



## Longer-Term Effects of the Better Care Reconciliation Act of 2017 on Medicaid Spending

In the Congressional Budget Office's assessment, Medicaid spending under the Better Care Reconciliation Act of 2017 would be 26 percent lower in 2026 than it would be under the agency's extended baseline, and the gap would widen to about 35 percent in 2036 (see Figure 1). Under CBO's extended baseline, overall Medicaid spending would grow 5.1 percent per year during the next two decades, in part because prices for medical services would increase. Under this legislation, such spending would increase at a rate of 1.9 percent per year through 2026 and about 3.5 percent per year in the decade after that.

CBO and the staff of the Joint Committee on Taxation do not have an insurance coverage baseline beyond the coming decade and therefore are not able to quantify the legislation's effect on insurance coverage over the longer term. However, the agencies expect that after 2026, enrollment in Medicaid would continue to fall relative to what would happen under the extended baseline.

On the basis of consultation with the budget committees, CBO's just-released cost estimate for the bill measured the costs and savings relative to CBO's March 2016 baseline projections, with adjustments for legislation that was enacted after that baseline was produced.<sup>1</sup> For consistency, this longer-term analysis uses CBO's extended baseline published in July 2016.<sup>2</sup> CBO analyzed these longer-term effects at the request of the Ranking Members of the Senate Budget Committee and the Senate Finance Committee.

### CBO's Extended Baseline

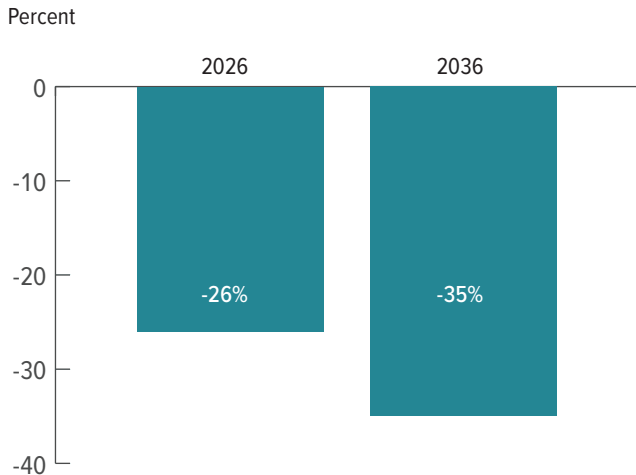
The first 10 years of projections in CBO's extended baseline match the agency's 10-year baseline projections, which are based on a detailed analysis of the Medicaid program. Beyond the coming decade, however, projecting federal spending on Medicaid becomes increasingly difficult because of the considerable uncertainties involved. A wide range of changes could occur—in people's health, in states' decisions about Medicaid eligibility and covered benefits, and in the delivery of medical care—that are almost impossible to predict but that could nevertheless have a significant effect on federal spending on Medicaid. Therefore, for the projections beyond 2026, CBO has adopted a formulaic approach—one that combines estimates of the number of enrollees with fairly mechanical projections of growth in federal spending on Medicaid per enrollee (adjusted to account for demographic changes in Medicaid enrollees). That straightforward approach, which was designed to help make long-term projections of federal deficits and debt, can be usefully applied only when analyzing proposed changes in law that, like this bill, would affect spending in a similarly straightforward manner.

The agency's estimates of per-enrollee growth in spending combine projected growth in potential gross domestic product (GDP) per person and projected excess cost growth for Medicaid, which together average 4.3 percent in CBO's extended baseline during the 2027–2036 period. Potential GDP expresses an estimate of the maximum sustainable level of growth in the economy. Excess cost growth is the growth rate of health care spending per person (after the effects of demographic changes are removed) relative to the growth rate of potential GDP per person. (CBO uses potential GDP rather than actual GDP in its estimate of excess cost growth to limit the effect of cyclical changes in the economy on its estimate.) The concept of excess cost growth and its phrasing are not intended to imply that growth in health care

1. Congressional Budget Office, cost estimate for H.R. 1628, the Better Care Reconciliation Act of 2017, an amendment in the nature of a substitute [LYN17343] as posted on the website of the Senate Committee on the Budget on June 26, 2017 (June 26, 2017), [www.cbo.gov/publication/52849](http://www.cbo.gov/publication/52849).
2. Congressional Budget Office, *The 2016 Long-Term Budget Outlook* (July 2016), [www.cbo.gov/publication/51580](http://www.cbo.gov/publication/51580).

