Center on Budget and Policy Priorities

820 First Street NE, Suite 510
Washington, DC 20002

Tel: 202-408-1080
Fax: 202-408-1056

center@cbpp.org
www.cbpp.org

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Medicaid Per Capita Cap Would Shift Costs to States and Undermine Key Part of Health Reform

by Edwin Park

Two prominent congressional Republicans have proposed placing a "per capita cap" on federal Medicaid funding, under which the federal government would no longer cover a fixed share of each state's overall Medicaid costs but instead would limit each state to a fixed dollar amount per beneficiary.[1]

The per capita cap proposal, part of a larger package of Medicaid changes proposed by House Energy and Commerce Chairman Fred Upton and Senator Orrin Hatch, the top Republican on the Finance Committee, would shift large costs to states. As a result, it would undermine health reform's Medicaid expansion and lead to deep cuts in the rest of Medicaid, likely leaving millions more low-income people uninsured and without access to needed care.

Federal Medicaid Funding Would Likely Become Increasingly Inadequate Over Time

The primary goal of a per capita cap for Medicaid, like the cap that Chairman Upton and Senator Hatch have proposed, is to produce substantial federal savings. To accomplish this, the cap must give states significantly less federal funding on a per beneficiary basis than they would receive under the current financing system.

Per capita cap proposals typically accomplish this by increasing annual federal per beneficiary payments at a slower rate than the projected rate of growth of per beneficiary Medicaid costs under current law, which reflects expected growth in overall health care costs and the aging of the U.S. population. (The Upton-Hatch proposal does not specify the growth rate for the caps.) As a result, with each passing year, states would receive less and less federal funding per Medicaid beneficiary, relative to what they would receive under current law.[2] (Federal policymakers could produce

[1] "Making Medicaid Work," Chairman Fred Upton, House Energy and Commerce Committee and Senator Orrin Hatch, Ranking Member, Senate Finance Committee, May 1, 2013, http://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/analysis/20130501Medicaid.pdf.

[2] For a more detailed discussion of 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 4, 2012, http://www.cbpp.org/cms/index.cfm?fa=view&id=3846.

additional savings and make the cost-shift to states still larger, if they chose, by setting the initial cap amounts below a state's historical level of federal Medicaid expenditures per beneficiary.)

Per Capita Cap Would Undermine Health Reform's Medicaid Expansion

A per capita cap would jeopardize successful implementation of the Affordable Care Act (ACA). The law's Medicaid expansion is a good financial deal for states; the federal government will pay nearly all of the cost.[3] But a per capita cap designed to produce federal savings would require states to bear more — possibly a great deal more — of the expansion's cost. States would almost certainly receive less federal funding for each newly eligible beneficiary than under current law.

In addition, if the per-capita cap amounts were set now or in the initial years of the Medicaid expansion, each state's funding cap would be established *before* policymakers knew the health status and health care costs of the newly eligible enrollees when the expansion had been fully implemented. If their per beneficiary costs turned out to be higher than federal policymakers had estimated when setting the state's per capita cap, the state would have to bear an even larger share of the cost of covering those beneficiaries.

The Supreme Court decision upholding the ACA gave states the choice of whether or not to implement the Medicaid expansion. A per capita cap thus would likely discourage many states from taking up the Medicaid expansion, including some of those that have recently elected to adopt it. Millions of poor Americans likely would remain uninsured as a result.

Current State Medicaid Programs Would Also Face Deep Cuts

In addition, to compensate for the federal funding reduction included in a per capita cap, states would either have to contribute substantially more of their own funds to their *current* Medicaid programs — regardless of whether they adopt the ACA's Medicaid expansion — or significantly cut their existing Medicaid expenditures per beneficiary.

Cutting per beneficiary costs without limiting access to needed care would be difficult. Medicaid costs per beneficiary already are well below those of private insurance: a key study found that after adjusting for differences in health status, Medicaid costs 27 percent less per beneficiary for children, and 20 percent less for adults, than private insurance, despite Medicaid's comprehensive benefits and lower cost-sharing charges.[4] (This is due primarily to Medicaid's lower payment rates to providers and lower administrative costs.) In addition, states have already cut both benefits and provider payments over the last decade to help close state budget shortfalls during the last two economic downturns (with little or no restoration of those cuts in the interim).

