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Commentary: Like a Block Grant, Medicaid Per Capita Cap Would Shift Costs to States and Place Beneficiaries at Risk

By Edwin Park

The health task force convened by House Speaker Paul Ryan reportedly will include a Medicaid “per capita cap” in the plan it will release next week.¹ That would radically restructure Medicaid’s current financing system, shifting costs to states while potentially harming tens of millions of vulnerable beneficiaries.

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 just over 57 percent. Previous Republican budget and health plans have proposed converting Medicaid into a block grant or imposing a per capita cap. They would each radically restructure Medicaid’s financing and have 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 could 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

¹ 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>; 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>.

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 only by overall inflation; historically, health costs have outpaced inflation, so the 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 actually face. These cuts could be much larger than the difference between currently projected federal spending and the cap amounts, for several reasons:

- **Potential for faster health care cost growth system-wide.** Costs throughout the health care system have grown at historically low rates in recent years. Setting per capita cap amounts now would essentially require an assumption of how much of this slowdown is permanent (due in part to health reform) and how much is temporary. If policymakers assume incorrectly, actual per-beneficiary Medicaid costs could be significantly higher than the cap assumed, forcing deeper cuts.
- **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." 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. Unless a per capita cap were designed to address this issue — which no per capita cap proposal we're aware of would do — a cap would cut state Medicaid programs by increasingly deeper amounts as more boomers move into "old-old age."
- **Unexpected increases in Medicaid 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, but at a high cost. When the HIV/AIDS epidemic struck, in contrast, the federal government and states *shared* the unexpected costs.

Moreover, while all states would face federal funding cuts, some could be hit disproportionately hard, including 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.

Per Capita Cap Would Put Medicaid Beneficiaries at Serious Risk

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 both private insurance, after adjusting for differences in health status, and Medicaid per-beneficiary costs have also grown much more slowly

than Medicare and private insurance over the past decade.² Moreover, states already take advantage of existing flexibility to limit Medicaid costs.³

Both a block grant and a per capita cap would mean substantial funding reductions for states. To compensate, they'd 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. 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 reduced low-income beneficiaries' access to needed care.

In addition, states could drop some benefits that federal law now requires states to cover and curtail or end eligibility for certain populations. For example, children in some states 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 and can get treatment for all health problems that the screenings find.

In addition, while the House Republican leadership's health plan would likely repeal health reform's Medicaid expansion, were a per capita cap to be established while leaving the expansion in place, it 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 end up having to bear considerably more than one-tenth of those costs. That would likely discourage more states from taking up the expansion and might lead some expansion states to drop it.

Conclusion

A Medicaid per capita cap would result in large and growing cost-shifts to states. That would put substantial 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. Moreover, while federal funding under a per capita cap would rise if Medicaid enrollment grew (unlike the funding formula under a block grant), it would not respond to greater-than-expected medical cost growth. The end result 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.

² 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>.

³ 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>.