Medicaid per Person Spending: Historical and Projected Trends Compared to Growth Factors in Per Capita Cap Proposals

In response to projections that federal and state Medicaid expenditures are expected to grow from $595.5 billion in 2017 to $957.5 billion in 2025, Congress is debating policy changes to reduce the future rate of growth (OACT 2016). Medicaid represents a growing portion of the federal budget, having increased from 7.0 percent of federal outlays in fiscal year (FY) 2007 to 9.5 percent in FY 2016 (OACT 2016, 2008). It also represents a growing share of state budgets, increasing from 12.8 percent of state-funded expenditures in 2007 to 15.8 percent in state fiscal year 2015 (MACPAC 2017).[1] The majority of the spending growth in Medicaid can be attributed to enrollment; spending per enrollee has grown at rates comparable to or lower than Medicare and private coverage in most years since the early 1990s (MACPAC 2016).

Both houses of the U.S. Congress are considering legislation that would change Medicaid's financing structure, replacing it with a system of per capita caps. A key question in considering the potential impact of these bills is how Medicaid spending under the caps would compare to historical and projected trends in Medicaid spending under current law. This brief looks at historical and projected spending for Medicaid and other payers, and how these compare to several measures of inflation and income. We also provide illustrative examples of the projected changes in Medicaid spending per enrollee by eligibility group under current law compared to the growth factors that are used under House and Senate bills to calculate the per capita cap for each Medicaid eligibility group.

Growth Factors for Projecting Spending

When analyzing spending trends, we typically compare historical or projected spending to other benchmarks that measure inflation (either economy-wide or in a specific sector) or growth in national income. The design of per capita caps requires selection of both a base year and a growth factor, i.e., the annual rate of growth for spending in future years.

Several growth factors for prices and economic output are commonly used to analyze growth in health care spending.[2] These growth factors include:

- **consumer price index for all urban consumers (CPI-U):** a measure of the changes in the prices paid by all urban consumers for a representative basket of goods and services (BLS 2017);
- **consumer price index for all urban consumers, medical care component (CPI-M):** a measure of the changes in the prices paid by all urban consumers for medical care (BLS 2017); and

- **gross domestic product (GDP):** the change in the value of the goods and services produced by the nation's economy less the value of goods and services used in production (BEA 2017).

CPI-U tends to have the lowest annual rate of growth of any of the factors listed above (Table 1); its annual rate of growth is consistently lower than projected growth in Medicaid under current law (CBO 2016). The rate of growth in CPI-M is higher and closer to projected Medicaid spending per person under current law, depending on the year. The annual rate of growth in GDP is generally lower than both Medicaid and CPI-M but higher than CPI-U.

Analysts also look at growth rates across payers, including Medicare and private health insurance. The projected annual growth in both Medicare and private health insurance are projected to be higher than CPI-U, CPI-M, and GDP (Table 1). Medicaid per enrollee spending has typically grown more slowly than Medicare or private insurance. Under current law, this pattern is projected to continue until 2024 and 2025 when it is projected to be higher.

It is important to note that changes in Medicaid spending per enrollee are influenced by a number of factors which may not be consistent across years. These include changes in prices and payment rates and the mix and composition of the beneficiary population. For example, the decrease in the rate of growth of Medicaid spending per enrollee in FY 2014 reflects a shift in the mix of enrollees—the addition of non-disabled adults who enrolled through the Medicaid expansion established under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended), which began on January 1, 2014.[3] Increased per enrollee spending in FY 2015, by contrast, may reflect state policies to pay higher rates to providers (Martin et al. 2016).

TABLE 1. Historical and Projected Average Annual Growth in Medicaid Spending per Enrollee and Various Benchmarks, by Calendar Year

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Average annual growth in spending per enrollee																
Medicaid[1]	-1.0	3.0	-3.6	4.1	-0.3	3.8	1.1	1.6	4.5	4.5	4.6	4.6	4.7	4.8	5.1	5.2
Medicare	1.7	2.6	0.3	0.0	1.9	2.2	1.4	3.2	4.7	5.2	5.2	4.7	4.8	5.0	4.7	4.0
Private health insurance[2]	5.9	4.1	1.8	2.3	3.3	4.5	5.0	5.9	5.2	5.1	4.2	4.6	4.7	4.7	4.7	4.6
Average annual growth in prices and economic output																
CPI-U	1.6	3.2	2.1	1.5	1.6	0.1	1.2	2.4	2.3	2.3	2.4	2.4	2.4	2.4	2.4	2.4
CPI-M[3]	3.4	3.0	3.7	2.5	2.4	2.6	3.8	3.8	4.3	4.2	4.2	4.2	4.2	4.2	4.2	4.2
GDP	3.8	3.7	4.1	3.3	4.2	3.7	2.9	4.2	3.9	3.6	3.5	3.8	3.9	4.0	4.0	4.0

TABLE 1. (continued)

Notes: Figures represent growth over the prior year. CPI-U is consumer price index for all urban consumers. GDP is gross domestic product.

