The Implications of a Per Capita Cap on Low-Income Medicare Beneficiaries

National Academy for Social Insurance
June 22, 2017

Lynda Flowers, JD, MSN, RN
Senior Strategic Policy Advisor
AARP Public Policy Institute
The Public Policy Institute informs and stimulates public debate on the issues we face as we age. The Institute promotes development of sound, creative policies to address our common need for economic security, health care, and quality of life, through timely policy analysis, policy research, and robust engagement in the marketplace of ideas.
Who are the Dual Eligibles?

1 in 5 Medicare beneficiaries—11 million people with very low income rely on Medicaid—called dual eligibles or duals.

Duals comprise 6.5 million older adults and 4.6 million people with significant disabilities.

Medicare beneficiaries with very low income and low-income and low-income people with disabilities qualify.
Full-Duals Have Disproportionately High Medicare and Medicaid Spending

In CY 2011, Full benefit duals accounted for 15 percent of Medicare enrollment but 27 percent of all Medicare spending.

During that same time period, full benefit dual eligible accounted for 11 percent of Medicaid enrollment but 32 percent of all Medicaid spending.

Source: Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid (Washington, DC, Medpac and MACPAC, January 2017).
Who are the Dual Eligibles, cont’d.?  

Duals are the poorest and sickest of all Medicare beneficiaries  

Duals rely on Medicaid for services they can’t get from Medicare, especially long-term services and supports  

**Nearly three quarters** (72 percent) of the duals receive full Medicaid benefits; the rest get help with Medicare cost sharing
Duals Have Poorer Health Status

People on Medicare who receive assistance from Medicaid are in poorer health than other people on Medicare:

- Require Help with Activities of Daily Living: 61% vs. 33%
- Cognitive/Mental Impairment: 58% vs. 29%
- 5+ Chronic Conditions: 37% vs. 27%
- In Poor Health: 18% vs. 6%

People on Medicare who receive assistance from Medicaid use more medical services than other people on Medicare

1+ Inpatient Hospital Stays
- Medicare Beneficiaries Who Receive Assistance From Medicaid: 26%
- Other Medicare Beneficiaries: 16%

1+ Emergency Room Visits
- Medicare Beneficiaries Who Receive Assistance From Medicaid: 21%
- Other Medicare Beneficiaries: 13%

1+ Days of Home Health Care
- Medicare Beneficiaries Who Receive Assistance From Medicaid: 13%
- Other Medicare Beneficiaries: 8%

Long-Term Care Facility Resident
- Medicare Beneficiaries Who Receive Assistance From Medicaid: 13%
- Other Medicare Beneficiaries: 1%

1+ Days in a Skilled Nursing Facility
- Medicare Beneficiaries Who Receive Assistance From Medicaid: 9%
- Other Medicare Beneficiaries: 4%

Note: Excludes Medicare beneficiaries in Medicare Advantage plans.
Per Capita Cap Proposal in The American Health Care Act

Mandatory caps for older adults and people with disabilities starting in 2020; optional for children and all adults

Baseline caps established by average 2016 per enrollee spending for aged and disabled groups trended to 2019 using M-CPI, and grown annually by M-CPI + 1

Senate bill might change the growth factor to CPI-U (general
Caps Based on Historical Medicaid Spending are Flawed

Will likely result in immediate funding shortfalls in many states

Will be inadequate to respond to the needs of an aging population with growing needs for LTSS

Will perpetuate inequities in state Medicaid spending and take away states’ ability to go in different policy directions
## Funding Shortfall At Baseline Under House and Potential Senate Bill

### Growth in Medicaid Spending per Full-Year Full-Benefit Enrollee, M-CPI, and CPI-U, 2016 to 2019

*Expressed as a percentage of 2016 spending. As a percentage of 2019 baseline projected spending, the shortfalls under AHCA range from 1.0 percent to 3.0 percent for the three affected groups and the shortfalls under CPI-U range from 3.9 percent to 6.9 percent. Source: AARP Public Policy Institute calculations based on US Department of Health & Human Services, Centers for Medicare & Medicaid Services (CMS), Office of the Actuary, 2016 Actuarial Report on the Financial Outlook for Medicaid, https://www.medicaid.gov/medicaid/financing-and-reimbursement/actuarial-report/index.html. The Consumer Price Index for urban consumers (CPI-U) have been added to this figure because it has been rumored that the Senate bill will likely include language that caps per-enrollee growth by CPI-U beginning around 2025. The impacts of CPI-U are for illustrative purposes only and do not purport to model actual bill language.*

