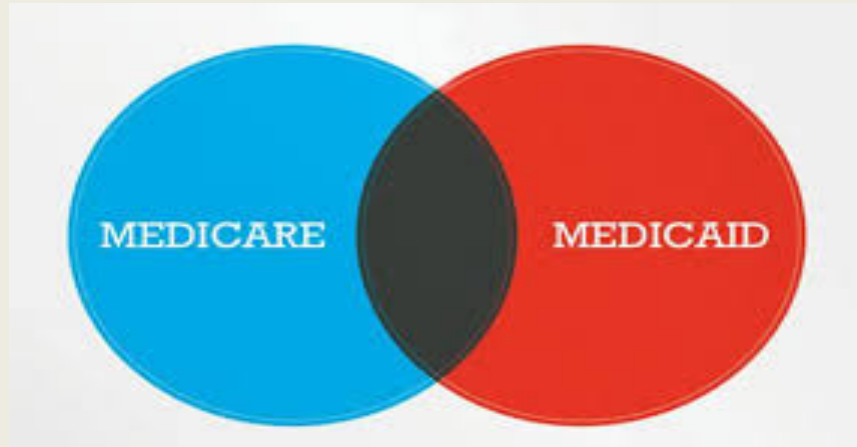


# The Implications of a Per Capita Cap on Low-Income Medicare Beneficiaries



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*AARP Public Policy Institute***

