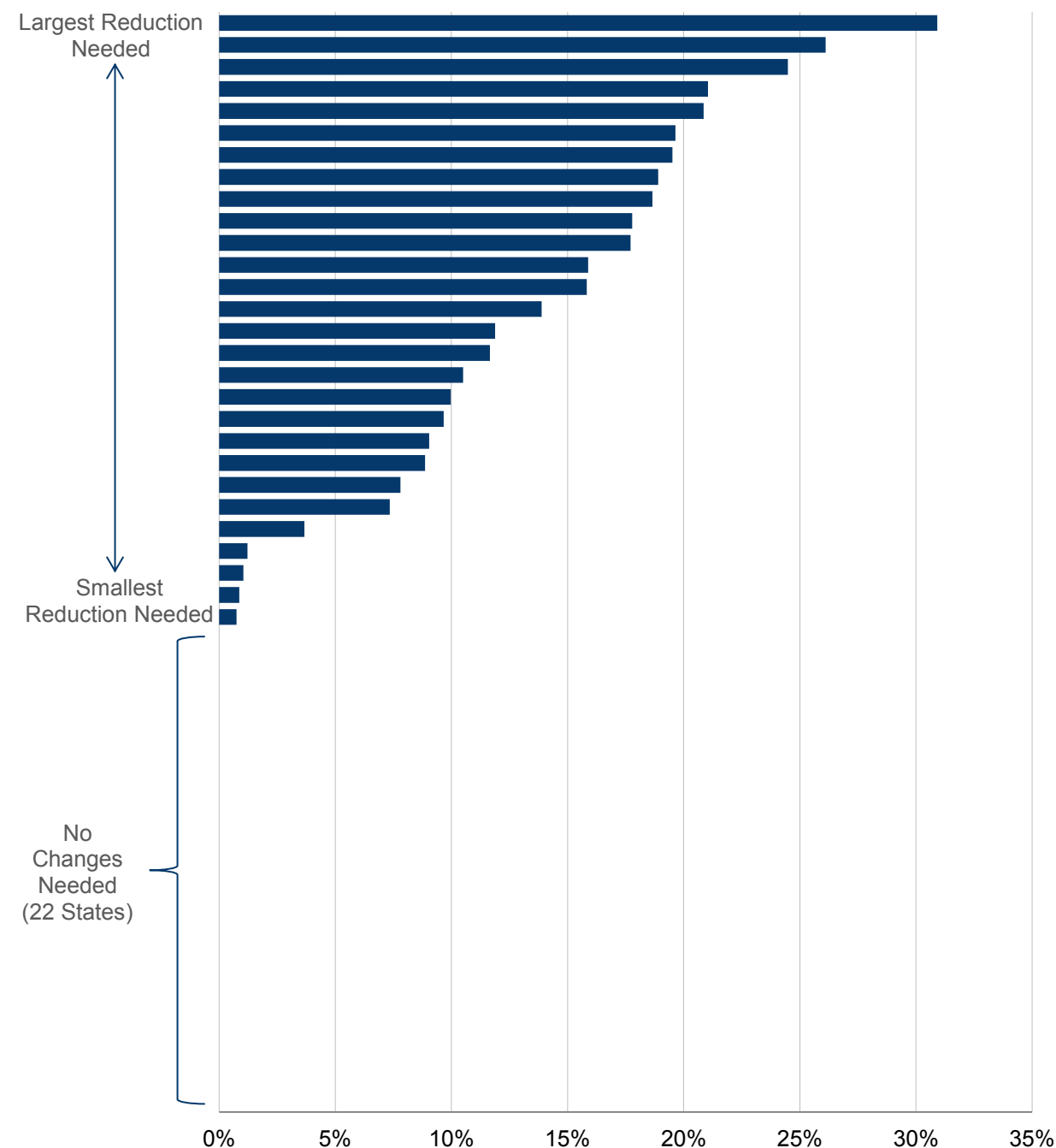
For states that would have faced a reduction in federal funding, the magnitude of that reduction varies significantly, due primarily to differences in spending trends across states during this period. The median state facing a reduction would have had to increase its spending on Medicaid by 19 percent in order to compensate for the loss in federal funding and thereby avoid making cuts to its program. At the high end, four states would each have needed to increase program spending by over 40 percent to replace the lost federal dollars, with one needing to increase its Medicaid spending by 77 percent.

