

# Medicaid Block Grants and per Capita Caps: The Coronavirus Highlights Risks to States

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*Timely Analysis of Immediate Health Policy Issues*

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## Introduction

In a January 30, 2020, letter to state Medicaid directors, the Centers for Medicare & Medicaid Services (CMS) announced a new opportunity for states to obtain more flexibility in the administration and design of their Medicaid programs in exchange for accepting a limit on their federal program support in the form of either a block grant or a per capita cap.<sup>1,2</sup> This initiative known as the Healthy Adult Opportunity (HAO) would permit states to apply for block grants or per capita caps that would apply to spending on enrollees who were made eligible under the Affordable Care Act (ACA) expansions and their adult beneficiaries who are not disabled and are covered at state option (including any such groups who might be added in the future). The outbreak and recent spread of the COVID-19 coronavirus has made the risks of block grants and per capita caps even more real. In this brief, we discuss various problems with block grants and per capita caps and why they are a flawed policy in general and especially in these times.

The HAO block grant would be based on current expenditures for the affected populations and would grow at the medical component of the consumer price index (CPI-M) plus 0.5 percent; the per capita cap would be based on current expenditures per enrollee and would grow at CPI-M. In exchange for accepting the cap on federal funding, states would have new flexibility over

eligibility and enrollment, which could allow for changes such as reducing income standards, cutting retroactive eligibility, and ending presumptive eligibility; the ability to limit benefits; the latitude to establish drug formularies; and the ability to charge premiums and cost sharing up to 5 percent of an enrollee's income. States would have to maintain 80 percent of current spending. Savings would be shared with the federal government. The federal share would be split with the state based on the state's current federal matching rate (e.g., if the federal matching rate is 60 percent, the state would receive 60 percent of any savings to the federal government).

Block grants have been a part of Republican policy proposals since the Reagan era<sup>3</sup> (per capita caps are a more recent addition). In 1995, a block grant proposal passed both the House and Senate but was vetoed by President Clinton. Additional attempts to enact block grants were mounted in subsequent years. The rationale has been that Medicaid spending is out of control and places unacceptable burdens on the federal and state budgets. Because of the federal matching rate structure (the federal government pays 50 percent to 75 percent of Medicaid costs, varying inversely with each state's per capita income, and 90 percent of the costs of adults made newly eligible by the ACA), states pay much less than the full cost of additional enrollees and benefits. Because of this, block grant proponents argue that states have little incentive

to be efficient. Moreover, they argue, Medicaid's rigid structure does not allow states to control spending, even if they wanted to limit program growth.

The argument against block grants is that they lock states into an amount of money that could grow at an inadequate rate and thus force states to make cutbacks that would harm Medicaid beneficiaries and inadequately compensate providers.<sup>4</sup> Furthermore, the argument for giving states more flexibility ignores that they already have considerable flexibility; 53 percent of overall spending is on optional beneficiaries and/or services not required by federal law or regulation.<sup>5</sup> States that take the block grant option would be particularly vulnerable during economic downturns, when people lose jobs, incomes, and employer-sponsored health insurance and become eligible for Medicaid. Medicaid rolls would increase, and states would not have the resources to support them.

In response to the concerns about the consequences of rising enrollment, a variant of block grants called per capita caps became a popular alternative in Republican proposals. These proposals would protect states from the additional spending associated with enrollment growth in bad economic times but limit per capita spending growth. Although per capita caps would address unexpected enrollment growth, they would not protect states against spikes in per enrollee spending such as those associated with the COVID-19 coronavirus or the rapid

introduction of expensive drugs (like those to treat hepatitis C) and health crises like the opioid epidemic.

In anticipation of the HAO guidance from the Centers for Medicare & Medicaid Services, several states developed their own proposals. In September 2019, Tennessee released the most developed variant, and it served as a model for what eventually came from CMS.<sup>6,7,8</sup> Tennessee proposed a hybrid—a block grant if the state could lower spending but a per capita cap that would allow spending to increase if enrollment increased unexpectedly. The state proposed that its per enrollee spending growth rate be set at the rate forecast by the Congressional Budget Office (CBO). The proposal also establishes a spending baseline tied to the levels that would have occurred had the 1994 TennCare Section 1115 waiver not been approved. The state argued that the waiver had reduced spending for which it should get credit. The proposal also would have given Tennessee a large amount of flexibility. The state also proposed a “shared savings approach” model under which the state would not only save on its own financial commitments but also get a percentage of federal savings equal to the state’s existing federal matching rate.