# About The 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.

## Who are the Dual Eligibles, cont'd.?

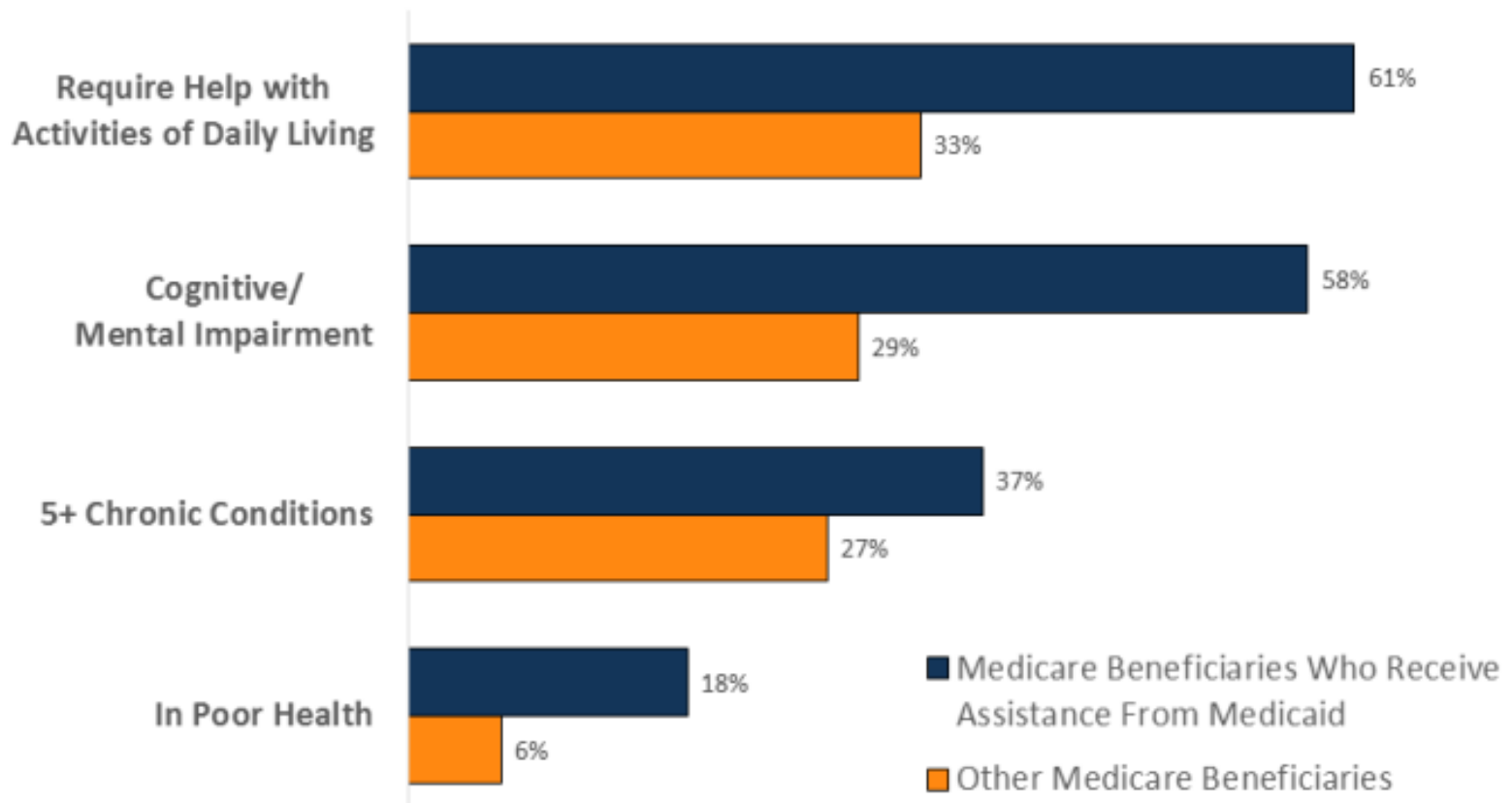
Duals are the poorest and sickest of all Medicare beneficiaries