Figure 3. Percent Increase in State Medicaid Funding Necessary to Continue Program Without Changes, 2011



Source: KFF/Urban Institute analysis of CMS data, Bureau of Labor Statistics, authors' calculations

Figure 4. Percent Reduction in Total Medicaid Spending Necessary to Stay Under Per Capita Cap, 2011



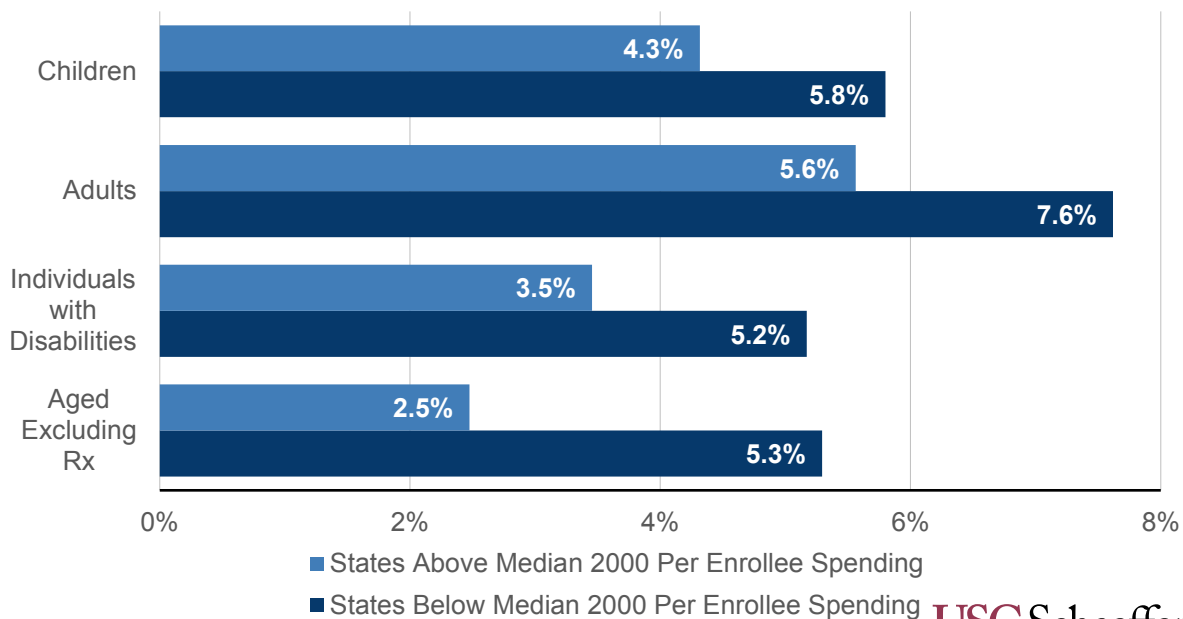
Source: KFF/Urban Institute analysis of CMS data, Bureau of Labor Statistics, authors' calculations

IMPACT WOULD HAVE BEEN SIGNIFICANTLY GREATER IN INITIALLY LOW-COST STATES

One notable feature of Medicaid spending trends over the 2000-2011 period is that state Medicaid spending per capita exhibited significant mean reversion, as the Kaiser Family Foundation observed in its original analysis of these data.¹⁸ That is, states starting the period with lower per enrollee Medicaid spending tended to see notably higher per enrollee spending growth from 2000 through 2011, while states beginning the period with higher per enrollee spending saw lower per enrollee spending growth over that period. As illustrated in Figure 5, per enrollee spending growth in initially low-spending states exceeded growth in initially high-spending states by a significant margin for each of the four beneficiary categories.

