# Medicaid Per Capita Caps and Addressing Medicaid's Biggest Cost Driver

MAY 25
2017

Jonathan Ingram
*Vice President of Research*


TheFGA.org

The vast majority of Medicaid spending increases over the past few decades has been the result of skyrocketing enrollment. Capping spending growth per enrollee will improve the sustainability of the program from a federal perspective, but the impact may be small and will not address the underlying cause of spending growth. In order to protect resources for the most vulnerable, states will need new tools to help manage enrollment. The American Health Care Act lays the groundwork for this new flexibility, giving states the option to create work requirements for able-bodied adults on Medicaid for the first time ever. The Senate should build upon this new flexibility and provide states with additional tools to ensure the program can become sustainable over the long run.

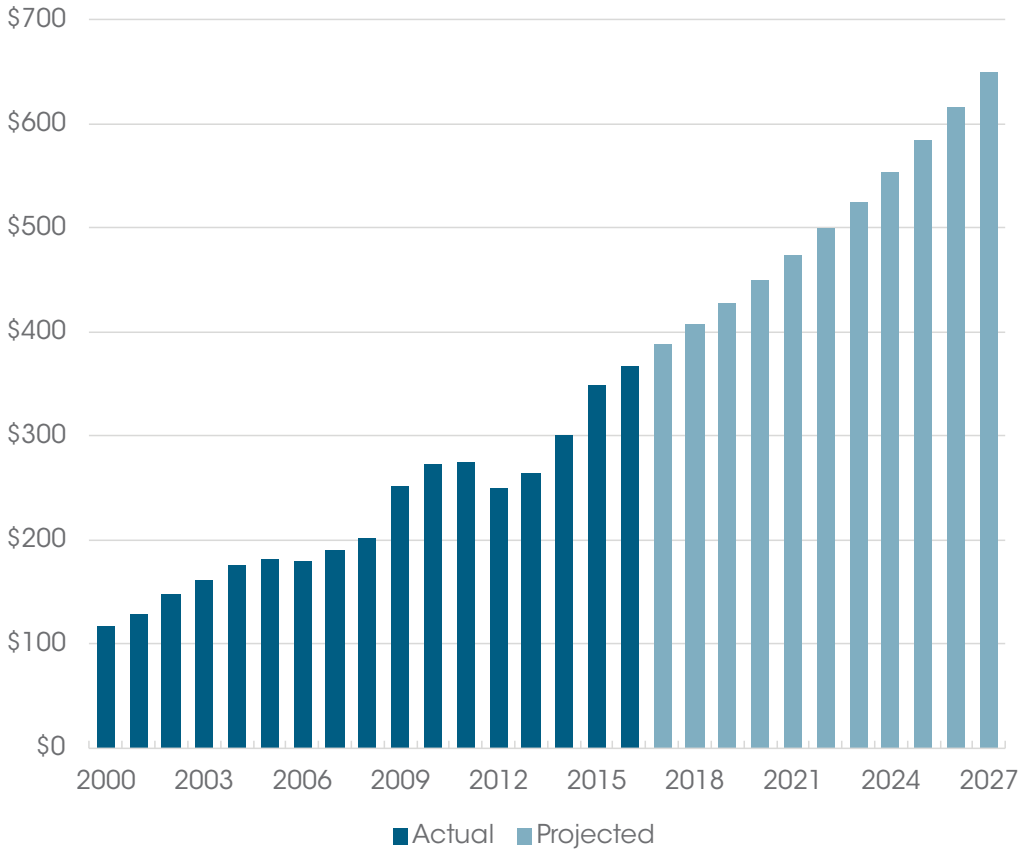
Congress should provide states with at least four additional reforms to give states the flexibility needed to protect limited resources for the truly needy:

1. Allow states to make eligibility and benefit changes prospectively, grandfathering existing enrollees
2. Allow states to check assets for most enrollees
3. Allow states to verify eligibility more frequently
4. Allow states to lower the home equity exemption

## Medicaid spending is spiraling out of control

Medicaid is one of the largest and fastest-growing line items in the federal budget. Federal spending on Medicaid grew to $367 billion in 2016, more than triple the $118 billion spent in 2000.[1] The Congressional Budget Office expects federal Medicaid spending to nearly double (again) during the next decade, reaching $650 billion per year by 2027.[2]

### Medicaid spending has tripled since 2000 and is expected to nearly double again by 2027




These skyrocketing costs are already crowding out resources for other core priorities, including education, public safety, infrastructure, and national defense. In 2000, Medicaid spending consumed less than 6 percent of federal revenues.[3] That share has already jumped to 11 percent and is only expected to climb higher over the coming years.[4-5]

## Proposals to cap Medicaid spending growth

In order to rein in this massive spending growth, Congress has proposed shifting Medicaid from an open-ended funding stream for states to an allotment that is more stable or predictable. The version of the American Health Care Act that passed the U.S. House of Representatives seeks to achieve this by capping the average spending per enrollee in various eligibility categories and letting those caps grow only at specified levels moving forward. States that allow Medicaid spending to grow faster than those levels will be responsible for the difference.

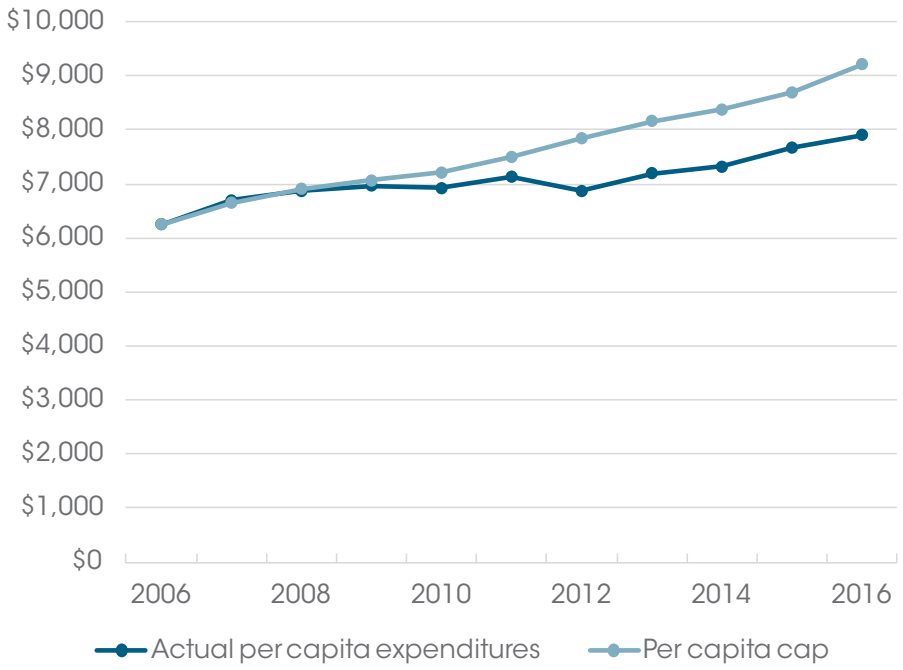
In the American Health Care Act (AHCA), per capita spending caps for children and non-disabled adults on Medicaid will grow at the rate of medical inflation, while per capita spending caps for seniors and individuals with disabilities will grow at the rate of medical inflation plus one percentage point.

