Top 10 Takeaways
CBO Report on Medicaid Spending Caps

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As a new session of Congress has begun, so too have we seen emerging proposals for Medicaid spending caps, typically in the form of "per capita caps." These proposals will likely mimic past Medicaid spending cap proposals which have repeatedly been rejected because they simply do not work. While addressing Medicaid spending is an important issue, spending caps are a case of the cure being far worse than the disease. Look no further than the November 2013 Congressional Budget Office (CBO) report on spending caps in Medicaid to understand why.[1] Here is our Top 10 Takeaways from the CBO report, illustrating why spending caps in Medicaid are a bad idea (with excerpts of key CBO text in endnotes).

1. **Medicaid spending caps create a massive cost-shift to states.** Medicaid is jointly funded by the federal and state governments. Medicaid spending caps reduce future *federal* Medicaid spending, meaning states will simply have to pay more of the Medicaid costs themselves (or cut services or enrollment).[2] Attempts to "index" health spending will not work, because indexes fail to account for the complex ways in which health care costs have historically grown.[3] To make matters worse, Medicaid spending caps also create huge uncertainty for state budgets: instead of budgeting with guaranteed federal matching dollars, states must speculate about unknown future caps.[4]

2. **The losses to states *increase* over time.** Not only do per capita caps shift costs onto states, the states' shares of costs actually increase over time.[5] The indexes used to calculate the federal share do not accurately calculate the full growth of Medicaid costs in the states, so every year the formula underestimates state costs more and more.[6]

3. **States will get less help when they need it most.** Medicaid is a "counter-cyclical" program by design. This means, for example, that if the economy falters and the number of uninsured people rises, *more* federal funding is available to states to meet increased health care needs. With spending caps, the illogical result can be that when the need for coverage grows, states will need to spend more on Medicaid with *less* federal support.[7]

4. **Medicaid enrollees will be harmed.** As states struggle to absorb the huge cost-shift, they will likely make cuts that harm the people who depend on Medicaid. States will also likely cut eligibility for vulnerable populations (such as seniors and persons with disabilities) as well as services for those who remain eligible.[8] States may also pass costs onto low-income enrollees[9] and cut payment rates to medical providers, creating access problems and threatening health care infrastructure.[10]

5. **States will try to dismantle federal standards.** The CBO made clear that it is not necessary for states to reject federal standards if they have spending caps.[11] However, in practice, states will find it difficult to comply with federal standards if their federal funding is reduced, so an eventual threat to federal standards is predictable.[12]

6. **Spending caps threaten the ACA's Medicaid expansion.** The ACA's Medicaid expansion offers states enhanced funding to expand Medicaid. States that have not expanded yet are likely to reject expansion with spending caps that directly contradict the enhanced ACA funding.[13] In fact, it might also lead to states that *already* expanded dropping the expansion, which some states specifically said they would do if the federal funding was decreased.[14]

7. **Designing spending caps is fraught with problems.** For example, the data needed to set and use caps is not available in the timeframe needed to actually implement them.[15] The CBO report notes numerous ineffective "fixes" to these types of problems that highlight the basic paradox of spending caps: adjustments to fix the serious problems with spending caps also reduce the illusory savings.[16]

8. **Spending caps discriminate unfairly between states.** Because state Medicaid programs vary so significantly (in size, spending, covered populations, etc.) every per capita cap payment formula will hurt some states more than others.[17] Moreover, it will be very difficult for CMS to set the baseline funding levels for states – using past data will be unfair to some states, while using future data will allow states to rig the funding levels.[18]

9. **Spending caps may lead to discrimination between populations.** Some populations cost more to cover than others.[19] For example, states with greater numbers of more costly older adults will be more harmed by a broad spending cap (and the older adults will be hurt more too). Designing separate caps for each population would be very complex and would still fail to account for significant factors such as state variations within populations and in covered services. It might also lead states to use the money for one population to pay for another population that has reached its cap.[20]

10. **CMS lacks the enforcement system needed for spending caps.** CMS would need to develop a system to ensure that states comply with spending caps, which would require complex mechanisms such as a "reconciliation" processes to adjust the caps on a yearly basis based on prior year over- or under-expenditures.[21]