[1] Per enrollee Medicaid spending growth includes federal and state spending on Medicaid benefits and administration.

[2] Private health insurance includes employer-sponsored coverage and direct purchase coverage and medical spending and corresponding net costs of property and casualty insurance. Direct purchase coverage includes Medicare supplemental and individually-purchased plans, including plans purchased on the exchanges (OACT 2017b).

[3] CPI-M projections are from the Office of the Actuary (OACT), Centers for Medicare & Medicaid Services. The Congressional Budget Office (CBO) projected that CPI-M would grow at an average annual rate of 3.7 percent from 2017–2026 in their scoring of the American Health Care Act (CBO 2017a).

Sources: MACPAC compilation of data from the Bureau of Labor Statistics (BLS 2017), CBO (CBO 2017b), and OACT (OACT 2017a, 2017b).

Per Capita Cap Growth Factors in the AHCA and BCRA

Both the American Health Care Act (AHCA, H.R. 1628), which passed the House on May 4, 2017 and the Better Care Reconciliation Act of 2017 (BCRA), the Senate discussion draft released on June 22, 2017, would change Medicaid financing from the current open-ended structure to a per capita cap system. Establishing the per capita caps includes calculating provisional target spending per enrollee for FY 2019 and then using that target to project the per capita caps going forward, starting in FY 2020.The AHCA and BCRA use CPI-M as the rate of growth in calculating the per capita caps for children, non-expansion adults, and expansion adults, and uses CPI-M plus one percentage point for individuals over age 65 and people with disabilities through FY 2024.[4] After FY 2024, AHCA continues to use these same growth factors, while BCRA uses CPI-U for all Medicaid populations.

Provisional target for FY 2019. Under AHCA, the first step in establishing a per capita cap is calculating provisional FY 2019 target spending per enrollee for each eligibility group. In establishing the provisional FY 2019 targets, a ratio is calculated comparing overall FY 2016 spending that has been trended forward to FY 2019 using CPI-M to the actual overall FY 2019 spending.[5] This ratio is then used to adjust the FY 2019 spending per enrollee for each eligibility group using the cumulative trend over this three-year period (Table 2). This calculation to adjust FY 2019 spending is based on overall per enrollee spending and does not take into account any potential changes in enrollee mix from FYs 2016–FY 2019. The cumulative trend under both bills is lower than the cumulative trend in projected change in spending for the disabled, child, and non-expansion adult enrollees groups, but the trend is the same or higher for individuals over age 65 and the new adult group.

The BCRA methodology for establishing the provisional FY 2019 cap is similar to the AHCA but differs in one key way. Instead of using FY 2016 as the base year, BCRA allows states to choose a period of eight consecutive fiscal quarters between the first quarter of FY 2014 and third quarter of FY 2017. Spending in this two-year period is divided by two to make it an annual number.

TABLE 2. Projected Growth in Medicaid Spending Per Enrollee by Eligibility Group under Current Law Compared to the AHCA and BCRA Growth Factor, FYs 2017–2019

Fiscal year	AHCA and BCRA growth factor (CPI-M)	Change in spending per enrollee				
		Aged	Disabled	Child	Non-expansion adult	New adult
2017	3.8%	3.4%	4.2%	3.5%	5.0%	-6.3%
2018	4.3	4.5	4.5	4.9	5.3	-3.3
2019	4.2	4.3	4.7	4.9	5.3	5.4
2017–2019 cumulative trend	**12.8**	**12.8**	**14.0**	**13.9**	**16.3**	**-4.5**

Notes: Figures represent growth over the prior year. AHCA is American Health Care Act. BCRA is Better Care Reconciliation Act. CPI-M is the medical care component of the consumer price index for all urban consumers. Annual change in spending per enrollee calculated using Centers for Medicare & Medicaid Services Office of the Actuary (OACT) projections for benefit spending per enrollee. These figures include some spending (e.g., disproportionate share hospital payments, Medicare cost sharing) and populations (e.g., partial benefit enrollees) that would not be included under the AHCA's per capita cap.

