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Medicaid Per Capita Cap Would Shift Costs and Risks to States and Harm Millions of Beneficiaries

By Edwin Park

House Republican leaders have announced that they plan to include either a Medicaid “per capita cap” or a Medicaid block grant, or give states a choice between the two, as part of the legislation to repeal the Affordable Care Act (ACA) that House committees will consider in March.¹ A Medicaid block grant² and a per capita cap are much more alike than different as they would both radically restructure Medicaid’s federal financing system and cut federal Medicaid funding for states over time. This would shift significant costs and risks to states while harming tens of millions of vulnerable low-income beneficiaries who rely on the program.³

Per Capita Cap Would Restructure Medicaid Financing and Shift Costs to States

The federal government now pays a fixed share of states’ Medicaid costs, varying by state but averaging about 64 percent. Previous congressional Republican budget and health plans have proposed converting Medicaid into a block grant or imposing a per capita cap.⁴ Both would

¹ See Jennifer Haberkorn, “Obamacare repeal-replace effort begins to jell,” *Politico*, February 7, 2017, <http://www.politico.com/story/2017/02/obamacare-repeal-replace-effort-begins-to-gel-234769> and Jacob Leibenluft *et al.*, “House Republicans Would Reverse ACA Coverage Gains and Radically Overhaul Medicaid, New Talking Points Confirm,” Center on Budget and Policy Priorities, February 17, 2017, <http://www.cbpp.org/research/health/house-republicans-would-reverse-aca-coverage-gains-and-radically-overhaul-medicaid>.

² Edwin Park, “Medicaid Block Grant Would Slash Federal Funding, Shift Costs to States, and Leave Millions More Uninsured,” Center on Budget and Policy Priorities, November 30, 2016, <http://www.cbpp.org/research/health/medicaid-block-grant-would-slash-federal-funding-shift-costs-to-states-and-leave>.

³ For further discussion of Medicaid per capita cap proposals, see Edwin Park and Matt Broaddus, “Medicaid Per Capita Cap Would Shift Costs to States and Place Low-Income Beneficiaries at Risk,” Center on Budget and Policy Priorities, October 5, 2012, <http://www.cbpp.org/research/medicaid-per-capita-cap-would-shift-costs-to-states-and-place-low-income-beneficiaries-at> and Edwin Park, “Medicaid Per Capita Cap Would Shift Costs to States and Undermine Key Part of Health Reform,” Center on Budget and Policy Priorities, May 8, 2013, <http://www.cbpp.org/research/medicaid-per-capita-cap-would-shift-costs-to-states-and-undermine-key-part-of-health-reform>.

⁴ For example, as part of his “Better Way” health plan, Speaker Ryan proposed last year to give states the choice of either a per capita cap or block grant. Edwin Park and Judith Solomon, “Per Capita Caps or Block Grants Would Lead to Large and Growing Cuts in State Medicaid Programs,” Center on Budget and Policy Priorities, June 22, 2016,

radically restructure Medicaid's financing and have similar, deleterious effects on states and beneficiaries. A block grant would cap federal funding for a state's Medicaid program, with a state responsible for any costs above the block grant amount. A per capita cap would cap federal Medicaid funding per beneficiary. In other words, the federal government would pay its share of a state's Medicaid costs only up to a fixed amount per beneficiary. The state would be responsible for *all* costs above that per-beneficiary cap.

Per Capita Cap Would Cut Federal Medicaid Funding for States

Like a block grant, a per capita cap is meant to produce significant federal budgetary savings over time. That would be accomplished by setting the cap for each state *significantly below* what the federal government is projected to spend under current law and/or adjusting the cap by a rate well below expected cost growth. Some proposals, for example, would initially set the cap based on states' current per-beneficiary spending and then raise it each year by overall inflation or less; historically, health costs have outpaced inflation, so the annual federal funding cuts would grow over time. Further savings could be achieved by also setting the initial cap amounts below states' current or historical levels of federal Medicaid spending per beneficiary.