[1] Congressional Budget Office (CBO Report), *Options For Reducing the Deficit: 2014-2023* (Nov. 2013), available at: https://www.cbo.gov/budget-options/2013/44687.
[2] *CBO Report* at page 193: "Capping federal Medicaid spending would fundamentally change the federal-state financial relationship in the program. A capped federal commitment would mean that the responsibility for any growth in the program's costs that exceeded the growth factor … would be shifted to the states. … [T]he federal payments to states under this option would be lower than the payments projected under current law. Those savings to the federal government would represent lost revenues to states…" *See also CBO Report* at page 187: "If the limits on federal payments were set low enough, they would shift additional costs—perhaps substantial costs—to states…"
[3] *CBO Report* at page 189: "…[G]rowth factors tied to price indexes or overall economic growth would not generally account for increases in the average quantity or intensity of medical services of the sort that have occurred in the past."
[4] *CBO Report* at page 187: "If the limits on federal payments were set low enough, they would shift additional costs—perhaps substantial costs—to states *and cause state Medicaid budgets to become less predictable*." (Emphasis added)
[5] *CBO Report* at page 193: "Those savings to the federal government would represent lost revenues to states, and the losses would increase over time as the gap between federal payments under a capped program and under the current program grew larger."
[6] *CBO Report* at page 193: "CBO expects Medicaid costs to grow faster than [the indexes] between 2015 and 2023, so the federal payments to states under this option would be lower than the payments projected under current law."
[7] *CBO Report* at page 187: "[D]epending on the structure of the caps, Medicaid might no longer serve as a countercyclical source of federal funds for states during economic downturns (meaning that a state might not automatically receive more federal funding if a downturn caused more state residents to enroll in Medicaid)."
[8] *CBO Report* at page 193: "Under alternatives that would lead to significant reductions in federal funding, many states would find it difficult to offset the losses solely through the potential efficiencies… Such states would have three potential approaches open to them: raise additional revenues, cut other state programs to devote a greater share of their resources to Medicaid, or produce additional savings by lowering payment rates to providers, reducing covered services, or decreasing the number of enrollees. States already have some ability to adjust those elements of their Medicaid programs, but more flexibility would give them the opportunity to offset the larger losses of federal funding estimated under this option without having to raise additional revenues or cut other state programs. CBO expects that states would adopt a mix of those various approaches." *See also CBO Report* at 193: "…[S]ome states might use extra flexibility to adjust the level of benefits provided to some enrollees so that, instead of receiving comprehensive benefits, as required under current law, those enrollees would receive a smaller set of targeted services to meet critical needs."
[9] *CBO Report* at page 193: "Proponents of caps also argue that giving states more flexibility could help them create incentives for Medicaid enrollees to use fewer services, such as through the use of increased cost sharing or of higher deductibles coupled with health savings accounts."
[10] *CBO Report* at page 193: "Under alternatives that would lead to significant reductions in federal funding, many states would find it difficult to offset the losses solely through the potential efficiencies described above. Such states would have three potential approaches open to them: raise additional revenues, cut other state programs to devote a greater share of their resources to Medicaid, or produce additional savings by *lowering payment rates to providers*, reducing covered services, or decreasing the number of enrollees … CBO expects that states would adopt a mix of those various approaches." (Emphasis added). *See also CBO report* at page 194: "If states reduced payment rates, enrollees might find fewer providers willing to accept Medicaid patients, especially given that Medicaid already pays significantly lower rates than Medicare or private insurance in many cases."
[11] *CBO Report* at page 190: "In principle, the structure of Medicaid's financing and the degree of state flexibility are separate issues: With a federal spending cap, the flexibility available under current law could remain the same or be altered to give states more or fewer options, and states' flexibility could be increased or decreased under the current financing structure."
[12] *CBO Report* at page 193: "With less federal funding and more budgetary uncertainty, states would have a stronger incentive than under current law to lower the cost of their Medicaid programs. To help states reduce costs, some proponents of Medicaid caps consider new programmatic flexibility for states to be an essential feature of such a policy … States could be permitted to run their programs without having to meet some or all of CMS's current administrative requirements … and they could be granted discretion to reduce coverage of mandatory services and eligibility groups."
[13] *CBO Report* at page 191: "…[C]apping federal Medicaid spending might cause some states that would otherwise expand coverage to *reject* the option instead. Limits on federal Medicaid payments represent a potential shifting of costs to states, which would affect their budget processes and decisions. One of the ways in which states could lower their Medicaid costs and reduce their financial risks would be to *drop* the optional expansion or fail to adopt it in the future (if not already implemented). CBO anticipates that the more that caps reduced federal funding below the level projected under current law, the greater the likelihood that states would turn