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

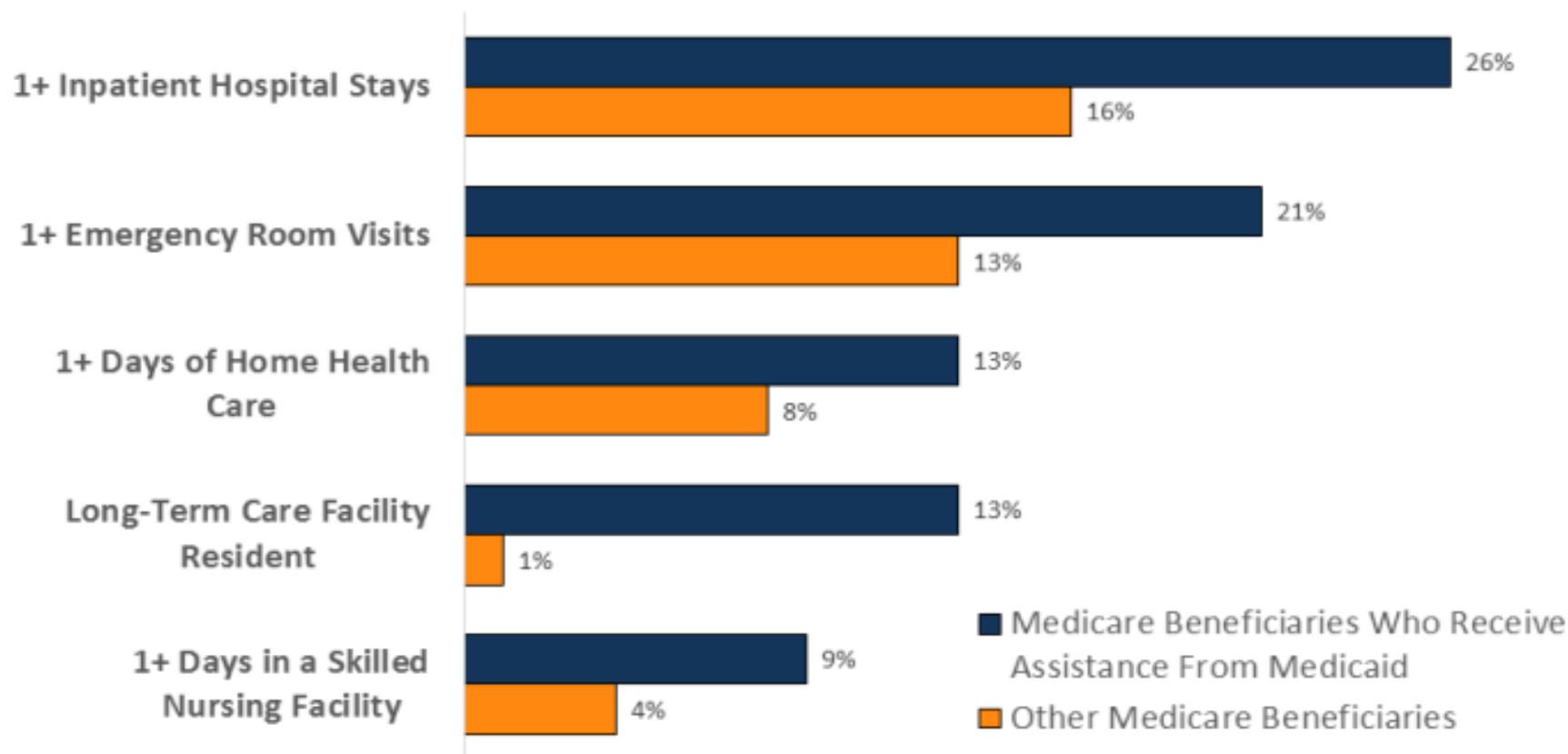
**People on Medicare who receive assistance from Medicaid are in poorer health than other people on Medicare**