The hope is that these growth rates are lower than the rates Medicaid spending would otherwise increase, providing not only budget certainty, but also making the program more sustainable over the long run.

## Per capita caps would have had little effect during the last decade

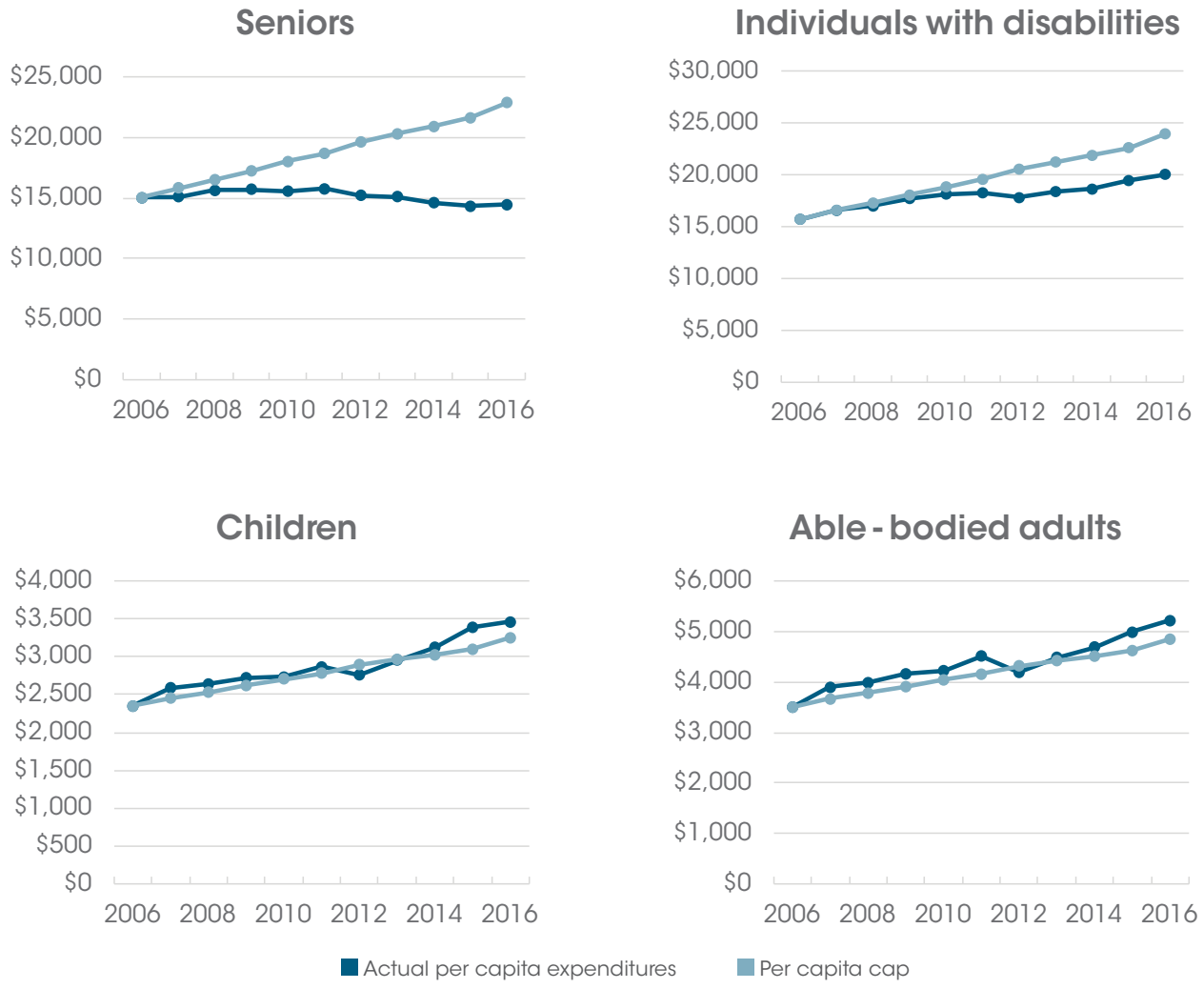
If the caps as currently structured were implemented a decade ago, they would have had little impact on total Medicaid spending. Between 2006 and 2016, per capita Medicaid spending grew by an average of 2.4 percent per year nationally.[6] But per capita caps as structured under the AHCA would have grown by an average of 4.0 percent per year during that same time.[7]

### Per capita caps would have grown faster than Medicaid spending during the last decade




During this period, per capita spending on children increased by an average of 3.9 percent per year, while per capita spending on non-disabled adults grew by an average of 4.1 percent per year.[8] Under the structure set forth in the AHCA, the per capita caps for these groups would have grown by just 3.3 percent during this time.[9] In these cases, actual per capita Medicaid spending slightly outpaced the target growth rate.