Figure 5. State Medicaid Spending Exhibited Mean Revision, 2000-2011

Per Enrollee Annual Spending Growth (2000-11) Relative to 2000 Per Enrollee Spending Levels



Note: Average per enrollee spending growth rates for each category are weighted by state spending for that enrollment group in 2000.

Source: KFF/Urban Institute analysis of CMS data, authors' calculations

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The fact that areas that started with low costs experienced faster growth in the subsequent years is likely not just an idiosyncratic feature of the 2000-2011 period we examine. While we are unaware of research that documents this pattern in Medicaid over other time periods, it is a common finding in research that compares health care spending trends across regions of the United States. For example, similar patterns have been documented in the past for per enrollee Medicare spending when looking across hospital referral regions and counties, as well as for overall per capita health care spending when looking across

¹⁸ Young, K., Rudowitz, R., Rouhani, S., and Garfield, R. Medicaid Per Enrollee Spending: Variation Across States. Kaiser Family Foundation. <http://kff.org/medicaid/issue-brief/medicaid-per-enrollee-spending-variation-across-states/>.

states.¹⁹ Indeed, if health care spending did not exhibit this form of mean reversion, the variation in per capita health care spending across states would grow without limit in the long run, which is implausible given that all states have access to the same set of medical technologies and are subject to the same national policies.

The fact that states that had relatively low Medicaid spending per enrollee in 2000 experienced faster growth in subsequent years implies that these states would have been more likely to exceed their caps had a per capita cap like the AHCA's been in effect. Conversely, states that started as high spenders in 2000 were likely to experience slower growth and, thus, would have been less likely to exceed their caps.

Indeed, as shown in Table 1, states with per capita Medicaid spending below the national median in 2000 account for nearly 90 percent of the overall reduction in federal funding that would have occurred under a per capita cap and include 18 of the 28 total states with reductions. These states would have experienced a total funding loss of more than \$15 billion or 19 percent of state Medicaid spending. By contrast, states that were above the national median in 2000 would have accounted for about 12 percent of the overall reduction, with a total funding loss of \$2.5 billion or about 3 percent of state Medicaid spending.

Table 1: Change in Federal Spending 2011 According to Starting Per Capita Cost

	Total Spending Above Cap	Spending Above Cap as % of Baseline	Federal Funding Reduction	% Increase in State Funding to Maintain Current Law Levels	# of States Experiencing Reductions
States Above Median 2000 per Enrollee Spending	\$4.2 billion	2.3%	\$2.5 billion	3.2%	10
States Below Median 2000 per Enrollee Spending	\$26.6 billion	14.4%	\$15.3 billion	19.3%	18

Source: Kaiser Family Foundation analysis of CMS data, Bureau of Labor Statistics, authors' calculations

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Concentrating spending reductions in states with low per enrollee spending is hard to justify. Whether one believes that overall Medicaid spending is too high or too low, there is no apparent rationale to targeting cuts in Medicaid spending to areas with lower spending at the start of the policy. In fact, there is reason to believe that this harm of reducing spending might be particularly large in low-spending states since the very fact that spending is low suggests these states are particularly unlikely to be suffering from diminishing returns or serious inefficiencies.

19 Chicklis, C., MaCurdy, T., Bhattacharya, J., Shafrin, J., Zaidi, S., & Rogers, D. (2015). Regional Growth in Medicare Spending, 1992–2010. *Health Services Research*. 50(5), 1574–1588. <http://onlinelibrary.wiley.com/doi/10.1111/1475-6773.12287/full><http://onlinelibrary.wiley.com/doi/10.1002/heh.1343/full>; Cubanski, J. & Neuman, T. (2015). The Latest on Geographic Variation in Medicare Spending: A Demographic Divide Persists But Variation Has Narrowed. Kaiser Family Foundation. <http://files.kff.org/attachment/report-the-latest-on-geographic-variation-in-medicare-spending-a-demographic-divide-persists-but-variation-has-narrowed>.