But even that formula doesn't fully capture the magnitude of the cuts that states could face. As under a block grant, the federal funding cuts states actually experience could be much larger than the difference between currently projected federal spending and the cap amounts states receive, because a per capita cap would shift financial risk to states for additional unanticipated costs or costs for which a per capita cap wouldn't account:

- **Faster health care cost growth system-wide.** Costs throughout the health care system have grown at historically low rates in recent years. For example, the Congressional Budget Office (CBO) has lowered its projection of federal Medicaid spending for the decade from 2011 to 2020 by \$311 billion — or 9.3 percent — since 2010, largely due to slower-than-expected growth in per-beneficiary costs.⁵ (These projections exclude health reform's Medicaid expansion.) Setting per capita cap amounts now would require an assumption of how much of this slowdown is permanent (due in part to the ACA) and how much is temporary. If policymakers assume incorrectly, actual per-beneficiary Medicaid costs could be significantly higher than a per capita cap assumed, meaning states would face even deeper federal funding cuts, relative to current law.
- **Aging of the population.** As the population ages, a larger share of Medicaid beneficiaries will be seniors and people with disabilities, whose average health care spending is about five times higher than children and other adults. Some per capita cap proposals claim to address this issue by setting separate caps for seniors and other beneficiary groups. But as the baby boomers age, a growing share of seniors will move from “young-old age” to “old-old age.”

<http://www.cbpp.org/research/health/per-capita-caps-or-block-grants-would-lead-to-large-and-growing-cuts-in-state>. As part of the House Republican budget plan for fiscal year 2017, then-House Budget Committee chair (and now Health and Human Services Secretary) Tom Price similarly proposed to give states a choice of a per capita cap or block grant, in order to reduce federal Medicaid spending by about \$1 trillion over ten years (on top of repeal of the Medicaid expansion). Edwin Park, “Medicaid Spending Per Beneficiary Would Shrink by Half Under House Budget's Per Capita Option,” Center on Budget and Policy Priorities, April 8, 2016, <http://www.cbpp.org/blog/medicaid-spending-per-beneficiary-would-shrink-by-half-under-house-budgets-per-capita-cap>.

⁵ CBPP analysis comparing CBO's August 2010 and January 2016 Medicaid and Affordable Care Act baselines.

People in their 80s or 90s have more serious and chronic health problems and are more likely to require nursing home and other long-term care than younger seniors. For example, seniors aged 85 and older incurred average Medicaid costs in 2011 that were more than *2.5 times higher* than those aged 65 to 74.⁶ A per capita cap would thus cut state Medicaid programs by increasingly deeper amounts as more boomers move into “old-old age.”

- **Unexpected increases in Medicaid per-beneficiary costs.** Under a per capita cap, states wouldn’t get more federal funds if medical costs per beneficiary rose faster than anticipated due to a new disease or outbreak like Zika, or a costly medical breakthrough, such as a new blockbuster drug that substantially improves the health of people with a particular disease or medical condition like diabetes, cancer, or Parkinson’s, but at a high cost. When the HIV/AIDS epidemic struck in the 1980s and early 1990s, in contrast, the federal government and states *shared* in the unexpected costs.

Moreover, while all states would face federal funding cuts, some could be hit disproportionately, including states whose current Medicaid per-beneficiary spending levels are already relatively low and those where Medicaid costs per beneficiary grew more quickly due to a variety of factors beyond states’ control, including faster overall health care cost growth, a natural disaster, or a disproportionately large increase in the number of very old seniors enrolled.⁷

Medicaid Is Already Efficient

Under a per capita cap, tens of millions of Americans who rely on Medicaid would be at risk of losing their coverage or seeing reduced access to needed care. Cutting per-beneficiary Medicaid expenditures substantially without limiting access to needed care would be very difficult. Medicaid costs per beneficiary already are far below those of private insurance, after adjusting for differences in health status, due to lower payment rates to health care providers and lower administrative costs, even though Medicaid provides more comprehensive benefits than private insurance at significantly lower out-of-pocket cost to beneficiaries. And over the past three decades, Medicaid per-beneficiary costs have also grown much more slowly, on average, than private insurance per-beneficiary costs.⁸ They are expected to continue growing more slowly than costs under private insurance in coming years, according to the Medicaid and CHIP Payment and Access Commission.⁹

Moreover, states already enjoy expansive flexibility in how they design and innovate in their Medicaid programs in order to improve quality of care while lowering costs. For example, states have expanded the use of managed care; more than three-quarters of beneficiaries are now in some

⁶ CBPP analysis of fiscal year 2011 Medicaid Statistical Information System data.