Figure 1.

### Changes in Medicaid Spending Under the Better Care Reconciliation Act Compared With CBO's Extended Baseline



Source: Congressional Budget Office.

These estimates are for the Better Care Reconciliation Act of 2017, a Senate amendment in the nature of a substitute to H.R. 1628.

Estimates are based on CBO's July 2016 extended baseline.

spending per person is necessarily excessive or undesirable; the term is used simply to describe the extent to which the growth in such spending exceeds the growth in potential output per person.

For Medicaid, the rate of excess cost growth is projected to be 0.7 percent in 2027 and to rise over the subsequent decade. In 2036, the rate is projected to be 0.9 percent, close to its 1985–2014 average of 1.0 percent. That trajectory of excess cost growth reflects competing pressures that are expected to affect the program. On the one hand, states are likely to face pressure—stemming from physicians' practice patterns, new technology, and other factors in the broader health care system—to increase payments to health care providers so that they continue to treat Medicaid enrollees. On the other hand, as health care costs rise, states are also expected to face pressure to slow the growth of spending for the program through actions—such as delivering services more efficiently, constraining payment rates for providers and managed care plans, limiting the optional services that Medicaid covers, or restricting the eligibility of certain groups—that would reduce both state and federal expenditures.

### Effects of the Legislation

The largest effects on spending under the Better Care Reconciliation Act of 2017 would be for Medicaid. Most of those effects would stem from three major provisions:

- Upon enactment, the legislation would eliminate penalties associated with the requirements that most people obtain health insurance coverage and that large employers offer their employees coverage that meets specified standards.
- Starting in 2020, the growth in per-enrollee payments for nondisabled children and nondisabled adults enrolled in Medicaid would be capped at no more than the medical care component of the consumer price index (CPI-M) and for most enrollees who are disabled adults or age 65 or older at no more than the CPI-M plus 1 percentage point. Starting in 2025, the rate of growth in per-enrollee payments for all groups would be pegged to the consumer price index for all urban consumers (CPI-U).
- Starting in 2021, the bill would reduce the federal matching rate for funding for adults made eligible for Medicaid by the Affordable Care Act (ACA); that rate would decline 5 percentage points per year through 2023 and then fall to equal the rate for other enrollees in a state in later years.

Overall, including all provisions affecting Medicaid, CBO estimates that spending for the program would be reduced by \$160 billion in 2026 compared with projections under current law.

Although it is generally not possible for CBO to provide detailed estimates of the effects of changes in the nation's health care and health insurance systems beyond the 10-year projection period used for cost estimates, the agency has developed a rough outlook for the decade following the 2017–2026 period by grouping the elements of the legislation into two broad categories and assessing the rate at which the budgetary impact of each of those broad categories is likely to increase over time:

- CBO separated out the portion of Medicaid spending in 2026 that would be affected by changes proposed by the bill. For that portion, CBO approximated spending growth, accounting for the changes to the expansion of Medicaid eligibility authorized by the ACA and for the per capita caps.

- CBO approximated the remainder of Medicaid spending using the growth rate of such spending in the agency's extended baseline.

As always, CBO has endeavored to develop budgetary estimates that are in the middle of the distribution of potential outcomes. Such estimates are inherently inexact because the ways in which federal agencies, states, insurers, employers, individuals, doctors, hospitals, and other affected parties would respond to the changes made by this legislation are all difficult to predict.