What if Medicaid Per Enrollee Spending Had Grown 1 Percentage Point Faster or Slower Over the 2000-2011 Period?

States with spending above the per capita cap are responsible for the full amount of additional Medicaid spending at the margin, so if underlying Medicaid costs are higher or lower than expected, the impact of a per capita cap will be higher or lower as well. This means that one important determinant of the effects of a per capita cap is whether the growth rate of the per capita spending targets (a combination of CPI-M and CPI-M plus one percentage point under the AHCA, as described previously) is faster or slower than the overall growth rate of per enrollee Medicaid spending.

In practice, medical inflation measures like the CPI-M will often differ markedly from trends in per enrollee Medicaid spending. Most importantly, the CPI-M captures trends in the unit prices of health care services, while growth in per enrollee Medicaid spending reflects trends in *both* the unit prices of health care services and per enrollee utilization.²⁰ Per enrollee utilization can change over time for many reasons, including demographic changes like the aging of the population, changes in health status stemming from developments like changes in health behaviors or disease outbreaks, changes in medical practice patterns, and the introduction of new technologies like new prescription drug therapies. Because utilization has generally risen over time, total spending growth will typically outpace medical inflation. In addition, because trends in utilization vary unpredictably over time, the extent to which spending trends will outpace medical inflation will also vary unpredictably.

This unpredictability translates into a significant risk that states could face larger or smaller cuts under a per capita cap than expected. To illustrate this uncertainty, the analysis in this section details how the effects of the AHCA's per capita cap would have changed if baseline Medicaid per enrollee spending had grown 1 percentage point faster or 1 percentage point slower annually from 2000-2011. The summary impacts of the AHCA's per capita cap proposal in these alternative scenarios are reported in Table 2 (on p. 14).

If Medicaid per enrollee spending had grown 1 percentage point faster annually over the 2000-2011 period, the AHCA's per capita cap would have reduced federal funding by nearly twice as much in 2011—\$34 billion—with 41 states seeing a cut. Among the states seeing a reduction, the median state would have needed to increase its own Medicaid spending by 25 percent in order to maintain their programs in their then-current forms. One state would have been required to roughly double its state spending to maintain its program, while nine state would have needed to increase state Medicaid spending by 40 percent or more.

²⁰ Trends in per capita Medicaid costs may differ from growth in the CPI-M for other reasons as well. For example, CPI-M is designed to capture trends in the prices for medical services purchased directly by consumers, which may differ from the prices for the services purchased by state Medicaid programs.

On the other hand, if Medicaid per enrollee spending had grown 1 percentage point slower annually over the 2000-2011 period, the AHCA's per capita cap would have reduced federal funding by slightly less than half as much—\$7.7 billion—with 18 states seeing a cut. Among states seeing a reduction, the median state would have need to increase its own Medicaid spending by about 12 percent to maintain their program in its then-current form.

Notably, the increase in the federal funding loss if spending growth is one percentage point faster than expected (\$16 billion) is larger in magnitude than the reduction in the federal funding loss if spending growth is one percentage point slower than expected (\$10 billion). The primary reason for this is the one-sided nature of the per capita cap. When spending grows more quickly than expected, the amount of “excess” spending increases by the full amount of the overall increase in spending for states already subject to the cap, and some states that were previously below the cap begin to exceed the cap. By contrast, when spending grows more slowly than expected, some states that were previously above the cap fall below the cap, so a smaller portion of the reduction in spending translates into a reduction in “excess” spending.