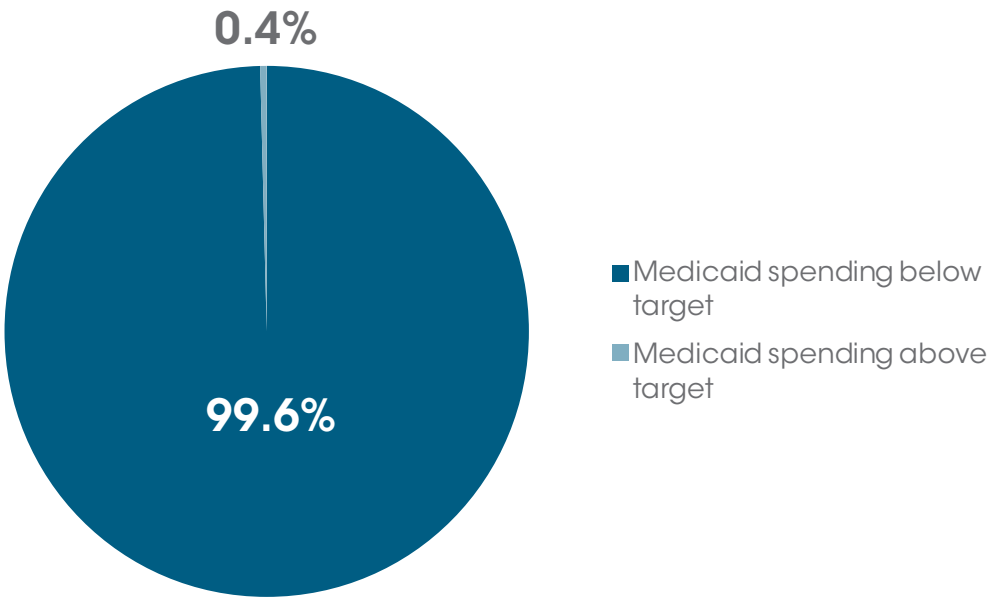
However, this was more than offset by the growth of spending among seniors and individuals with disabilities. **During this period, per capita spending on seniors actually declined by an average of 0.4 percent per year, while per capita spending on individuals with disabilities grew by only 2.5 percent.**[10] Under the structure set forth in the AHCA, the per capita caps for these groups would have grown by 4.3 percent during this time.[11]




## Few states would have been impacted by per capita caps

Although the caps would have had no impact on Medicaid spending if pegged at the national average, some states may have experienced faster growth than average. An analysis of state-level data from 2005 through 2011 – the most recent year available – shows that the impact would have remained relatively small. **During this timeframe, only six to seven states would have been impacted in any given year.**[12] During this period, savings from the states that exceed the cap would have averaged no more than $1 billion per year.[13] Altogether, just 0.4 percent of Medicaid spending would have been above the per capita targets in states that went over the caps.

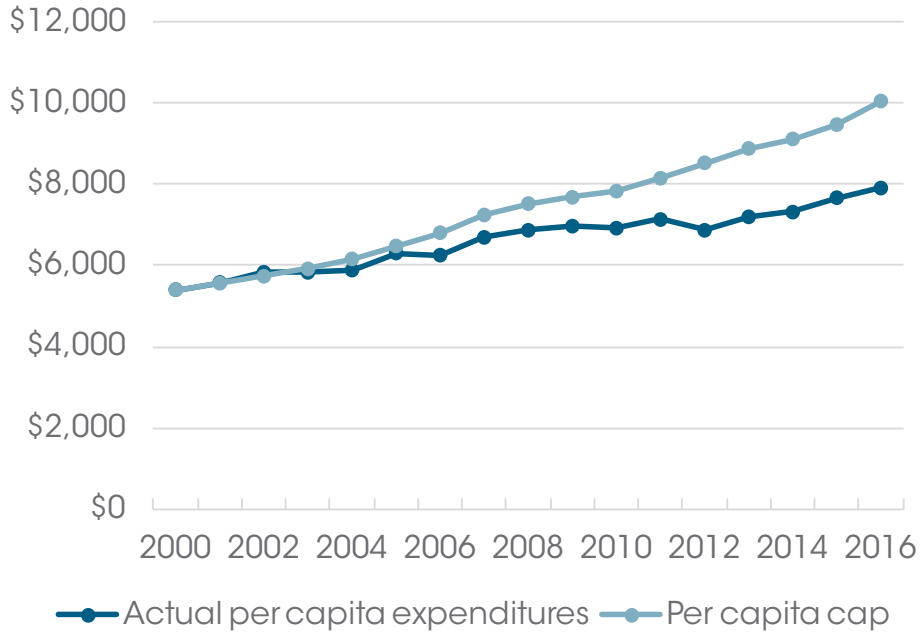
### Virtually all Medicaid spending would have been below AHCA targets in 2005-2011