<table>
<thead>
<tr>
<th>Year</th>
<th>Spending per full-year full-benefit enrollee under current law</th>
<th>Growth rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Children</td>
<td>Adults</td>
</tr>
<tr>
<td>2017</td>
<td>+3.5%</td>
<td>+5.0%</td>
</tr>
<tr>
<td>2018</td>
<td>+4.9%</td>
<td>+5.3%</td>
</tr>
<tr>
<td>2019</td>
<td>+4.9%</td>
<td>+5.3%</td>
</tr>
<tr>
<td>Cumulative 2016–19</td>
<td>+13.9%</td>
<td>+16.3%</td>
</tr>
<tr>
<td>Shortfall under AHCA*</td>
<td>1.1%</td>
<td>3.5%</td>
</tr>
<tr>
<td>Shortfall under CPI-U*</td>
<td>5.6%</td>
<td>8.0%</td>
</tr>
</tbody>
</table>

Over the Next 35 Years Oldest Old Population Will Triple: Caps Will Not Respond

Projected Population by Age Group, Percentage Increase since 2015

Source: AARP Public Policy Institute Analysis of US Census population projections.
Per Capita Caps Lock In Inequities in State Spending

FY2013 Total Medicaid Spending per Full-Year Full-Benefit Enrollee by State and Eligibility Group, % of US Average

### Per Capita Caps Would Lock in Lowest-Spending States Forever

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

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

States Left Holding the Bag When Funds Fall Short

Capped funding not likely to keep pace with costs associated with new technologies, new pharmaceuticals, growth in service use, medical inflation, changing demographic
Possible State Responses to Capped Funding

- Reallocate state funds

- Raise taxes to preserve other state services

- Cut optional eligibility categories that impact duals

- Cut optional services like HCBS that duals rely on and will need to rely on more in the future as the population ages
Possible State Responses to Capped Funding, cont’d.

- Establish waiting lists or place tight limits on services
- Tighten eligibility criteria for receipt of services
- Cut provider rates, thereby limiting access
- Incentivize cost shifting between Medicaid and Medicare
### Optional Cuts that Could Harm Duals

<table>
<thead>
<tr>
<th>Optional Eligibility Categories</th>
<th>Optional Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Special Income Limit Pathway (300 percent of SSI for people in institutions or receiving HCBS)</td>
<td>Home and Community-Based Services</td>
</tr>
<tr>
<td>Poverty-Related Pathway (age 65 + or person with disability with income at or below 100 percent of the FPL)</td>
<td>Personal Care Services</td>
</tr>
<tr>
<td>Medically Needy Pathway (spend own money on medical care until state-established income level is reached)</td>
<td>PACE</td>
</tr>
</tbody>
</table>
Per Capita Caps Could End Up Costing the Federal Government Even More

Medicare costs for duals could go up if states diminish access by cutting provider rates or limiting access to LTSS and duals end up becoming sicker.

Changes that states make to optional eligibility, optional services (like HCBS) programs could force duals to have unmet needs, become sicker, and ultimately rely on costly Medicare-financed hospital and emergency room care.
Implications for Duals Receiving Coordinated Care Through Managed LTSS

Federal regulation requires capitation payments to be sufficient to meet the needs of the covered population, and to be actuarially sound.

States using managed care for duals are on the hook if per capita payments are too low to meet the federal requirement.

If states can’t make up the shortfall, many duals could lose access to coordinated care as MCOs are unable to meet the federal actuarial soundness requirement.
## Sound MLTSS Capitation Rate vs. Faulty Caps

<table>
<thead>
<tr>
<th>Key Objective</th>
<th>MLTSS Rate Setting Methodology</th>
<th>AHCA Per Capita Cap Methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actuarially sound methodology designed to cover all reasonable, appropriate and attainable costs necessary to protect access and quality for Medicaid enrollees and to support sustainable Medicaid managed care programs. Rates are renegotiated annually and on an as needed basis</td>
<td>Budget driven methodology designed to limit federal Medicaid spending.</td>
</tr>
</tbody>
</table>
Things Could Go From Bad to Worse: Preliminary PPI Analysis

**House Bill Projection:** Would cut between $335 billion and $2.7 trillion (total federal and state Medicaid spending) from Medicaid over 20 years (2017-2036)

**Senate Bill Projection:** Would cut between $2 and $4 trillion (total federal and state spending) over 20 years (2017-2036)
Establishing baseline based on historical spending is problematic

Per capita funding won’t keep pace with medical inflation. Using a general measure of inflation moves things from bad to worse

States will face difficult choices

Fully-integrated Medicare-Medicaid MLTSS programs could face risks
Thank You PPI Team!

Susan Reinhard, SVP, AARP Public Policy Institute

Lina Walker, VP, Health Security, AARP Public Policy Institute

Jean Accius, VP, IL/LTSS and New NASI Torchbearer!

Ari Houser, Senior Methods Advisor, AARP Public Policy Institute

Brendan Flinn, Policy Research Senior Analyst, AARP Public Policy Institute
Thank You!
Iflowers@aarp.org

KEEP CALM AND
Hope for the BEST