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ISSUE BRIEF

HOW PER-CAPITA SPENDING CAPS CAN HELP ADVANCE EQUITY IN MEDICAID

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Executive Summary

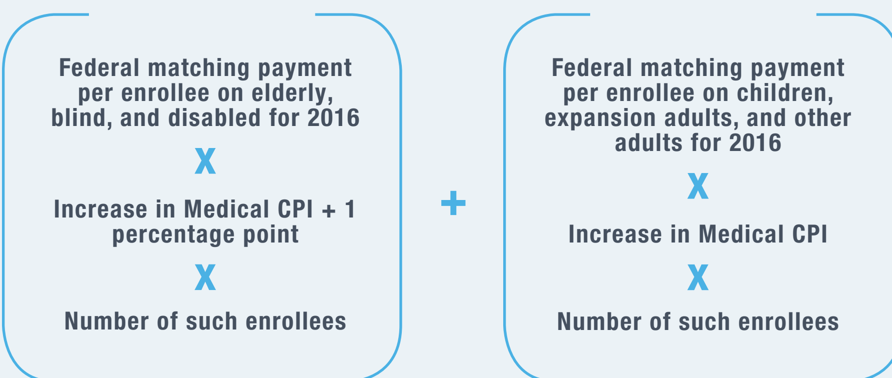
Medicaid was primarily intended to help the poorest states with the thinnest tax resources and the greatest unmet health-care needs. In practice, however, the federal government currently distributes funds to states according to how much they are themselves able to spend on the program. As a result, the wealthiest states with the deepest tax bases and lightest social-services burdens currently receive the largest subsidies. Those states use these additional funds less to increase the provision of medical care than to expand eligibility for long-term services and supports.

The Medicaid reforms in the American Health Care Act (AHCA), which the House passed on May 4, offer a way to correct a systematic bias favoring the wealthiest states. The means for doing so—per-capita federal spending caps—have been widely and variously denounced as draconian. They are not. The caps would increase well above the rate of per-enrollee Medicaid spending growth over the past 20 years. They are a very modest first step that does not alter the program's existing commitments. But they would constrain states from unilaterally expanding federally supported benefits. By doing so, they establish regular scrutiny and a conversation about priorities, purposes, and opportunity costs in the Medicaid program, so that its future growth is better focused on the nation's most pressing unmet health-care needs.

How Are Per-Capita Caps Calculated?

FIGURE 1.

AHCA Per-Capita Spending Formula



Source: American Health Care Act, H.R. 1628

The American Health Care Act proposed by the House of Representatives to replace the Affordable Care Act proposes to cap *increases* in annual federal Medicaid payments to states, based on categories of enrollees, with sicker and older (higher-risk) enrollees benefiting from a higher growth rate for federal funding support. Starting in 2020, federal Medicaid payments to each state would be capped at the following level:

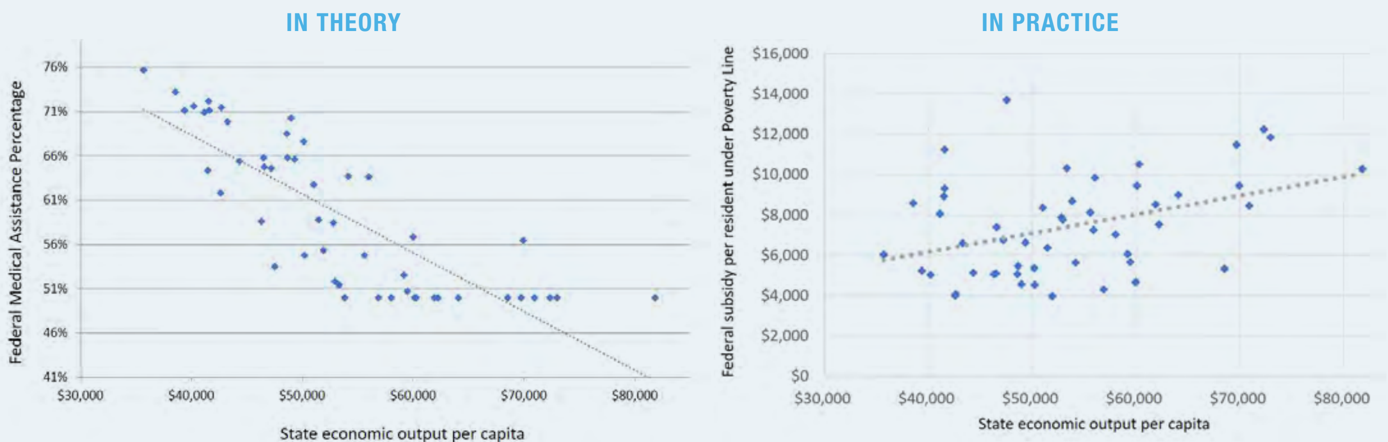
Subsidies for uncompensated hospital care under the Disproportionate Share Hospital program and the state health-care pools established by AHCA, as well as Medicaid payments for Medicare cost-sharing, would be exempt from these caps.