## Per capita caps would have had little effect since 2000

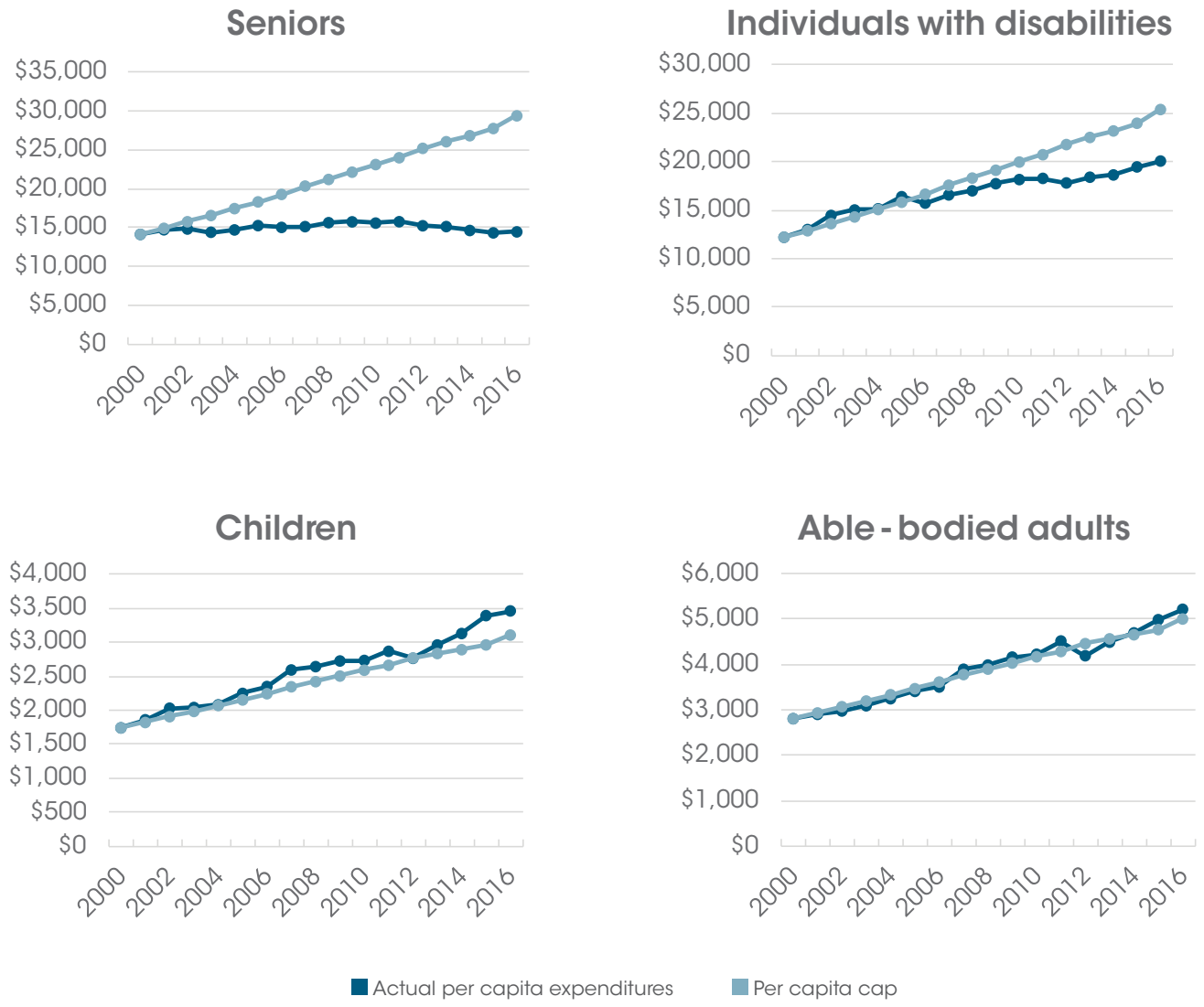
The results would have been similar if the caps had been implemented even earlier. If the caps had been implemented in 2000, for example, spending targets would have grown by an average of 4.0 percent annually.[14] But per capita Medicaid spending grew at only 2.4 percent annually during that same timeframe.[15]

### Per capita targets have grown faster than Medicaid spending since 2000



As with the period during the last decade, per capita spending on children and non-disabled adults rose slightly faster than allowed under the structure of per capita caps found in the AHCA. However, this faster growth was more than offset by lower growth among seniors and individuals with disabilities. Per capita spending on children grew by an average of 4.4 percent annually, while per capita spending on non-disabled adults grew by an average of 4.0 percent.[16] The target growth rate under the structure outlined in the AHCA would have been 3.7 percent annually for these groups.[17]

However, per capita spending on seniors grew by only 0.1 percent annually over this time, while per capita spending on individuals with disabilities grew by 3.2 percent per year.[18] The target growth rate for these groups would have been 4.7 percent annually.[19] Altogether, per capita spending growth would have remained under the targets as structured in the AHCA.

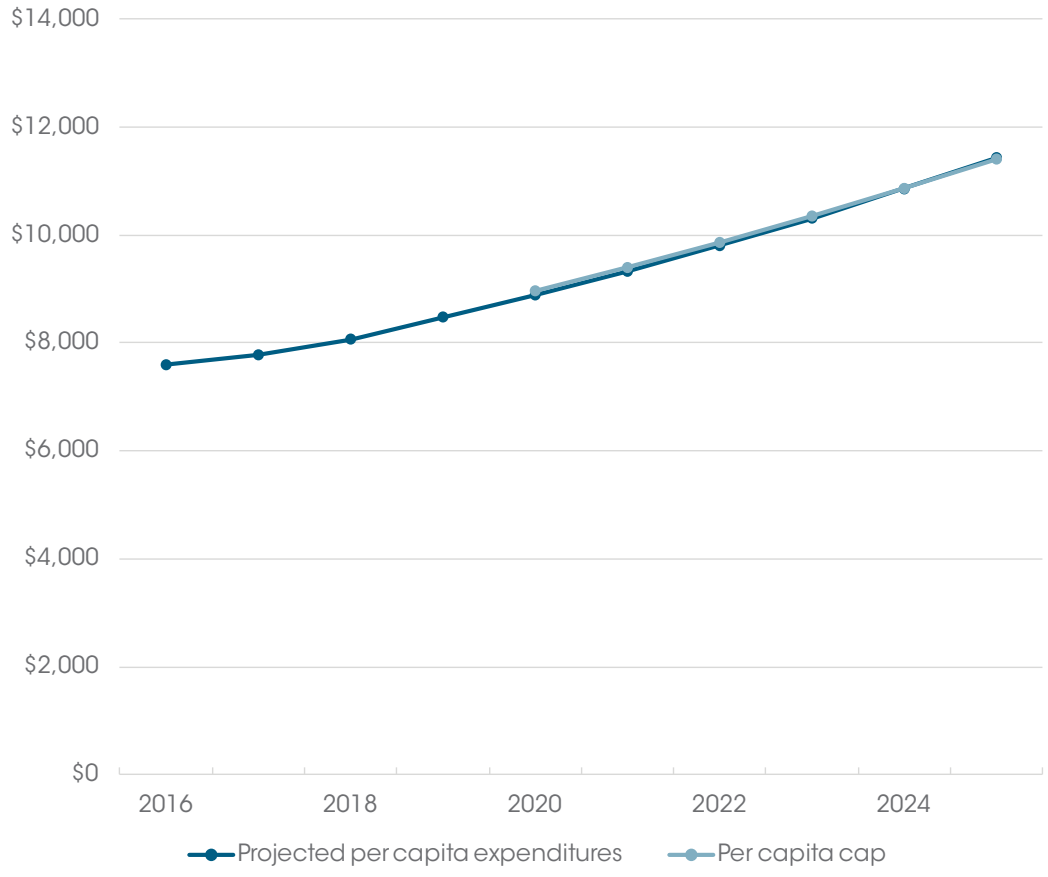


## Per capita caps will have little effect moving forward

The Congressional Budget Office projects that over the next decade, per capita Medicaid spending will grow by an average of 4.4 percent annually, while medical inflation will grow by only 3.7 percent.[20-21] However, because seniors and individuals with disabilities have higher target growth rates under the AHCA, the per capita caps will likely grow by an average of 4.4 percent per year, based on the Congressional Budget Office's data.[22]