### Per Capita Caps for Medicaid

The per capita caps under this legislation would constrain Medicaid spending in stages. Beginning in fiscal year 2020, the federal government would limit the amount of reimbursement it provides to states. That limit would be set for a state by calculating the average per-enrollee cost of medical services for most enrollees who received full Medicaid benefits over eight consecutive quarters of the state's choosing between the first quarter of federal fiscal year 2014 and the third quarter of 2017. Those enrollees would be in five specified categories: the elderly, disabled adults, nondisabled children, adults made eligible for Medicaid by the ACA, and all other adults. The Secretary of Health and Human Services would then inflate the average per-enrollee costs for each state as described—for most nondisabled children and nondisabled adults enrolled in Medicaid using the CPI-M and for most enrollees who are disabled adults or age 65 or older using the CPI-M plus 1 percentage point. Disabled children would be excluded from the per capita caps and covered as under current law. Beginning in 2025, the Secretary would shift the inflation factor for all groups to the CPI-U. The final limit on federal reimbursement for each state starting in 2020 would be the average cost per enrollee for the five specified groups of enrollees, reflecting growth from the base period in the relevant inflation factors multiplied by the number of enrollees in each category. The amount of spending subject to those limits would be a large share of total spending.

If a state spent more than the amount eligible for federal reimbursement, the federal government would provide no reimbursement for spending over the limit. By CBO's projections for the 2017–2024 period, the

limit on federal reimbursement would reduce outlays because Medicaid spending, on a per-enrollee basis, for nondisabled children and nondisabled adults under current law (after the changes to the Medicaid expansion population have been accounted for) would grow faster, at 4.9 percent, than the CPI-M, at 3.7 percent. However, for most enrollees who are disabled adults or age 65 or older, that rate under current law would be 3.3 percent, lower than the CPI-M plus 1 percentage point. The per capita caps would have a small effect on spending for those groups, even though the caps would not generally be binding for them, because some shifting of costs among groups would probably occur, and spending for a particular group in a particular year could be affected.

In 2025 and beyond, the differences between spending growth for Medicaid under current law and the growth rate of the per capita caps for all groups would be substantial. CBO projects the growth rate of the CPI-U in those years to be 2.4 percent.

### Effects on Spending

Over the next decade, CBO projects, a large gap would grow between Medicaid spending under current law and under this bill. In later years, that gap would continue to widen because of the compounding effect of the differences in spending growth rates. CBO projects that the growth rate of Medicaid under current law would exceed the growth rate of the per capita caps for all groups covered by the caps starting in 2025.

In CBO's extended baseline, Medicaid spending is projected to be 2.0 percent of GDP in 2017 and 2.4 percent by 2036. The 35 percent reduction in that spending that CBO estimates for 2036 under this legislation would result in Medicaid spending of 1.6 percent of GDP.<sup>3</sup>

3. CBO generally presents long-term estimates as percentages of GDP and not in nominal dollars. In the agency's judgment, a presentation in nominal dollars can be misleading. The key problem is that a dollar today means something very different from a dollar in the distant future, for at least two reasons. First, the cumulative effect of changes in prices over a long period can be quite large, so a dollar amount in the distant future will have much lower value than the same dollar amount today. Second, the population, the economy, and people's incomes will all grow substantially over time, so a dollar amount in the distant future will be much smaller relative to the size of the economy or a person's income than the same dollar amount today.

Under this legislation, after the next decade, states would continue to need to arrive at more efficient methods for delivering services (to the extent feasible) and to decide whether to commit more of their own resources, cut payments to health care providers and health plans, eliminate optional services, restrict eligibility for enrollment, or adopt some combination of those approaches. Over the long term, there would be increasing pressure on more states to use all of those tools to a greater extent.

This document was requested by the Ranking Member of the Senate Committee on the Budget and the Ranking Member of the Senate Committee on Finance. Jeffrey Kling prepared it with guidance from Holly Harvey and with contributions from Xiaotong Niu, Lisa Ramirez-Branum, Michael Simpson, and Robert Stewart. Jessica Banthin, Chad Chirico, Theresa Gullo, Mark Hadley, and David Weaver reviewed the document, John Skeen edited it, and Casey Labrack prepared it for publication. An electronic version is available on CBO's website ([www.cbo.gov/publication/52859](http://www.cbo.gov/publication/52859)).



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