Moving Toward Fairness and Equal Subsidy

The inequity of allocating Medicaid resources through matching funds is systematic. For every dollar that states spend on Medicaid, the federal government spends one to three dollars, depending on the state's Federal Medical Assistance Percentage (FMAP). In theory, this is supposed to provide the most resources to poorer states—those with the largest percentage of low-income residents in need of assistance and the least ability to fund medical services out of their own tax revenues. In practice, the ability to claim federal matching funds depends on a state's own economic strength. The wealthier states are able to put up more money, and therefore, despite FMAPs, federal Medicaid spending actually worsens national economic inequalities **(Figure 2)**.

FIGURE 2.

Medicaid Matching-Fund Formula Tilts Spending Toward Wealthier States



Source: ASPE (HHS Assistant Secretary for Planning and Evaluation), "FY2017 Federal Medical Assistance Percentages," Jan. 4, 2016; U.S. Bureau of Economic Analysis, "Per Capita Real GDP by State," May 11, 2017; U.S. Census Bureau, American Fact Finder, "Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2015"; MACPAC (Medicaid and CHIP Payment and Access Commission), *MACSTATS: Medicaid and CHIP Data Book*, "Exhibit 17: Total Medicaid Benefit Spending by State and Category, FY 2015 (millions)," Dec. 2016

The distribution of Medicaid funds also reflects an extensive history of state attempts to inflate the payments they receive from the federal government through "Medicaid maximization" strategies. A popular version of this was for states to tax hospitals, and then to charge the federal government for the cost imposed—keeping the profits of this scheme, i.e., the tax revenues, for non-health-care purposes. Although the federal government eventually cracked down on that particular tactic, other similar ones soon emerged, and revenues generated from it were nonetheless grandfathered on a permanent basis.[1]

What Accounts for State Spending Disparities?

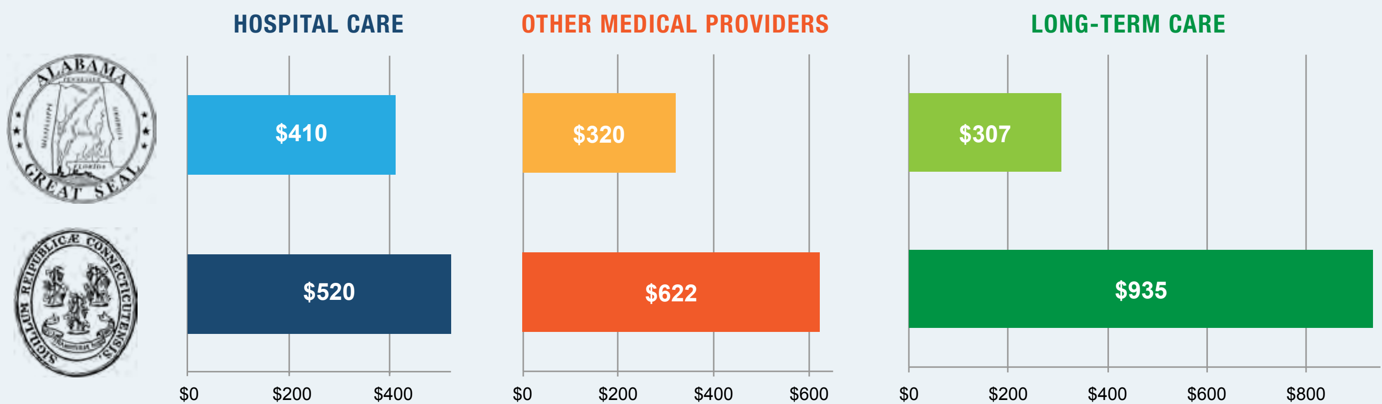
Medicaid spending can be hard to compare across states, as provider costs, beneficiary medical conditions, service definitions, and eligibility can all vary greatly. Furthermore, as most states delegate large portions of the administration of Medicaid to managed-care organizations, data on various services provided through them are generally amalgamated. Nonetheless, by examining Alabama and Connecticut (two states without costs pooled under the heading "managed care"), it is possible to compare the relative size of broad categories of expenditures from a low-spending Medicaid program with those in a high-spending program[2] **(Figure 3)**.