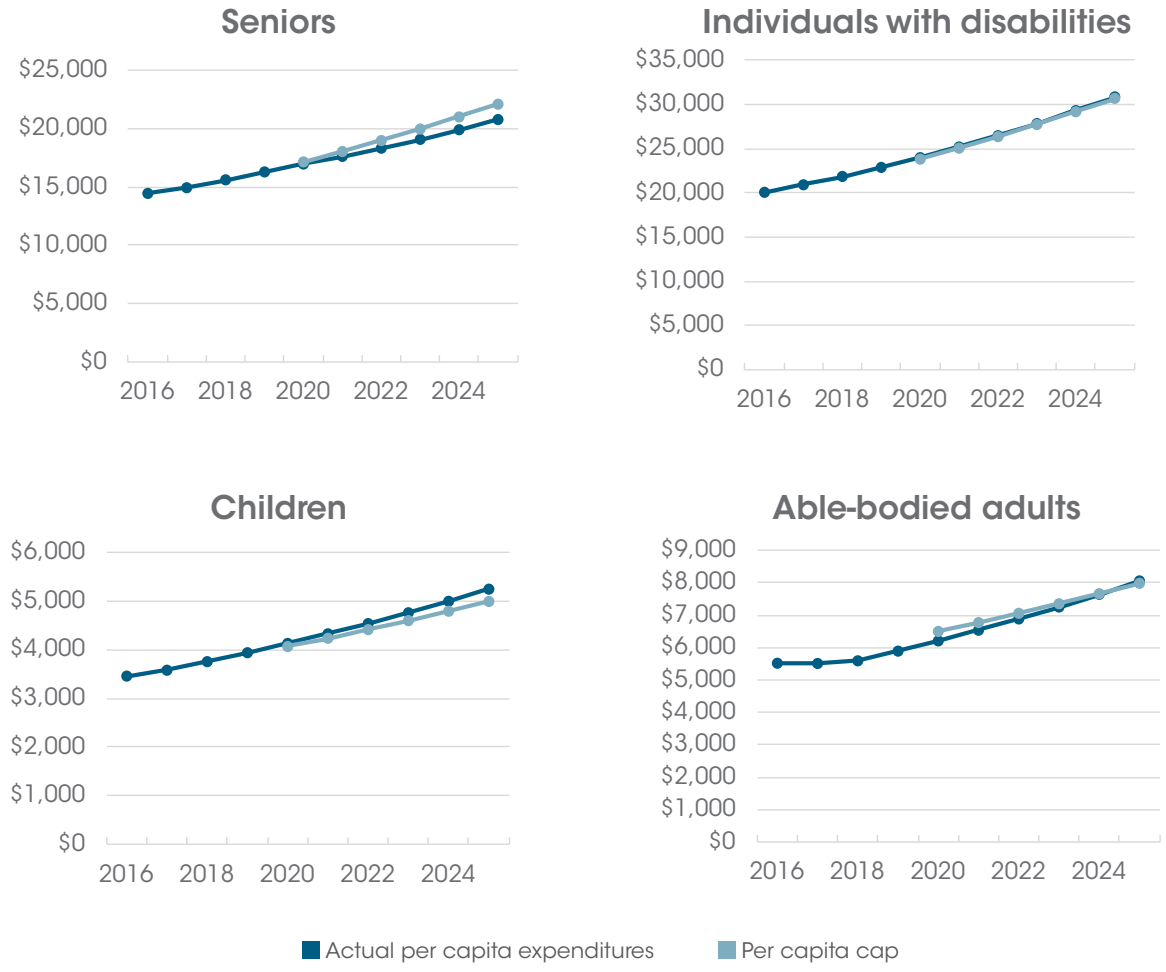
The Office of the Actuary at the Centers for Medicare and Medicaid Services predicts similar rates of growth. Per capita Medicaid spending is projected to grow by an average of 4.3 percent annually, while medical inflation is expected to rise by 4.0 percent per year.[23] Based on this data, the per capita caps under the AHCA are expected to grow by an average of 4.3 percent.[24] Per capita Medicaid spending would remain under those caps until fiscal year 2025.[25] In 2025, approximately 0.2 percent of Medicaid spending would be above the cap.[26]

### AHCA spending caps will have a small effect on Medicaid spending




Per capita spending on children and non-disabled adults is expect to rise slightly faster than allowed under the structure of per capita caps found in the AHCA. However, this faster growth is mostly offset by lower growth among seniors and individuals with disabilities. Per capita spending on children is projected to grow by 4.9 percent annually between 2019 and 2025, after the caps are implement, while per capita spending on non-disabled adults is expected to grow by 5.4 percent.[27] The target growth rate for these groups is expected to be 4.2 percent annually.[28]

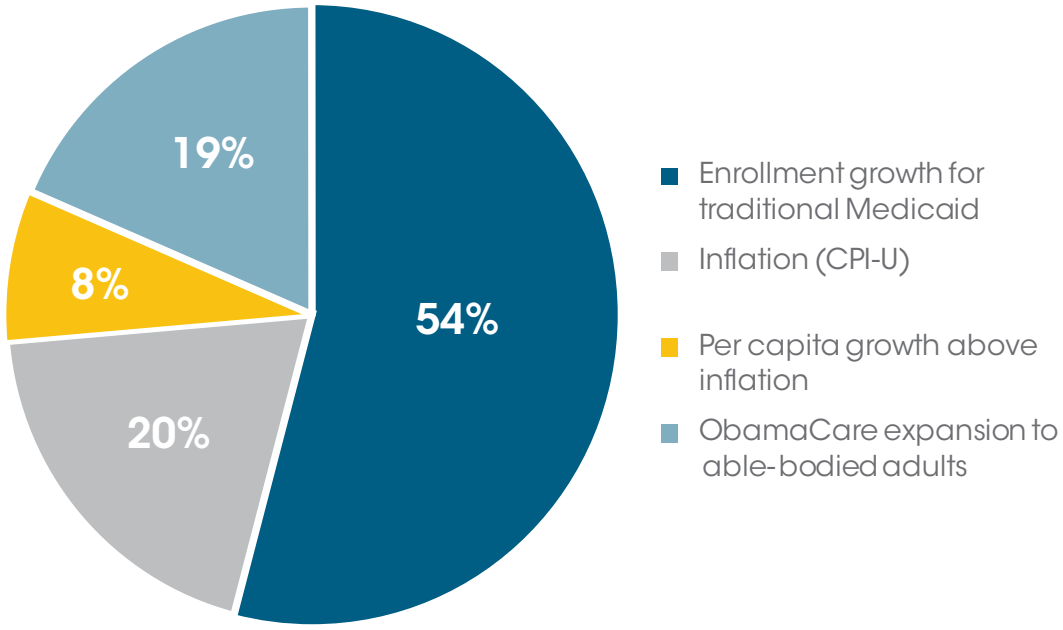
However, per capita spending on seniors is projected to grow by 4.1 percent annually over this time, while per capita spending on individuals with disabilities is expected to rise by 5.1 percent per year.[29] The target growth rate for these groups is projected to be 5.2 percent annually.[30]