Table 2. Summary Impacts of AHCA Per Capita Cap Proposal Under Different Scenarios, 2011

	Base Scenario	1 Percentage Point Faster Annual Per Enrollee Medicaid Spending Growth	1 Percentage Point Slower Annual Per Enrollee Medicaid Spending Growth	Caps Grow With National Average Per Enrollee Category Spending
Total excess spending above cap	\$30.8 billion	\$58.5 billion	\$13.5 billion	\$26.7 billion
Excess spending as % of baseline Medicaid	8.5%	14.5%	4.1%	7.3%
Median excess spending % (among states seeing cuts)	12.9%	17.9%	9.3%	12.0%
Federal funding reduction	\$17.8 billion	\$33.9 billion	\$7.7 billion	\$15.3 billion
Federal funding reduction as % of state Medicaid spending	11.3%	19.5%	5.4%	9.8%
Median % increase in state funding to maintain current program levels (among states seeing cuts)	19.0%	25.4%	12.4%	17.8%
Number of states experiencing reduced funding	28	41	18	25

Source: Kaiser Family Foundation analysis of CMS data, Bureau of Labor Statistics, authors' calculations

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What if the Per Capita Targets Increased Annually with the Actual National Average Growth in Per Enrollee Spending?

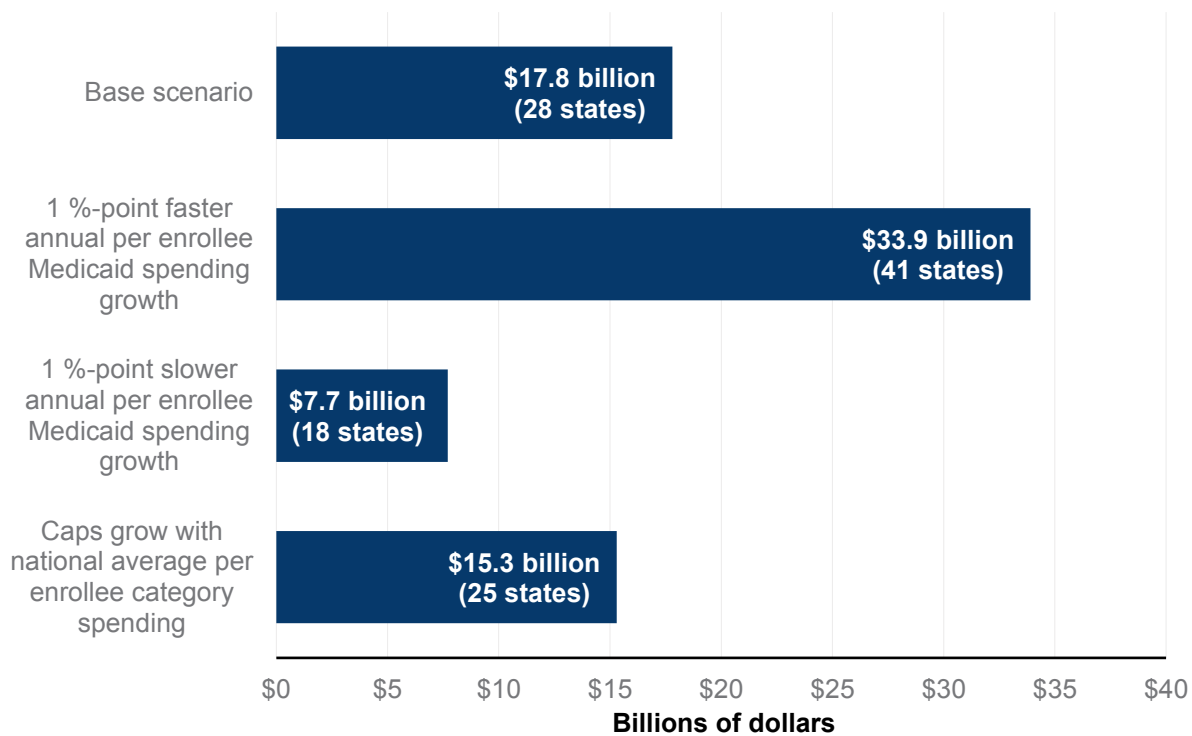
The prior section illustrates that unexpected differences between the growth rate of the per capita targets and the national average growth rate in per enrollee Medicaid spending can have a large impact on the effect of a per capita cap. One approach to mitigating that uncertainty would be to index the per capita targets based on actual health spending for Medicaid enrollees rather than a price index. It is important to note, however, that even a per capita cap that exactly matched underlying trends in program costs, on average, nationwide would still generate significant cuts in state Medicaid programs due to the substantial cross-state variation in spending growth.