Source: Kaiser Family Foundation analysis of CMS Medicare Current Beneficiary Survey Cost & Use File, 2012.

# Duals Use More Health Services

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



**Note:** Excludes Medicare beneficiaries in Medicare Advantage plans.

**Source:** Kaiser Family Foundation analysis of CMS Medicare Current Beneficiary Survey Cost & Use File, 2012.

# 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



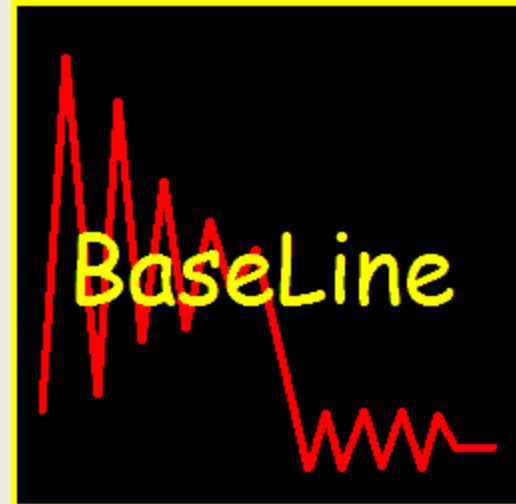


# Caps Based on Historical Medicaid Spending are Flawed

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

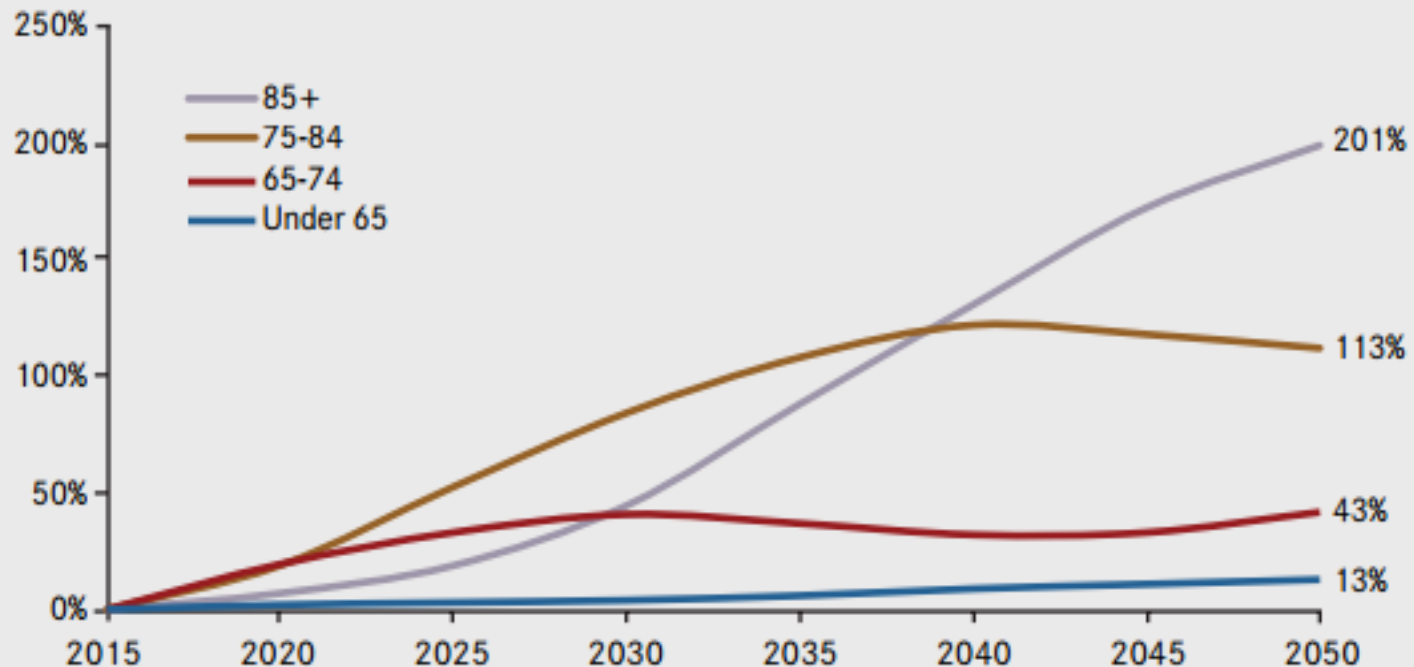
Growth in Medicaid Spending per Full-Year Full-Benefit Enrollee, M-CPI, and CPI-U, 2016 to 2019

Year	Percentage Change from Previous Year (CMS Projection)					
	Spending per full-year full-benefit enrollee under current law				Growth rate	
	Children	Adults	Disabled	Aged	M-CPI	CPI-U
2017	+3.5%	+5.0%	+4.2%	+3.4%	+3.8%	+2.8%
2018	+4.9%	+5.3%	+4.5%	+4.5%	+4.3%	+2.7%
2019	+4.9%	+5.3%	+4.7%	+4.3%	+4.2%	+2.6%
Cumulative 2016–19	+13.9%	+16.3%	+14.0%	+12.8%	+12.8%	+8.3%
Shortfall under AHCA*	1.1%	3.5%	1.2%	-	-	-
Shortfall under CPI-U*	5.6%	8.0%	5.7%	4.4%	-	-

\* 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.