In Alabama, 17% of the state's population lived under the poverty level in 2015, compared with 9% in Connecticut.[3] In February 2017, 18% of Alabama residents were enrolled in Medicaid, compared with 21% in Connecticut.[4] Nonetheless, Alabama's Medicaid program received much less federal support ($786) per capita than Connecticut ($1,253).[5] This disparity was little altered by the Affordable Care Act's expansion of Medicaid to healthier able-bodied adults, as Alabama in 2009 received $563 and Connecticut $799 in per-capita support for the program from the federal government.[6]

Despite much broader eligibility requirements and a higher regional cost of living, Connecticut's Medicaid hospital spending per state resident is only a quarter more than that in Alabama. But its per-capita spending on other medical services (physicians, clinics, dentists, medical devices, and drugs) is almost double what Alabama spends, while its spending on long-term-care services is more than three times higher. Indeed, the disparity in per-capita long-term-care spending between the two states accounts for 60% of the total difference in per-capita Medicaid spending between the two states.

FIGURE 3.

Medicaid Spending Per Resident, 2015: Alabama vs. Connecticut



Source: MACSTATS, Exhibit 17; U.S. Census Bureau, Annual Estimates of the Resident Population

For elderly and disabled individuals, states are able to use Medicaid funds to provide long-term-care services that are not offered by Medicare. Medicaid initially covered only nursing-home care, but has gradually been expanded by states to make available nonmedical services to individuals able to remain in their own homes. These services include assistance for activities of daily living, such as bathing, housekeeping, shopping, meal preparation, and also support for activities such as dealing with bills and finances. These can be vital for those who are housebound, and there is an important role for Medicaid to support their provision to individuals who have no means of affording them. However, as the value of these support services is not limited to the disabled, the money that could be spent on them is potentially infinite. Moreover, states very greatly in the extent of eligibility that they allow for long-term services and supports under Medicaid, with coverage permitted of individuals with home equity up to $840,000.[7] The states taking greatest advantage of this opportunity, unsurprisingly, have been the wealthiest.

The AHCA’s “Deep Cuts to Medicaid” Are a Myth

Politicians, interest groups, and lobbyists have launched a variety of epithets[8] at the AHCA’s per-capita caps, ranging from “unsustainable”[9] and “damaging”[10] to saying that they are the “real death panels”[11] and that “people will die.”[12] However, a look at what has been proposed—Medical CPI + 1% (for the elderly, blind, and disabled) and Medical CPI (for children and able-bodied adults)—suggests something quite different **(Figure 4)**.

FIGURE 4.

AHCA Proposed Per-Capita Medicaid Spending Exceeds Historical Trends in Medicaid Spending

Source: U.S. Bureau of Labor Statistics, “Medical Care in U.S. City Average, All Urban Consumers, Not Seasonally Adjusted,” June 19, 2017; MACSTATS, “Exhibit 10: Medicaid Enrollment and Total Spending Levels and Annual Growth, FYs 1966–2015”

Over the past two decades, the nationwide growth of per-enrollee Medicaid spending in any particular year has rarely breached the caps proposed. In fact, if multiple consecutive years are considered together, spending growth falls well short of proposed per-capita caps.