To illustrate this fact, this section of the analysis examines the effects of a modified version of the AHCA's per capita cap. Under this modified proposal, the per capita spending target for each beneficiary category would grow at the baseline national average growth rate of per enrollee Medicaid spending for that beneficiary category rather than at the CPI-M-based growth rates actually prescribed under the AHCA.²¹

Table 2 reports how the modified per capita cap would have affected state Medicaid programs over the same 2000-2011 period examined in our base analysis. As shown in the table, the modified per capita cap would still have reduced federal funding in 2011 by \$15.3 billion, just 14 percent less than the \$17.8 billion in the base scenario. Likewise, 25 states would have seen funding reductions under this modified proposal, only 3 fewer than under the actual AHCA proposal.

²¹ While considering this modified version of the AHCA's per capita cap is a useful thought experiment, it would not be possible to implement this policy in practice. For the purposes of this exercise, we can directly measure the baseline national average growth rate of per enrollee Medicaid spending because the per capita cap was not actually in effect during the 2000-2011 time period. If the cap were actually in effect, some states would reduce their spending in order to remain below the cap, so the actually observed growth rate of Medicaid spending would be lower than the underlying baseline growth rate.

Figure 6: Comparing Medicaid Funding Reductions Under Alternative Scenarios, 2011



Source: KFF/Urban Institute analysis of CMS data, authors' calculations

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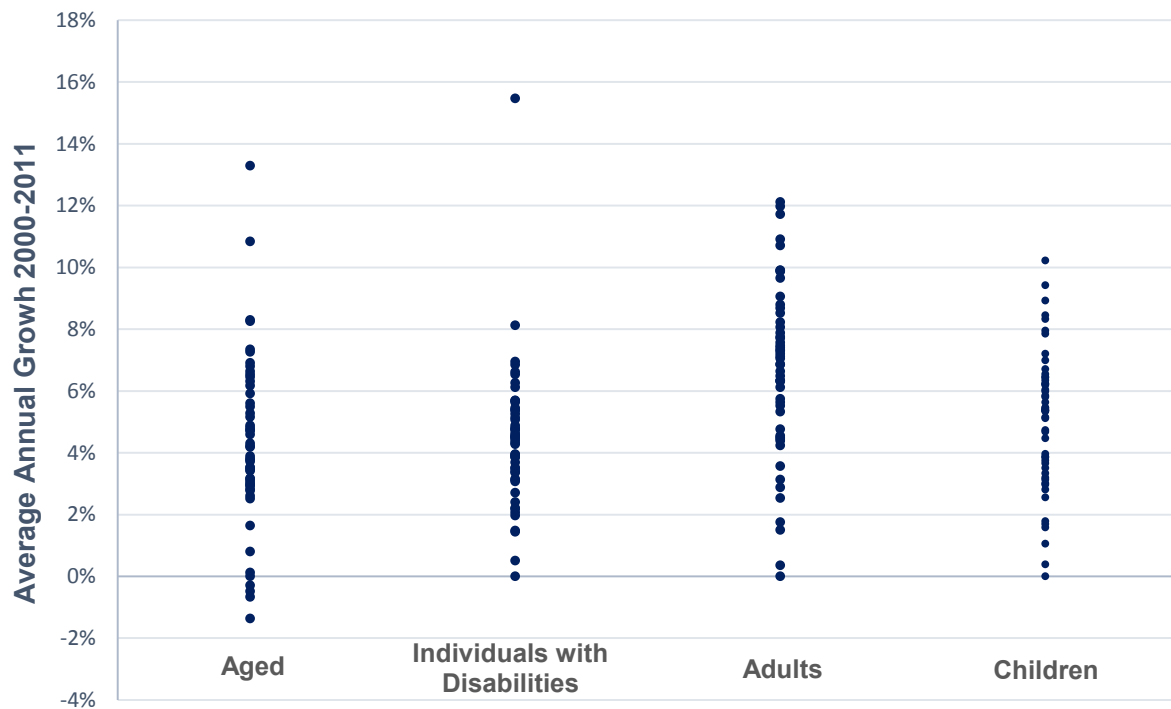
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There are two striking aspects of this result. The first is the relatively small impact that modifying the growth rate has on the total reduction in federal Medicaid funding under the per capita cap. This is because Medicaid per enrollee spending only modestly exceeded the target growth rates specified under the AHCA over the 2000-2011 period we examine in this analysis. Over this period, Medicaid spending per full-benefit enrollee among the aged, people with disabilities, other adults, and children grew at an average annual rate of 3.7 percent, 4.5 percent, 5.6 percent, and 5.3 percent, respectively, while CPI-M grew at an average annual rate of approximately 3.9 percent.²²