## The real drivers of skyrocketing Medicaid spending

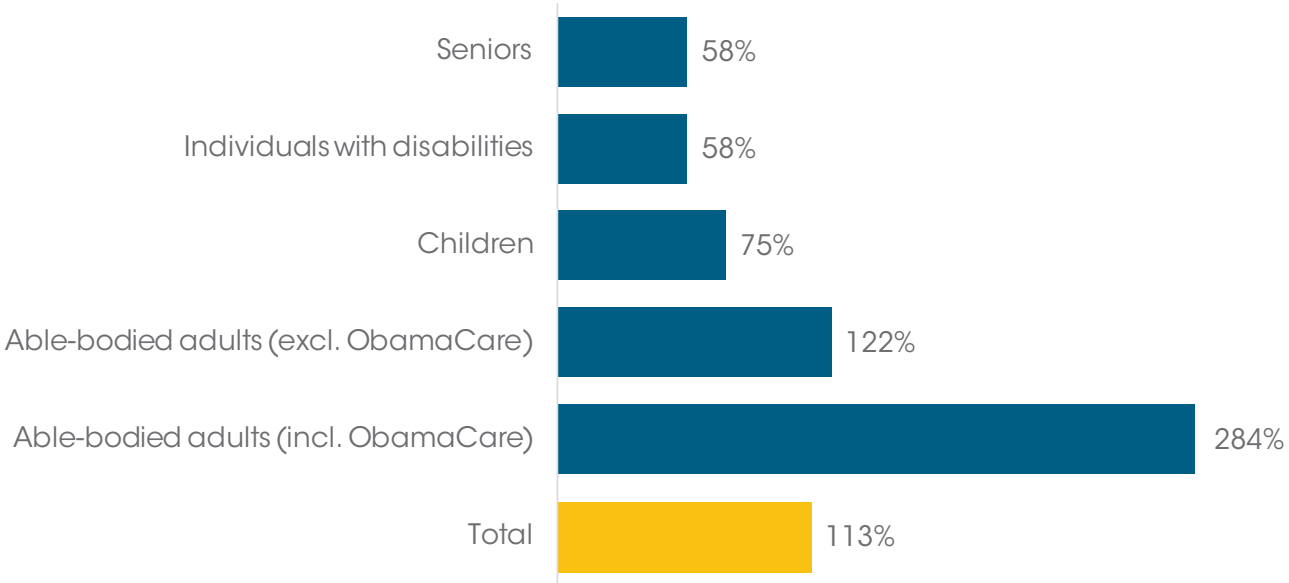
If per capita caps would have little effect on overall Medicaid spending, why are Medicaid costs growing so quickly? **Nearly three-quarters of this spending growth is the result of enrollment – in both traditional Medicaid as well as ObamaCare's expansion to able-bodied adults. More than 54 percent of the growth in Medicaid spending is the result of skyrocketing enrollment among non-expansion eligibility groups.**[31] Nearly 19 percent of the growth is from enrollment in ObamaCare expansion.[32] Nearly 20 percent of the growth is the result of overall inflation, while just 8 percent is the result of per capita spending growing faster than the consumer price index for all products.[33]

## Enrollment growth is driving skyrocketing Medicaid spending




Every eligibility category has experienced massive enrollment growth, with the biggest growth among able-bodied adults.[34] The number of able-bodied adults on Medicaid has grown by 284 percent since 2000.[35] Skyrocketing enrollment among able-bodied adults – including ObamaCare's Medicaid expansion – is driving nearly a third of the total cost growth in the Medicaid program.[36]

## Medicaid enrollment is growing among every eligibility group



## States need more flexibility to control costs

In order to protect resources for the most vulnerable, states will need new tools to help manage skyrocketing enrollment – the number one driver of Medicaid cost growth. **The AHCA, as passed by the U.S. House of Representatives, lays the groundwork for this new flexibility, giving states the option to create work requirements for able-bodied adults on Medicaid for the first time ever. But more work still needs to be done. The Senate should build upon this new flexibility and provide states with additional tools to ensure the program can become sustainable over the long run.**

Congress should provide states with at least four additional reforms to give states the flexibility needed to protect limited resources for the truly needy:

- **Allow states to make eligibility and benefit changes prospectively, grandfathering existing enrollees**
- **Allow states to check assets for most enrollees**
- **Allow states to verify eligibility more frequently**
- **Allow states to lower the home equity exemption**

## Prospective eligibility changes

Current rules prevent states from making prospective eligibility changes through a state plan amendment. If a state wishes to eliminate an eligibility category, for example, it is forced to remove all individuals enrolled under that group at once. This process is administratively complex and politically painful, leaving states with few options to unwind expansions, even when those expansions have wreaked havoc on state budgets and siphoned away resources from the truly needy.

But states could effectively unwind expansion in just a few years by closing the program to new applicants and allowing those currently enrolled to exit as their circumstances improve.[37] A similar process is frequently used when making changes in other policy areas. In pension reform, for example, defined benefit plans are frequently protected for existing employees, while new employees and future earnings are moved into 401(k) plans. Likewise, states should be free to cap or freeze enrollment for eligibility groups as needed.

## Asset tests

ObamaCare banned states from checking assets when determining eligibility for most Medicaid applicants. Under the new rules, individuals applying for coverage under the Modified Adjusted Gross Income (MAGI) standards are subject to no asset test, though seniors and individuals with disabilities who receive institutional care are still subject to the traditional asset test.