The CMS-issued proposal could have limited appeal. States most likely to accept a block grant in exchange for increased flexibility are politically conservative. But these states for the most part have not adopted the Medicaid expansion at the heart of the CMS proposal, nor have they typically covered large optional adult populations (although some states may

find Medicaid expansion more politically acceptable under conditions of a block grant or a per capita cap). States that have adopted the Medicaid expansion would likely be fearful of entering any arrangement to cap unexpected growth in enrollment or spending. But the CMS proposal could be a “foot in the door” and could be extended to other populations, with perhaps different formulas for growth in federal spending.

### Three Issues with Block Grant and per Capita Cap Proposals

#### Establishing Appropriate Growth Rates Is Difficult

In this brief, we argue that block grant or per capita cap proposals have three essential problems. The first is that even with all possible efficiencies, it is extraordinarily difficult to establish a growth rate that will accommodate the spending growth needed to provide adequate health care for Medicaid-eligible low-income populations even in normal times. It is also possible that the growth rates would be too high, causing federal spending to be larger than it otherwise would be.<sup>9</sup> Small differences in growth rates in block grant or per capita limits and growth in spending in the absence of a cap can grow to be quite large gaps over a several year period. We discuss the other two essential problems in later sections.

The CMS letter to state Medicaid directors proposed that the growth rate of block grants be CPI-M plus 0.5 percent and that per capita caps grow at CPI-M. From 2010 through 2018, the CPI grew by an average of 1.8 percent per year,

while CPI-M grew by an average of 2.9 percent.<sup>10</sup> The growth in CPI-M is slightly higher than recent growth in Medicaid spending per enrollee but is well below the growth in overall Medicaid spending. More ominously, it is below the growth in Medicaid spending and spending per enrollee projected by CMS for 2019 through 2027 and by CBO for adults for 2019 through 2028. (These projections were prior to the coronavirus outbreak)

As shown in Table 1, CMS is projecting Medicaid spending to increase by 6.0 percent annually.<sup>11</sup> It projects that enrollment will grow by 1.2 percent and spending per enrollee by 4.8 percent. CBO projects that overall spending (for adults) will increase by 6.1 percent annually from 2019 through 2028, with enrollment growing by 0.6 percent and spending per enrollee growing by 5.3 percent.<sup>12</sup> These projected growth rates for overall spending are well above the 2.9 percent growth in CPI-M recently. On the other hand, per enrollee spending growth rates projected by CBO and CMS are considerably higher than those seen in the previous decade. Both agencies seem to be arguing that the previous decade was an aberration and have predicted growth rates closer to those seen in the previous two decades. If either projection is correct, the growth rates in the CMS letter will not be large enough to pay for program costs without changes to Medicaid. Agreeing to the CMS growth rate could force states to cut enrollment, benefits, or both.

Neither the CMS nor the CBO projection takes into account the possibility of a recession, now increasingly likely. During

**Table 1. Average Annual Growth in Medicaid Spending, Enrollment, and Spending per Enrollee (Actual and Forecast - Selected Time Periods)**

	Spending	Enrollment	Spending per Enrollee
2010–18 (CMS)	5.2%	3.8%	1.4%
2019–27 (CMS)	6.0%	1.2%	4.8%
2019–28 (CBO)	6.1%	0.6%	5.3%

Sources:

Urban Institute analysis of CMS data used in Hartman M, Martin AB, Benson J, Catlin A, and the National Health Expenditure Accounts Team. (2020). National Health Care Spending in 2018: Growth Driven By Accelerations in Medicare And Private Insurance Spending. Health Affairs: Vol. 39, No. 1. <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2019.01451>.

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Congressional Budget Office, “Medicaid—CBO’s May 2019 Baseline” (May 2019), <https://www.cbo.gov/system/files/2019-05/51301-2019-05-medicaid.pdf>.

**Figure 1. Annual Growth Rate in Medicaid Enrollment from 2000 to 2018**

Source: Urban Institute analysis of the Centers for Medicare & Medicaid Services national health expenditure accounts. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical>.

the most recent recession, Medicaid enrollment growth increased by 3.5 percent in 2008, 7.8 percent in 2009, and 6.1 percent in 2010, following no growth or a decline in enrollment in 2006 and 2007 (Figure 1).<sup>13</sup> Enrollment growth was also elevated in the early years of the 2010s because of residual effects of the Great Recession. Enrollment then spiked with the introduction of the ACA. In the case of a recession, states that had moved to a block grant or per capita caps would have to make drastic cuts or appeal to the federal government to relax the conditions of the block grant or per capita caps.