The historical periods in which the growth of per-enrollee Medicaid spending has exceeded the Medical CPI are easily recognized. These include the early years of the program (in which services were still being made available for the first time in many states); the George H. W. Bush years (when the Democratic-controlled Congress led a charge to expand benefits; and states imposed taxes on providers to inflate the reimbursements that they could claim from the federal government); and the late 1990s (when President Clinton pushed through an increase in program spending). Other than initially, aggregate national payments to states significantly exceeded the proposed caps only when there were changes in federal legislation.

The Brookings Institution recently caused some alarm with research suggesting that "implementing a Medicaid per-capita cap during the 2000s would have reduced federal Medicaid funding to more than half of states."[13] The study further suggested that one state would be forced to increase its own spending on the program by 77% to fill the funding shortfall. However, the way the statistic is framed exaggerates its significance. If the unnamed state in question had an FMAP rate of 75%, it would have needed only to cut spending on the program by 19% to balance its books. This is less than the nationwide average increase in Medicaid spending for 2011—the final year of the Brookings analysis (**Figure 5**).

FIGURE 5.

Recent Growth in Medicaid Spending

	2009	2010	2011	2012
Change in federal payments	22%	8%	**-7%**	-2%
Change in state spending	-10%	3%	**22%**	12%

Source: MACSTATS, Exhibit 10

Brookings' analysis was undertaken for the period 2000–2011 and owes much to the peculiarities of policy change under that period. In 2011, federal stimulus funds provided to Medicaid through the 2009 American Recovery and Reinvestment Act (ARRA) expired.[14] As a result, states were required to suddenly increase their Medicaid spending to compensate, because of that legislation's Maintenance of Effort requirements.[15]

These figures therefore do more to demonstrate the upward ratchet effect on spending induced by the ARRA and its longer-term consequences for state budgets than they do to illustrate the counterfactual of a Medicaid program subject to per-capita caps—which were obviously not part of legislative considerations when those spending commitments were made.

Assuming no further addition to existing spending commitments, the Congressional Budget Office predicts that net outlays for federal health-care programs are currently expected to increase from 5.5% of GDP in 2016 to 8.9% in 2046.[16] On top of this, it would cost an additional $228 billion per year (1.2% of 2016 GDP) to bring every state up (despite savings from bringing Vermont down) to Connecticut's level of Medicaid spending per individual below the poverty level—a change that by itself would cost more than the total that the federal government currently spends on transport and education put together.

Here is the bottom line: from 1999 to 2015, Medicaid per-enrollee spending increased at an average of 2.0% per year. The proposed per-capita caps would have increased at 4.7% (CPI-M+1) for the aged and disabled over that period, and 3.7% (CPI-M) for able-bodied adults and children. For 2016–27, CBO predicts that per-enrollee spending with no changes would increase by an average of 5.4% for the aged and disabled and by 6.1% for children and able-bodied adults.

If CBO's projections of Medicaid's spending growth path are broadly correct, aggregate program expenditures are about to surge and urgently need addressing.[17] If CBO has overestimated the growth of Medicaid costs, then the per-capita caps proposed will impose little constraint on states. If CMS (Centers for Medicare & Medicaid Services) baseline projections are correct, per-capita caps would be responsible for only 0.4% of the Medicaid cuts in the AHCA.[18]

"Shifting Risk to the States"

A number of policy shops, including the Center for Budget and Policy Priorities, have suggested that block grants and per-capita caps are instruments by which Republicans seek to "shift risk to states."[19] Yet both proposals are specifically designed to allow states to better bear risks that are beyond their control.

The existing system of matching funds bears little relation to risk. During economic downturns, Medicaid caseloads increase and their aggregate expenses spike, but federal terms of assistance to states remain the same. Governors and state legislatures are therefore able to expand Medicaid benefits and eligibility rules when economic times are good, leaving their successors in a tight spot when the business cycle turns.