This change allowed able-bodied adults with unlimited financial resources to qualify for Medicaid. Indeed, a new cottage industry has popped up helping individuals with significant assets structure their income streams to qualify for Medicaid.[38] One insurance broker in Iowa, for example, acknowledged that he has clients with up to $5 million in assets that have enrolled in Medicaid as a result of this change.[39] In Michigan and Maine, state officials report that individuals with large lottery winnings – sometimes totaling in the millions – are still receiving

Medicaid benefits.[40-42] The change has also taken away access to bank account information, leaving caseworkers with fewer tools to identify regular deposits of unreported income.[43]

Allowing states to once again check assets would allow them to prevent these abuses, provide an additional program integrity tool to caseworkers, and preserve limited resources for the truly needy.

## More frequent eligibility checks

ObamaCare limited how often states could verify eligibility for most Medicaid enrollees to just once per year unless they receive information that circumstances have changed.[441] But life changes that affect eligibility happen much more frequently and often go unreported. According to federal data, nearly 10 percent of all Medicaid spending is improper, with most improper Medicaid payments since 2010 caused by eligibility errors.[45] This waste, fraud, and abuse not only costs taxpayers billions, it also robs limited resources from the truly vulnerable.

States should have the flexibility to check Medicaid eligibility more frequently. Prior to ObamaCare, states were required to check eligibility at least once per year, with many checking more frequently than that. States have saved millions of dollars by using new technology to notify caseworkers of life changes, the only exception that allows an eligibility redetermination between renewal periods, in order to help mitigate the higher costs imposed by these new ObamaCare rules.[46] These states have identified individuals who have found work, received raises, moved out of state, or even died, but who would otherwise have remained enrolled on the program. The AHCA requires Medicaid expansion states to redetermine eligibility every 6 months for the expansion population. States should have the same option for any eligibility group.

## Lower home equity exemptions

Although Medicaid was intended to serve only the truly needy, eligibility expansions and loopholes have turned the program into a middle-class entitlement. Many attorneys now help middle-class and affluent seniors plan their estates in ways to qualify for Medicaid.[47-48] Although federal law restricts long-term care eligibility to individuals with limited countable assets, numerous exemptions and exclusions enable people with substantial resources to qualify for the program. Under current law, at least $560,000 in home equity is exempt from Medicaid's asset limit on those applying for long-term care.[49] In some states, the exemption is as high as $840,000.[50]

States should have the flexibility to set lower exemptions that reflect local differences in real estate markets and unique needs in their communities. The AHCA changes the home equity exemption to a flat $500,000. This flat level should remain the maximum exemption allowed, but states should be given new flexibility to set the exemption at lower amounts.

## Conclusion

Skyrocketing enrollment is responsible for the vast majority of Medicaid spending increases over the past few decades. Capping spending growth per enrollee will improve the sustainability of the program from a federal perspective, but the impact may be small and will not address the underlying cause of spending growth. In order to protect resources for the most vulnerable, states will need new tools to help manage enrollment. The AHCA lays the groundwork for this new flexibility, giving states the option to create work requirements for able-bodied adults on Medicaid for the first time ever. But more work needs to be done. The Senate should build upon this new flexibility and provide states with additional tools to ensure the program can become sustainable over the long run.

Congress should provide states with at least four additional reforms to give states the flexibility needed to protect limited resources for the truly needy:

- Allow states to make eligibility and benefit changes prospectively, grandfathering existing enrollees
- Allow states to check assets for most enrollees
- Allow states to verify eligibility more frequently
- Allow states to lower the home equity exemption

A number of governors have supported work requirements, prospective eligibility changes, asset tests, and other changes, including additional flexibility for plan design, service delivery reform, payment reforms, enforceable premiums, and elimination of retroactive, presumptive, and transitional eligibility.[51-52]

These changes will give states the flexibility to refocus on the program on the most vulnerable and ultimately move the program to a sustainable path forward.