If the growth rates projected for the next decade by both CMS and CBO are close to accurate, states could achieve savings only by making dramatic reductions in enrollment and benefits. In other words, if their spending were to otherwise grow at rates forecast by CBO and CMS, they would have to make major changes to live within the spending increase caps of the CPI-M or CPI-M plus 0.5 percent.

There is also the possibility that CMS could approve block grants or per capita caps with higher growth rates in the future. The Tennessee proposal, for example, recommended that future growth in

spending per enrollee be set at CBO levels. This would at least be consistent with CMS and CBO projections. But if Medicaid spending per enrollee instead grew at the low rates of the past decade, it would be relatively easy for a state to save money, which it could then split with the federal government. In this case, however, the federal government would be spending more than it would have without the block grant or per capita cap policy.

The remaining issues are that what problem the block grant or per capita cap initiatives are intended to solve is not clear. In the past, block grant proposals have been advocated as the solution to the Medicaid cost problem. However, the evidence does not support this argument. Specifically, the second issue is that Medicaid spending levels are low compared with those of other payers, and the third issue is that recent Medicaid growth rates have also been too low.

#### Medicaid Spending per Enrollee Has Not Been Excessive

Medicaid spending is said to be out of control largely because states do not have enough incentive to rein in cost

growth. That is, they pay 25 to 50 percent of the costs, so most of the dollar savings from any belt-tightening efforts would go to the federal government. Of course, a 10 percent reduction in overall spending would mean a 10 percent reduction in state spending. But even though the incentives would seem to be in the direction of causing excessive spending levels, little evidence exists that this has occurred. (However, examples can be found, such as some supplemental payment programs.) Medicaid is the second-largest item in state budgets (from their own funds), and governors typically favor other priorities like K–12 and higher education.

Indeed, a large body of evidence shows that when researchers control for health status and demographic characteristics of populations, they find that Medicaid spending is lower than private health insurance spending. For example, using data from the Medical Expenditure Panel Survey from 1996 through 1999, Hadley and Holahan found that spending on people with Medicaid would be significantly greater if they were given private coverage (once adjustments were made for differences in health status, disability, chronic conditions, and demographic characteristics).<sup>14</sup>

**Table 2: Spending, Enrollment, and Spending per Enrollee in Medicare, Medicaid, and Private Insurance, 2006 through 2018**

	2006	2010	2013	2015	2018	2006-2018
<b>Medicare</b>						
<b>Spending (in millions)</b>	<b>\$403,690</b>	<b>\$519,783</b>	<b>\$588,928</b>	<b>\$648,783</b>	<b>\$750,182</b>	
Average annual growth rate		6.5%	4.3%	5.0%	5.0%	5.3%
<b>Enrollment (in millions)</b>	<b>42.4</b>	<b>46.6</b>	<b>51.3</b>	<b>54.3</b>	<b>58.7</b>	
Average annual growth rate		2.4%	3.3%	2.9%	2.6%	2.7%
<b>Spending per enrollee</b>	<b>\$9,521</b>	<b>\$11,154</b>	<b>\$11,480</b>	<b>\$11,948</b>	<b>\$12,780</b>	
Average annual growth rate		4.0%	1.0%	2.0%	2.3%	2.5%
<b>Medicaid</b>						
<b>Spending (in millions)</b>	<b>\$306,680</b>	<b>\$397,410</b>	<b>\$445,204</b>	<b>\$542,628</b>	<b>\$597,387</b>	
Average annual growth rate		6.7%	3.9%	10.4%	3.3%	5.7%
<b>Enrollment (in millions)</b>	<b>45.6</b>	<b>54.0</b>	<b>59.1</b>	<b>69.3</b>	<b>72.8</b>	
Average annual growth rate		4.3%	3.1%	8.3%	1.7%	4.0%
<b>Spending per enrollee</b>	<b>\$6,725</b>	<b>\$7,359</b>	<b>\$7,533</b>	<b>\$7,830</b>	<b>\$8,206</b>	
Average annual growth rate		2.3%	0.8%	2.0%	1.6%	1.7%
<b>Private</b>						
<b>Spending (in millions)</b>	<b>\$736,676</b>	<b>\$858,481</b>	<b>\$939,125</b>	<b>\$1,060,932</b>	<b>\$1,243,050</b>	
Average annual growth rate		3.9%	3.0%	6.3%	5.4%	4.5%
<b>Enrollment (in millions)</b>	<b>198.3</b>	<b>188.5</b>	<b>191.0</b>	<b>200.3</b>	<b>200.5</b>	
Average annual growth rate		-1.3%	0.4%	2.4%	0.0%	0.1%
<b>Spending per enrollee</b>	<b>\$3,715</b>	<b>\$4,554</b>	<b>\$4,917</b>	<b>\$5,297</b>	<b>\$6,200</b>	
Average annual growth rate		5.2%	2.6%	3.8%	5.4%	4.4%

Source: Urban Institute analysis of the Centers for Medicare & Medicaid Services national health expenditure accounts. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical>.