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

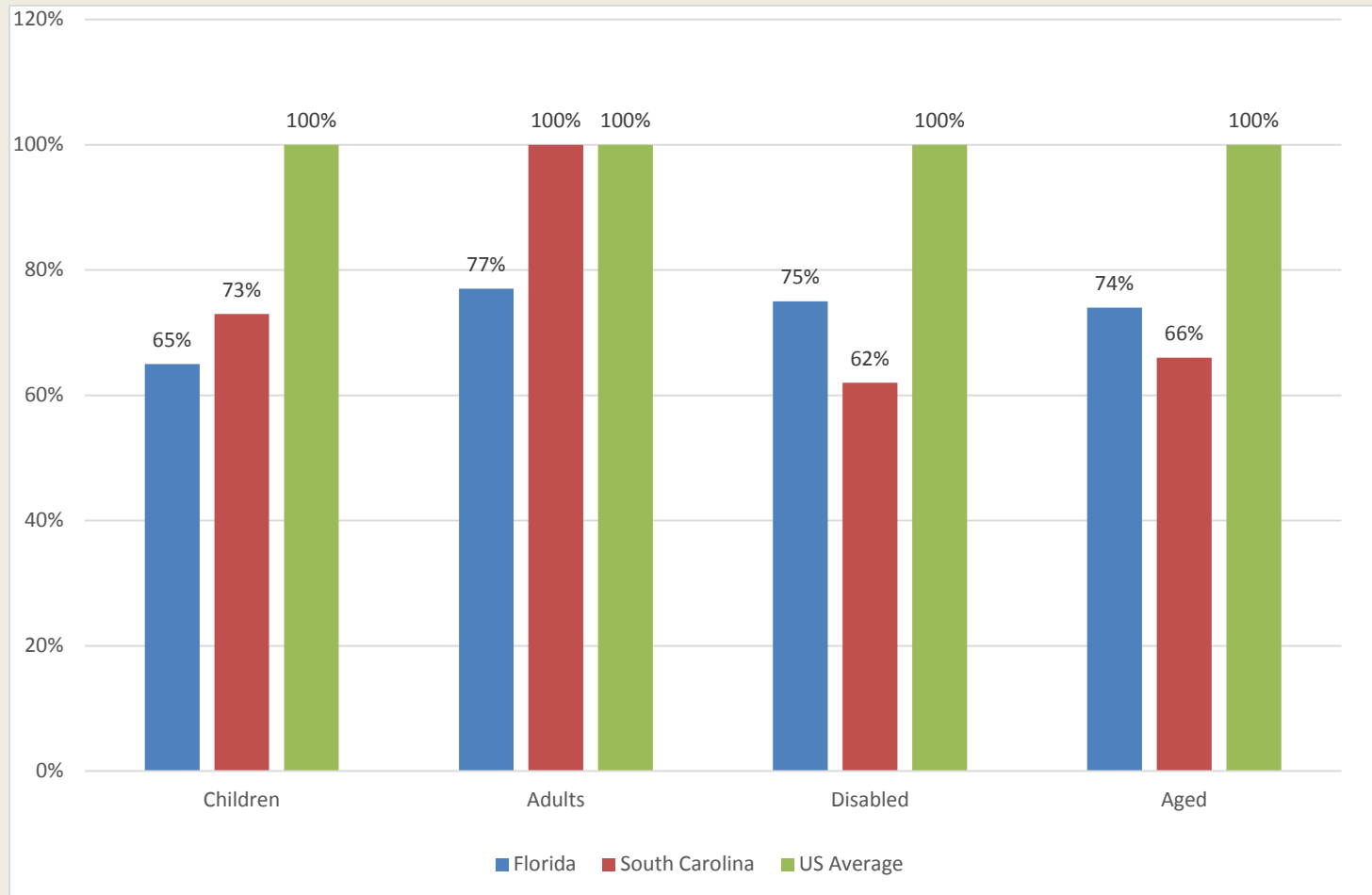
Projected Population by Age Group, Percentage Increase since 2015



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



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

# 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**

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

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

# 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

Optional Eligibility Categories	Optional Services
<b>Special Income Limit Pathway</b> (300 percent of SSI for people in institutions or receiving HCBS)	<b>Home and Community-Based Services</b>
<b>Poverty-Related Pathway</b> (age 65 + or person with disability with income at or below 100 percent of the FPL)	<b>Personal Care Services</b>
<b>Medically Needy Pathway</b> (spend own money on medical care until state-established income level is reached)	<b>PACE</b>

# 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

	MLTSS Rate Setting Methodology	AHCA Per Capita Cap Methodology
Key Objective	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 re-negotiated annually and on an as needed basis	Budget driven methodology designed to limit federal Medicaid spending.

# 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)



THE SITUATION HAS  
GONE FROM BAD TO  
WORSE,.

Ed Whitfield

QUOTEHD.COM

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



summary

# Thank You PPI Team!

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**Thank You!**

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**KEEP  
CALM  
AND**

**Hope for the  
BEST**