Sources: MACPAC analysis of OACT, 2017, *2016 Actuarial report on the financial outlook for Medicaid*.

Per capita caps starting in FY 2020. Once the provisional FY 2019 per capita target amounts for each eligibility group have been calculated, they are inflated to FY 2020, the first year subject to the per capita cap, and all subsequent years using the growth factors specified for each eligibility group. The AHCA uses CPI-M as the growth factor for children, non-expansion adults, and new adults. For people over age 65 and people with disabilities, it is CPI-M plus one percentage point (Table 3). The BCRA uses the same growth factors through FY 2024, after which the growth factor is CPI-U for all enrollee groups.

Expected impact. The CMS Office of the Actuary estimates that the growth for the child, non-expansion adults, and new adults from FYs 2020–2025 will be higher than the growth rate specified in the AHCA and BCRA. For people over age 65 and people with disabilities, the growth in spending per enrollee is similar to or below the specified AHCA rate and the BCRA rate through FY 2024 due to the additional 1 percentage point added to CPI-M (Table 3). In FY 2025, the growth in spending per enrollee for these groups is projected to be higher than the BCRA growth rate.

TABLE 3. Projected Growth in Medicaid Spending per Enrollee by Eligibility Group under Current Law Compared to AHCA and BCRA Growth Factors, FYs 2020–2025

	2020	2021	2022	2023	2024	2025 +
Aged and disabled						
AHCA growth factor (CPI-M +1)	5.2%	5.2%	5.2%	5.2%	5.2%	5.2%
BCRA growth factor (CPI-M +1/CPI-U)[1]	5.2	5.2	5.2	5.2	5.2	2.4
Projected spending current law - aged	4.1	3.9	4.0	4.1	4.3	4.4
Projected spending current law - disabled	4.8	5.0	5.1	5.2	5.3	5.3
Child, non-expansion adult, expansion adult						
AHCA growth factor (CPI-M)	4.2%	4.2%	4.2%	4.2%	4.2%	4.2%
BCRA growth factor (CPI-M/CPI-U)[1]	4.2	4.2	4.2	4.2	4.2	2.4
Projected spending current law-child	4.8	4.8	4.9	4.9	5.0	5.0
Projected spending current law-non-expansion adult	5.2	5.1	5.2	5.2	5.3	5.3
Projected spending current law-expansion adult	5.6	5.5	5.5	5.5	5.6	5.6

Notes: Figures represent growth over the prior year. AHCA is American Health Care Act. BCRA is Better Care Reconciliation Act. FY is fiscal year. CPI-M is the medical care component of the consumer price index for all urban consumers. CPI-U is the consumer price index for all urban consumers. Annual change in spending per enrollee calculated using Centers for Medicare & Medicaid Services Office of the Actuary (OACT) projections for benefit spending per enrollee. These figures include some spending (e.g., DSH, Medicare cost-sharing) and populations (e.g., partial benefit enrollees) that would not be included under the AHCA per capita cap.

[1] Beginning in fiscal year 2025, the BCRA reduces the growth factor from CPI-M plus one percentage point for the aged and disabled, and CPI-M for children and adults to CPI-U.

Sources: MACPAC analysis of OACT, 2017, *2016 Actuarial report on the financial outlook for Medicaid.*

A state may spend more or less than the per capita cap amount for any particular individual or across an eligibility group, but the federal match would only be available up to the aggregate amount of spending as determined by the per capita caps; that is, the product of the per capita cap for each eligibility group and the number of enrollees in each eligibility group. States would be responsible for financing any spending above the per capita caps.

Endnotes

[1] State fiscal years typically run from July 1 through June 30.

[2] For example, the Congressional Budget Office used the consumer price index for all urban consumers (CPI-U) to project spending under a proposal that would cap federal Medicaid spending in their most recent publication on options for reducing the deficit (CBO 2016).

[3] Adults tend to cost less per person than other eligibility groups, with the exception of children who cost least on average. See CBO projections of per person costs in its most recent baseline projections from January 2017 (CBO 2017c).

[4] The BCRA excludes from the per capita caps children under age 19 who qualify for Medicaid on the basis of being blind or disabled. This population of children is included in the per capita caps under AHCA.

[5] FY 2016 spending per enrollee is trended forward to FY 2019 based on the percentage increase in CPI-M from September 2016 to September 2019. This trended FY 2016 spending per enrollee is then multiplied by the total number of FY 2019 enrollees to calculate a total spending amount. A ratio is calculated based on the trended FY 2016 total spending amount divided by the actual FY 2019 total spending.

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