Note: Average annual growth rates for 2010, 2013, 2015, 2018 are from the prior year displayed in the table.

They found little difference between the service use of Medicaid beneficiaries and people with private insurance, and most of the difference in expenditures was due to differences in provider payment rates. Using data from 2003 through 2009, Coughlin, Long, Clemans-Cope, and Resnick found that Medicaid provided access to health care services comparable to employer-sponsored insurance, but at significantly lower costs.<sup>15</sup> Compared with employer-sponsored insurance, Medicaid coverage for the same population would be 22 percent less costly. In 2016, Clemans-Cope, Holahan, and Garfield reviewed 40 studies that were conducted from 2000 through 2015 and published in peer-reviewed journals or working papers and reports. After adjusting for the greater health needs of Medicaid enrollees, they found consistent evidence that per capita spending was

lower in Medicaid programs than in private insurance plans.<sup>16</sup>

A recent study by Blavin, Karpman, and Arnos examined whether ACA marketplace coverage was still more expensive than Medicaid or whether the intense competition in marketplaces and the presence of Medicaid plans as leading competitors had reduced spending levels in private coverage compared with those seen in Medicaid.<sup>17</sup> The results suggested that marketplace spending levels were higher, although they were not statistically significant. But when the same study compared Medicaid spending levels with those of all private employer-based (i.e. group) coverage, it found that Medicaid spending was about \$800, or about 13.5 percent, lower for people with the same characteristics. That is, for people with the same health conditions, age, sex, race, marital

status, and other factors, their health care spending would be lower if they got their health insurance through Medicaid rather than private group insurance.

### Medicaid Spending per Enrollee Growth Rates Are Also Low

As noted, Medicaid growth rates are low compared with those of other payers.<sup>18</sup> Despite the supposedly weak incentives, states have many tools to control spending and recently have generally exercised these aggressively. Cost containment methods used by states include lowering provider payment rates, aggressively using managed care, and moving people out of nursing homes, or at least halting the growth of nursing home use. Medicaid also has large drug rebates, greater than those offered to any other private or public payer.

Table 2 shows that annual spending per enrollee growth rates between 2010 and 2013, between 2013 and 2015, and between 2015 and 2018 were considerably lower for Medicaid than for private insurance.<sup>18,19</sup> The per enrollee growth rates for Medicaid were also somewhat lower than those for Medicare. Medicaid spending growth has mostly been driven by enrollment growth caused by the economy and the ACA coverage expansion. Medicaid enrollment grew by 4.3 percent per year between 2006 and 2010 largely as a result of the Great Recession. Enrollment grew by 3.1 percent per year between 2010 and 2013, reflecting the continued impact of slow economic growth. Between 2013 and 2015, enrollment grew by 8.3 percent per year because of the ACA expansion. Enrollment growth then slowed to 1.7 percent between 2015 and 2018 and is

forecast to be even slower over the next decade. Spending per enrollee remained low between 2006 and 2018, averaging about 1.7 percent per year. This is well below the average annual growth rate for private insurance, 4.4 percent.

### Conclusion

Block grant and per capita cap proposals are difficult to design so that they will not cause harm. Caps on spending growth could too easily result in reductions in coverage and benefits because of budgetary pressures when the nation still has 32 million uninsured people. These caps are particularly harmful in times like today, as the nation is trying to cope with the coronavirus. There are also scenarios in which the federal government could end up spending more than it otherwise would in certain circumstances. These

risks are unwarranted given the lack of evidence of a Medicaid cost problem; a large number of studies show that Medicaid programs have aggressively pursued cost containment and have spending levels below those of private payers for comparable populations. Moreover, Medicaid growth rates have been below those of other payers.

States' desire for more flexibility is understandable, but flexibility could lead to harmful cuts. That the federal government's Medicaid contribution to states ultimately comes from taxpayers in other states strongly implies that a federal consensus on how that money is used is warranted—that is, what national standards should exist and what state discretion or flexibility should be permitted.

## NOTES

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