down the optional expansion. … To the extent that states responded to caps by declining the optional expansion, some people would lose access to Medicaid coverage … Of the people with income below the federal poverty guidelines who no longer had access to Medicaid, most would become uninsured…" (Emphasis added).

[14] *Id.*

[15] *CBO Report* at page 192: "If the caps were based on the actual values of the [two proposed indexes], CMS would not know the final spending limits until after the end of the fiscal year, when the growth rates for those measures were finalized. In addition, for per-enrollee caps, CMS would need to wait until final Medicaid enrollment for the year was known to determine the spending limits for Medicaid's four main eligibility groups. Because it currently takes up to two years to finalize states' reports of enrollment, CMS would need to establish more timely reporting of enrollment to avoid large adjustments well after the close of the year."

[16] *CBO Report* at page 188: "…[C]aps could limit federal Medicaid spending on children and certain adults … but could leave spending on the elderly and the disabled uncapped. However, … caps that did not apply to those two groups would save far less than caps that covered all eligibility groups…" *See also CBO report* at page 189: "One way to address [the problem of states with caps based on low prior spending] would be to add supplemental amounts to base-year spending levels for states defined as "low spending," which would give them more room to expand their programs over time. That approach would reduce the savings from the caps, however." *See also CBO report* at page 193: "With per-enrollee caps whose growth was based on [the CPI-U index], federal payments would rise in response to increases in enrollment, but payments would not respond when the growth of health care costs exceeded the growth of the [CPI-U index]. With per-enrollee caps whose growth was based on [the NHE index], payments would adjust to average changes in the nationwide health care system but … the federal savings from that alternative would be much smaller…"

[17] *CBO Report* at page 187: "In addition, because states differ significantly in the size of their Medicaid programs—and because spending varies widely (and grows at varying rates) for different types of enrollees within a state—policymakers could find it difficult to set caps at levels that accurately reflect states' costs." *CBO Report* at page 189: "Another consideration is that using a prior base year would essentially lock in states' past choices about their Medicaid programs and perpetuate those choices… Once caps were set on the basis of states' prior choices, it would be increasingly difficult over time for states to significantly raise their payment rates or voluntarily add covered services because, unlike under current law, such changes would not lead to higher federal payments."

[18] *CBO Report* at page 189: "Another important choice in selecting a base year is whether to use a past or future year… The main reason for using a past year is that states cannot raise payment rates for providers, make additional one-time supplemental payments, or move payments for claims from different periods into the base year to maximize Medicaid spending and thereby boost their future spending limits. However, policymakers might want to choose a future base year in situations in which a past year would not adequately reflect an upcoming program change, such as the implementation of the optional coverage expansion starting in 2014… Another consideration is that using a prior base year would essentially lock in states' past choices about their Medicaid programs and perpetuate those choices."

[19] *CBO Report* at page 187: "…[S]pending varies widely (and grows at varying rates) for different types of enrollees within a state…"

[20] *CBO Report* at page 187: "[One proposed] approach would be to set one total limit based on the sum of the limits for [all of the populations], but allow states to cross-subsidize groups (spend more than the cap for some eligibility groups and less than the cap for others)…"

[21] *CBO Report* at page at page 192: "For both the overall and per enrollee spending caps, CMS would have to establish new enforcement mechanisms to ensure compliance with the spending limits… CMS would need to adopt a reconciliation process to enforce compliance with the caps, either disallowing expenditures over the caps or lowering the following year's caps by the same amount."