⁷ See John Holahan and Matthew Buettgens, “Block Grants and Per Capita Caps: The Problem of Funding Disparities among States,” Urban Institute, September 8, 2016, <http://www.urban.org/research/publication/block-grants-and-capita-caps> and Katherine Young *et al.*, “Medicaid Per Enrollee Spending: Variation Across States,” Kaiser Family Foundation, January 28, 2015, <http://kff.org/medicaid/issue-brief/medicaid-per-enrollee-spending-variation-across-states/>.

⁸ Edwin Park *et al.*, “Frequently Asked Questions About Medicaid,” Center on Budget and Policy Priorities, updated January 21, 2016, <http://www.cbpp.org/research/health/frequently-asked-questions-about-medicaid>.

⁹ Medicaid and CHIP Payment and Access Commission, “Report to Congress on Medicaid and CHIP,” June 2016, <https://www.macpac.gov/wp-content/uploads/2016/06/Trends-in-Medicaid-Spending.pdf>.

form of managed-care arrangement. They have also established accountable care organizations and health homes to better coordinate care for those with chronic conditions. States have also shifted much of their spending on long-term services and supports from nursing homes and other institutions to home- and community-based services (HCBS) so more people can stay in their homes and communities. (In 1995, HCBS accounted for just 18 percent of spending on long-term services and supports, but by 2014 its share had increased to 53 percent.) Some states use Medicaid to help fund home visitation services by nurses or to provide enhanced primary care services, both of which are aimed at fostering children’s healthy development.¹⁰

In addition, Medicaid has given states flexibility to respond to an array of public health and other problems and emergencies like the opioid epidemic and Zika. For example, states like Illinois, Maryland, Massachusetts, New Hampshire, and West Virginia are working to address the opioid epidemic by creating evidence-based systems of care for people with substance use disorders. States like Louisiana and Texas have provided mosquito repellent to Medicaid beneficiaries to prevent transmission of the Zika virus. Michigan is using Medicaid to help address the lead crisis in Flint.¹¹

Finally, states have used existing authority under section 1115 of the Social Security Act — usually referred to as Medicaid waivers — to try new ways of delivering care. Over the last several years, states like Massachusetts, New York, Oregon, and Texas have used upfront federal Medicaid funds made available through Medicaid waivers to pay for building the infrastructure to improve coordination and communication among providers — which is essential for improving delivery systems and saving money in the long term.¹²

Per Capita Cap Would Force Deep State Cuts, Put Medicaid Beneficiaries at Serious Risk

To compensate for the substantial funding cuts under a Medicaid per capita cap, states would either have to contribute significantly more of their own funds or, as is far likelier, institute cuts to eligibility, benefits, and/or payments to health care providers and plans.

In the short term, states might try to avoid cutting eligibility or benefits and attempt instead to fill the funding shortfall by discouraging enrollment among prospective beneficiaries. For example, because a per capita cap likely would also weaken or eliminate federal minimum standards for state Medicaid programs, states could opt to charge beneficiaries substantial premiums, which research indicates would discourage enrollment and leave more poor people uninsured. They also could impose deductibles and co-payments at levels that would reduce low-income beneficiaries’ access to needed care.

¹⁰ See Judith Solomon, “Caps on Federal Medicaid Funding Would Give States Flexibility to Cut, Stymie Innovation,” January 18, 2017, <http://www.cbpp.org/research/health/caps-on-federal-medicaid-funding-would-give-states-flexibility-to-cut-stymie> and Hannah Katch, “States Are Using Flexibility to Create Successful, Innovative Medicaid Programs,” Center on Budget and Policy Priorities, June 13, 2016, <http://www.cbpp.org/research/health/states-are-using-flexibility-to-create-successful-innovative-medicaid-programs>.

¹¹ Solomon, *op cit.*

¹² Solomon, *op cit.*

In addition, states would likely reduce payments to providers and health plans, which would also make it harder for beneficiaries to access care. Moreover, a per capita cap could weaken or drop federal requirements that ensure that provider payments are adequate and that payments to managed care plans are “actuarially sound.” Without these standards in place, states could cut payments even further, which would result in many beneficiaries having a harder time finding providers or needing to travel long distances to obtain care.