# REFERENCES


1. Office of Management and Budget, "Fiscal year 2017 budget of the U.S. government: Historical tables," Executive Office of the President (2016), https://obamawhitehouse.archives.gov/sites/default/files/omb/budget/fy2017/assets/hist.pdf.
2. Christina Hawley Anthony et al., "The budget and economic outlook: 2017 to 2027," Congressional Budget Office (2017), https://www.cbo.gov/sites/default/files/115th-congress-2017-2018/reports/52370-budeconoutlook.pdf.
3. Office of Management and Budget, "Fiscal year 2017 budget of the U.S. government: Historical tables," Executive Office of the President (2016), https://obamawhitehouse.archives.gov/sites/default/files/omb/budget/fy2017/assets/hist.pdf.
4. Ibid.
5. Christina Hawley Anthony et al., "The budget and economic outlook: 2017 to 2027," Congressional Budget Office (2017), https://www.cbo.gov/sites/default/files/115th-congress-2017-2018/reports/52370-budeconoutlook.pdf.
6. Author's calculations based upon actual average per enrollee spending and actual enrollment among four separate groups: seniors, individuals with disabilities, children, and non-disabled adults. Adults made eligible by ObamaCare's Medicaid expansion have been excluded from this analysis, as they were not eligible until 2014. Data was provided by the Office of the Actuary at the Centers for Medicare and Medicaid Services. See, e.g., Centers for Medicare and Medicaid Services, "2016 actuarial report on the financial outlook for Medicaid," U.S. Department of Health and Human Services (2016), https://www.medicaid.gov/medicaid/financing-and-reimbursement/downloads/medicaid-actuarial-report-2016.pdf.
7. Author's calculations based upon the actual growth in medical care component of the consumer price index, as of September of the relevant year, for children and non-disabled adult enrollees and the medical care component of the consumer price index increased by one percentage point for seniors and individuals with disabilities. See, e.g., Bureau of Labor Statistics, "Consumer price index for all urban consumers: medical care," U.S. Department of Labor (2017), https://fred.stlouisfed.org/series/CPIMEDSL.
8. Author's calculations based upon actual average per enrollee spending on children and non-disabled adults.
9. Author's calculations based upon the actual growth in medical care component of the consumer price index, as of September of the relevant year.
10. Author's calculations based upon actual average per enrollee spending on seniors and individuals with disabilities.
11. Author's calculations based upon the actual growth in medical care component of the consumer price index, as of September of the relevant year, plus one percentage point.
12. Author's calculations based upon average per enrollee spending, actual enrollment, and the appropriate growth target based upon the medical component of the consumer price index, disaggregated by state. Data was provided by the Centers for Medicare and Medicaid Services. See, e.g., Centers for Medicare and Medicaid Services, "Medicare and Medicaid statistical supplement," U.S. Department of Health and Human Services (2013), https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Archives/MMSS/index.html.
13. Ibid.
14. Author's calculations based upon the actual growth in medical care component of the consumer price index, as of September of the relevant year, for children and non-disabled adult enrollees and the medical care component of the consumer price index increased by one percentage point for seniors and individuals with disabilities.
15. Author's calculations based upon actual average per enrollee spending and actual enrollment among four separate groups: seniors, individuals with disabilities, children, and non-disabled adults.
16. Author's calculations based upon actual average per enrollee spending and children and non-disabled adults.
17. Author's calculations based upon the actual growth in medical care component of the consumer price index, as of September of the relevant year.
18. Author's calculations based upon actual average per enrollee spending on seniors and individuals with disabilities.
19. Author's calculations based upon the actual growth in medical care component of the consumer price index, as of September of the relevant year, plus one percentage point.
20. 20 Kate Fritzsche et al., "Cost estimate: American Health Care Act – Budget reconciliation recommendations of the House Committees on Ways and Means and Energy and Commerce, March 9, 2017," Congressional Budget Office (2017), https://www.cbo.gov/sites/default/files/115th-congress-2017-2018/costestimate/americanhealthcareact.pdf.
21. Christina Hawley Anthony et al., "The budget and economic outlook: 2017 to 2027," Congressional Budget Office (2017), https://www.cbo.gov/sites/default/files/115th-congress-2017-2018/reports/52370-budeconoutlook.pdf.
22. Authors' calculations based upon the Congressional Budget Office's projected average federal spending on benefit payments per enrollee and projected enrollment, disaggregated by eligibility category, and annual medical inflation of 3.7 percent.
23. Author's calculations based upon projected medical inflation, average per enrollee spending, and enrollment among four separate groups: seniors, individuals with disabilities, children, and non-disabled adults. This analysis includes adults made eligible by ObamaCare.
24. Authors' calculations based upon the Centers for Medicare and Medicaid Services' projected average spending per enrollee and projected enrollment, disaggregated by eligibility category, and projected annual medical inflation.

25. Ibid.
26. Ibid.
27. Author's calculations based upon projected average per enrollee spending and children and non-disabled adults.
28. Author's calculations based upon projected growth in medical care component of the consumer price index, as of September of the relevant year.
29. Author's calculations based upon actual average per enrollee spending on seniors and individuals with disabilities.
30. Author's calculations based upon the actual growth in medical care component of the consumer price index, as of September of the relevant year, plus one percentage point.
31. Author's calculations based upon actual Medicaid expenditures and enrollment in fiscal years 2000 and 2016.
32. Ibid.
33. Ibid.
34. Ibid.
35. Ibid.
36. Ibid.
37. Jonathan Ingram, "Unwinding ObamaCare's Medicaid expansion," Foundation for Government Accountability (2017), https://thefga.org/wp-content/uploads/2017/01/MedEx-UnwindingObamaCareMedEx-FreezeMemo-noCongress.pdf.
38. Melissa Quinn, "Millionaires are qualifying for Medicaid under ObamaCare," Daily Signal (2016), http://dailysignal.com/2016/02/09/millionaires-are-qualifying-for-medicaid-under-obamacare.
39. Ibid.
40. Maine Department of Health and Human Services, "Maine welfare lottery winners from 2010-2014," Maine Department of Health and Human Services (2015), https://assets.documentcloud.org/documents/2646238/Maine-Welfare-Lottery-Winners-2010-2014.pdf.
41. Michigan Department of Human Services, "Preserving assistance for our state's truly needy: Calendar year 2012 report – Lottery winners and welfare programs," Michigan Department of Human Services (2013), https://www.michigan.gov/documents/dhs/Lottery_Report_2012_417514_7.pdf.
42. Michigan Department of Human Services, "Lottery match report 2014," Michigan Department of Human Services (2014), https://cbsdetroit.files.wordpress.com/2014/10/lotteryreport_legislature2014_2_472170_7.pdf.
43. Kay E. Brown et al., "Supplemental Nutrition Assistance Program: Improved oversight of state eligibility expansions needed," Government Accountability Office (2012), http://www.gao.gov/assets/600/593070.pdf.
44. 42 C.F.R. § 435.916 (2016), https://www.gpo.gov/fdsys/pkg/CFR-2016-title42-vol4/pdf/CFR-2016-title42-vol4-sec435-916.pdf.
45. Author's calculations based upon national payment error rate measurement reports published by the Centers for Medicare and Medicaid Services.
46. Jonathan Ingram, "Stop the scam: How to prevent welfare fraud in your state," Foundation for Government Accountability (2015), https://thefga.org/wp-content/uploads/2015/04/StoptheScam-PreventWelfareFraud-Paper-final.pdf.
47. John A. Miller, "Medicaid spend down, estate recovery and divorce: Doctrine, planning and policy," Elder Law Journal 23: 42-82 (2015), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2567041.
48. Sean R. Bleck et al., "Preserving wealth and inheritance through Medicaid planning for long-term care," Michigan State University College of Law Journal of Medicine and Law 17: 153-201 (2013), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2126111.
49. Kristen J. Colello, "Medicaid financial eligibility for long-term services and supports," Congressional Research Service (2017), https://fas.org/sgp/crs/misc/R43506.pdf.
50. Ibid.
51. John Kasich et al., "Letter to Majority Leader McConnell and Speaker Paul Ryan: Principles and policies to support repeal and replace," Ohio Governor's Office of Health Transformation (2017), http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=S_gEqkALBFY%3D&tabid=160.
52. Mary C. Mayhew, "Letter to Congressman Tom Price, U.S. Secretary of Health and Human Services Nominee," Maine Department of Health and Human Services (2017), http://www.maine.gov/dhhs/documents/CMS-1115-Letter_1-25.pdf.