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[3] January Angeles, "How Health Reform's Medicaid Expansion Will Impact State Budgets," Center on Budget and Policy Priorities, revised July 25, 2012, http://www.cbpp.org/cms/?fa=view&id=3801.

[4] Leighton Ku and Matthew Broaddus, "Public and Private Insurance: Stacking Up the Costs," *Health Affairs* (web exclusive), June 24, 2008. See also Jack Hadley and John Holahan, "Is Health Care Spending Higher Under Medicaid or Private Insurance?," *Inquiry* 40: 323-342, Winter 2003/2004.

Millions of low-income individuals and families who now rely on Medicaid would therefore be at risk of losing access to needed care under a per capita cap. To compensate for inadequate federal funding, states likely would have to impose the largest cuts on their highest-cost, most vulnerable beneficiaries — poor seniors and people with disabilities, who account for nearly *two-thirds* of Medicaid costs.

Moreover, over time, states are likely to face increasingly large federal funding shortfalls under a per capita cap. Demographic changes will push up per-beneficiary Medicaid costs. The share of Medicaid beneficiaries who are seniors or people with disabilities will rise markedly as the population ages, while the share who are children or non-elderly adults will decline (once the ACA's Medicaid expansion has taken effect). Seniors and people with disabilities have Medicaid costs at least five times higher, on average, than children and non-elderly adults.[5]

Separate per capita caps could be set for various groups, including seniors, and the Upton-Hatch proposal would do so. But that would not compensate for an increasing share of seniors moving from "young-old" age into "old-old" age over the next few decades. Older seniors are much more likely to be frail, to have serious health problems and multiple health conditions, and to need nursing home care and other long-term care services and supports. Analysis of Medicaid administrative data indicates that in 2009, Medicaid spending for seniors aged 75-84 was *50 percent higher*, on average, than for seniors aged 65-74. And seniors aged 85 and older incurred average Medicaid costs that were more than *2.5 times higher* than those aged 65-74.[6] Average Medicaid spending per elderly beneficiary thus will rise substantially over time as the baby-boom cohort ages. This would significantly enlarge the federal funding shortfalls that states would face under a per capita cap crafted like the Upton-Hatch proposal.

In addition, history shows that advances in medical technology — such as the development of new treatments and medications that significantly improve health and save lives but increase costs — can produce unanticipated increases in health care costs. So can changes in health care utilization patterns and the onset of epidemics or new illnesses (like HIV/AIDS). Faced with such developments, states would — under a per capita cap — either have to bear all of the resulting increase in health care expenditures themselves, or as is more likely, institute even deeper cuts to their Medicaid programs over time.

Mid-1990s Discussion of Per Capita Cap Not Relevant to Current Debate

Some supporters of a per capita cap, including Chairman Upton and Senator Hatch, point out that some Senate Democrats and the Clinton administration supported the idea in 1995-1996. But that past support is not applicable to the current debate, for three reasons in particular.

First, the political context was very different in that earlier debate. In 1995, under the Contract with America Congress, both the House and Senate passed a Medicaid block grant that would have sharply cut federal Medicaid funding and shifted costs to the states. In the ensuing budget battle,

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[5] Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FY 2009 MSIS and CMS-64 reports, 2012 at http://statehealthfacts.org/comparemaptable.jsp?ind=183&cat=4.

[6] CBPP analysis of FY 2009 MSIS data.

the Clinton Administration and some Democrats developed a per capita cap as a "lesser of two evils" alternative. Unlike a block grant, federal Medicaid funding under a per capita cap would rise when enrollment grows, such as during a recession.