Per-capita caps provide a built-in protection against this risk. During recessions, unemployment rises and substantially increases the number of Medicaid enrollees. But these individuals, who would be working but for the business cycle, are disproportionately healthy relative to comparable long-term Medicaid enrollees. Their enrollment into Medicaid reduces the average cost per enrollee, while per-enrollee caps would continue to increase along the normal growth path. This situation means that per-capita caps would likely ease during recessions while temporarily facilitating additional spending on other beneficiaries. Conversely, in times of plenty, per-capita caps constrain politicians from adding benefits that their states won't be able to afford in the long term, and would give Congress a better chance to deliberate the merits of any new commitments.[20]

While the business cycle is, if anything, an argument *for* reforming federal financing of Medicaid in the direction of capitated allocations, a sudden spike in the cost of caring for individuals could leave states short of funds.

The recent experiences of treating cases of the Zika virus or making the Hepatitis C drug Sovaldi available have placed genuine strain on state budgets. Yet this also serves as a demonstration of the inadequacy and inequity of Medicaid's current matching-fund setup. The proportion of Medicaid beneficiaries with Hepatitis C receiving prescriptions for Sovaldi in the first quarter of 2014 ranged from 0.8% in West Virginia to 39% in Hawaii.[21] Beneficiaries in poorer states would therefore likely fare better without the misguided assumption that Medicaid's matching-fund setup takes good care of them.

Sudden spikes in medical needs therefore deserve an open debate in Congress and discrete appropriations, rather than reliance on a matching fund system set on autopilot.

Per-Capita Caps in Theory and Practice

The Medicaid reforms proposed in the AHCA are a step in the right direction but could be improved. Basing per-capita caps on existing spending levels in each state may prevent disparities between high- and low-spending states from getting worse, but it may lock in an advantage for states with more fat in the system. Caps would do a better job of assuring a fair and efficient distribution of spending if states with Medicaid spending below the national average were allowed a relatively faster rate of growth and if those above had their caps increased at a relatively slower rate.

More significantly, the definition of "per capita" as "per enrollee" in the House bill is problematic. Enrollment is the main cost driver of Medicaid over recent years, and unnecessarily broad enrollment is the most easily fixable part of the Medicaid long-term-care spending boom that looms as baby boomers retire in vast numbers. So it makes no sense for this to be initially exempt from caps.

Also, it would be more prudent to employ a definition of "per capita" that states cannot directly manipulate by adding healthy enrollees to inflate their caps while making it hard for them to access services. A metric such as "per resident under the poverty level," "per aged Medicare enrollee," or "per SSI-eligible resident" would serve this purpose and may even better gauge a state's low-income health-care needs. As with the "per enrollee" metric, these targets should similarly loosen automatically during recessions.

Per-capita caps do not alter Congress's right to change its mind in the future, or its ability to revise the caps in the budget every year or prevent further expansions of benefits or eligibility by future Congresses. For all the fearmongering of "deep cuts," per-capita caps are an inherently modest instrument, whose purpose is largely limited to giving federal taxpayers a say over unilateral attempts by states to expand benefits greatly beyond Medicaid's current spending path. The prospect that they offer is one of establishing regular scrutiny and a conversation about priorities, purposes, and opportunity costs in the Medicaid program.

Endnotes

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4 Kaiser Family Foundation, "Total Monthly Medicaid and CHIP Enrollment," Mar. 2017.

5 MACSTATS, Exhibit 16.

6 Laura Snyder et al., "Why Does Medicaid Spending Vary Across States: A Chartbook of Factors Driving State Spending," Kaiser Family Foundation Issue Paper no. 8378 (Nov. 1, 2012).

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19 Edwin Park, "Medicaid Per Capita Cap Would Shift Costs and Risks to States and Harm Millions of Beneficiaries," Center on Budget and Policy Priorities, Feb. 27, 2017. The AHCA includes block grants for Medicaid, but as an option via a waiver.

20 Medicaid contains a core set of mandatory benefits, which states are required to provide to eligible individuals, as well as a loosely defined array of additional optional services for which they are able to claim federal funding.

21 Joshua A. Liao and Michael A. Fischer, "Early Patterns of Sofosbuvir Utilization by State Medicaid Programs," letter to the editor, *New England Journal of Medicine* 373 (Sept. 24, 2015): 1279–81.

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