Under current law, all eligible individuals who apply for Medicaid must be allowed to enroll. But eventually, as federal funding shortfalls grew larger over time (or if per-beneficiary costs rose much faster than anticipated), states would have no choice but to make explicit cuts in eligibility and benefits (and further deep reductions in payment rates for health care providers and managed care plans that limit access). For example, the per capita cap proposal in House Speaker Paul Ryan’s health plan would permit states to use waiting lists or cap enrollment for any groups of “optional” Medicaid beneficiaries that federal law does not require states to cover, including children and pregnant women with incomes above 138 percent of the poverty line, seniors and people with disabilities with incomes above 75 percent of the poverty line, and working parents with incomes less than half the poverty line in many states.

In addition, because states would receive increasingly inadequate federal funding for each low-income individual they enroll, they would likely make many fewer people eligible for Medicaid, including groups like children, seniors, and people with disabilities that federal law requires states to cover today (if the per capita cap rolls back those requirements). This could leave significant numbers of low-income people who would be eligible today uninsured — a particular risk for working families during economic downturns when more people lose their jobs and would otherwise become eligible for Medicaid.

A per capita cap could also permit states for the first time to impose a work requirement and terminate coverage for people deemed non-compliant. This could result in people with various serious barriers to employment — such as people with mental health or substance use disorders, those who have difficulty coping with basic tasks or have very limited education or skills, and those without access to child care or transportation — going without health coverage.¹³

Moreover, states could drop some benefits that federal law now requires states to cover. For example, the more than 30 million children on Medicaid today could lose access to a comprehensive pediatric benefit that federal law now requires known as EPSDT (Early Periodic Screening, Diagnostic, and Treatment). This critical benefit is designed to ensure that low-income children, particularly those with complex health care conditions and other special health care needs, receive preventive medical screening to determine whether they are meeting key developmental benchmarks and can get treatment for all health problems that the screenings find. That includes dental care, eyeglasses, or special equipment such as a wheelchair that may not otherwise be covered for adult Medicaid beneficiaries.

¹³ Hannah Katch, “Medicaid Work Requirement Would Limit Health Care Access Without Significantly Boosting Employment,” Center on Budget and Policy Priorities, July 13, 2016, <http://www.cbpp.org/research/health/medicaid-work-requirement-would-limit-health-care-access-without-significantly>.

Finally, while the House Republican legislation to repeal the ACA would likely repeal health reform's Medicaid expansion outright, it's possible the bill would establish a per capita cap that leaves the expansion in place. But this would force states to bear more of the expansion's costs. The federal government now picks up at least 90 percent of expansion costs on a permanent basis, but a per capita cap would effectively shrink that percentage. That's because if, as is likely, the cap amounts increasingly fell over time further behind the level of federal funding needed to finance 90 percent of the expansion beneficiaries' health costs, states would have to bear considerably much more than one-tenth of those costs. In some expansion states, this would immediately terminate the expansion; when a number of states enacted legislation adopting the expansion, they included provisions that would end the expansion if federal support for it fell. Over time, more of the remaining expansion states would drop it as their overall federal funding shortfalls grew.

Alternatively, it's possible the legislation would repeal the expansion but give states the flexibility to continue coverage for the expansion population; prior to the expansion, states were generally not permitted to cover low-income adults without children. For example, congressional Republicans could add some upfront funding for states to temporarily maintain coverage for the expansion population as part of a per capita cap. But the growing cuts in overall federal funding over time caused by a per capita cap would eventually force states to drop the expansion population, as well as eliminate or scale back coverage for tens of millions of other beneficiaries.¹⁴

Conclusion

A Medicaid per capita cap would shift large and growing costs, as well as substantial risks, to states. That would put increasingly severe pressure on state budgets and likely lead to significant Medicaid cuts affecting low-income beneficiaries and the health care providers and health plans that serve them. While federal funding under a per capita cap would rise if Medicaid enrollment grew (unlike with the funding formula under a block grant), the federal funding cuts a per capita cap imposes would result in states making considerably fewer people eligible or otherwise limiting enrollment. Moreover, like a block grant, a per capita cap would not respond to greater-than-expected medical cost growth and the impact of the aging of the population. Combined with the likely repeal of the Medicaid expansion, the end result of a per capita cap would almost certainly be the loss of health coverage and less access to needed health care for tens of millions of low-income Americans who rely on Medicaid.

¹⁴ Hannah Katch, "Block Grant, Per Capita Cap No Substitute for ACA Medicaid Expansion," Center on Budget and Policy Priorities, January 19, 2017, <http://www.cbpp.org/blog/block-grant-per-capita-cap-no-substitute-for-aca-medicaid-expansion>.