Second, annual per beneficiary cost growth in Medicaid was much higher in the early and mid-1990s due, in part, to rapid health care cost growth systemwide. In addition, state "gaming" of Medicaid rules to maximize their federal funding, particularly related to Disproportionate Share Hospital (DSH) payments, also substantially increased federal spending at the beginning of that decade. The federal government, however, has since largely addressed this gaming problem; legislation enacted in 1992, 1997, 2000, and 2006, as well as various regulations and guidance, have imposed wide-ranging restrictions on states' ability to inappropriately draw down additional federal Medicaid funds. States have also subsequently cut per beneficiary cost growth in Medicaid by, for example, expanding the use of managed care, instituting cost containment strategies in prescription drug spending, and (as noted above) substantially cutting benefits and provider payments to close large budget gaps arising from the last two recessions. Medicaid per-beneficiary costs grew, on average, an estimated 7.5 percent between 1988 and 1995.[7] In comparison, over the previous decade (2000-2009), Medicaid costs per beneficiary increased, on average, 4.6 percent (after excluding the effects of shifting drug coverage for the "dual eligibles" from Medicaid to Medicare).[8]

As a result, costs per beneficiary in Medicaid have risen considerably more slowly than private health insurance premiums in recent years.[9] The Centers for Medicare and Medicaid Services projects that Medicaid spending per beneficiary (excluding the effects of the ACA Medicaid expansion) will grow no more rapidly through 2021 than spending per beneficiary with private insurance.[10]

Indeed, the Congressional Budget Office (CBO) now expects Medicaid costs per beneficiary to grow much more slowly in coming years than it projected only a few years ago. Largely for this reason, CBO has, since August 2010, reduced its estimate of federal Medicaid spending over the 2011-2020 period by about *$218 billion*.[11] (This figure excludes additional reductions in projected Medicaid spending due to the Supreme Court decision on the Affordable Care Act.)

Third, as noted above, the Supreme Court decision upholding the ACA leaves it up to states whether to adopt health reform's Medicaid expansion. By shifting significant costs to states, a per capita cap would discourage states from going ahead with the expansion and thus would likely leave

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[7] John Holahan and David Liska, "Where is Medicaid Spending Headed?," the Urban Institute, November 1996.

[8] John Holahan *et al.,* "Medicaid Spending Growth over the Last Decade and the Great Recession, 2000-2009," Kaiser Commission on Medicaid and the Uninsured, February 2011

[9] Edwin Park, "Medicaid Costs Growing More Slowly Than Private Insurance," *Off the Charts* blog, March 2, 2011, http://www.offthechartsblog.org/medicaid-costs-growing-more-slowly-than-private-insurance/. See also Holahan et al., *op cit*..

[10] John Holahan and Stacey McMorrow, "Medicare and Medicaid Spending Trends and the Deficit Debate," *New England Journal of Medicine,* 367:393-395, August 2, 2012 and Sean Keehan *et al.,* "National Health Expenditure Projections: Modest Annual Growth Until Coverage Expands and Economic Growth Accelerates," *Health Affairs*, June 12, 2012.

[11] Edwin Park, "Projected Medicaid Spending Has Fallen by More than $200 Billion," *Off the Charts* blog, March 11, 2013, http://www.offthechartsblog.org/projected-medicaid-spending-has-fallen-by-more-than-200-billion/.

millions more poor people uninsured. There was no similar dynamic in the 1990s under which large cost-shifts to states, as under a per capita cap, would undermine an essential element of a long-awaited comprehensive health reform law.

In fact, for this reason, the Obama Administration's fiscal year 2014 budget no longer includes two Medicaid savings proposals — to establish a "blended rate" for Medicaid and the Children's Health Insurance Program, and another to restrict state use of provider taxes to finance their Medicaid programs — that would shift costs to states and which the Administration had previously supported. The Administration dropped these proposals in recognition of the fact that in the aftermath of the Supreme Court decision, cost shifts could deter states from adopting the Medicaid expansion and thereby cause large numbers of poor Americans to remain without health insurance.[12]

Thus, the main argument for a per capita cap in the mid-1990s — that Medicaid costs per beneficiary were growing out of control — is no longer true. Today, trying to cut Medicaid costs in isolation from the rest of the health care system, such as through a per capita cap, would shift costs to states that would have difficulty absorbing them. It would thereby both undermine health reform's Medicaid expansion and lead to deep cuts in state Medicaid programs, making the U.S. system more of a two-tier health care system based on income.

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[12] Edwin Park, "President's Budget Affirms that Washington Will Pay Nearly All the Costs of Expanding Medicaid," *Off the Charts* blog, April 10, 2013, http://www.offthechartsblog.org/presidents-budget-affirms-that-washington-will-pay-nearly-all-the-costs-of-expanding-medicaid/.