The second, more fundamental, finding is that even the modified per capita cap still generates large reductions in state Medicaid spending. The explanation for this potentially counterintuitive result lies in the interaction of two factors. The first is that per capita spending growth varies widely across states, as illustrated in Figure 7. Over the 2000-2011 period, the average annual growth rate of per capita Medicaid spending growth ranged from -1 percent to 13 percent for aged enrollees; 1 percent to 16 percent for people with disabilities; 0 percent to 14 percent for adults; and 0 percent to 12 percent for children.

²² Although faster than the CPI-M, per enrollee spending growth in Medicaid over this period was slower than either private coverage, in which growth averaged 6.9 percent per year, or Medicare, in which growth averaged 5.4 percent per year (excluding 2006 to avoid distortions from the creation of Medicare Part D). This relatively slow growth likely reflects, at least in part, the fact that Medicaid already operates under relatively tight state fiscal constraints.

Figure 7. Variation in Medicaid Spending Growth by State and Eligibility Category, 2000-2011



Source: KFF/Urban Institute Analysis of CMS data

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This second finding highlights the impacts of the “one-sided” nature of a per capita cap. Because states receive less funding if they exceed the cap, but do not receive additional funding if spending is below the cap, states with above average spending growth experience large reductions in federal funding in this scenario, while states with below average spending growth receive the same funding they would have received in the absence of the cap. The net result is that, even with this modification, a per capita cap generates significant reductions in federal Medicaid funding overall.

Conclusion

This paper analyzes how a per capita cap would have affected state Medicaid programs in 2011 if it had been implemented in 2004 based on spending in 2000. We demonstrate that a per capita cap like the AHCA's would have reduced Medicaid funding for more than half of states, while providing no states with additional funding. We also demonstrate that the one-sided structure of the cap and the tendency of state spending to move toward the national average over time would have generated large and difficult-to-justify cuts for states that begin the period with relatively lower spending. These patterns would be repeated in the future under a cap like the one included in the AHCA, although precisely what states are affected and to what extent would differ.

Our results also illustrate the consequences of the fact that states above the cap bear the entire burden of any secular acceleration in health care utilization, such as increases due to the introduction of new drugs or changes in population health. We show that a 1 percentage point per year increase in Medicaid spending growth would have nearly doubled the reduction in federal funding under the AHCA's per capita cap and the corresponding requirements for new state funding, while a similar reduction in spending growth would not have diminished the reduction in federal funding to a similar degree. The paper also demonstrates that a per capita cap would cause substantial reductions in Medicaid spending even if the per capita targets were linked to health care spending, rather than just health care prices, due to the significant variation in spending trends across states.