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Per Capita Caps or Block Grants Would Lead to Large and Growing Cuts in State Medicaid Programs

By Edwin Park and Judith Solomon

The health plan that Speaker Paul Ryan and other House Republican leaders unveiled today would radically restructure Medicaid by forcing states to accept reductions in federal funding for their Medicaid programs through either a “per capita cap” or a block grant, both of which would shrink federal funding for state Medicaid programs over time, relative to current law. This would shift significant costs to states and almost certainly lead states to cut Medicaid substantially over time, potentially placing millions of low-income Americans at risk of losing part or all of their health coverage.

The plan is somewhat vague on the exact per-capita-cap and block grant funding levels that would be provided. But the budget that the Republican majority on the House Budget Committee approved in March, with Speaker Ryan’s support, provides more clarity. It would give states the same choice — between a per capita cap and a block grant — with the federal funding levels set so this would cut federal Medicaid funding for states by *\$1 trillion* over ten years, compared to current law. The result of such a cut would almost inevitably be a large increase in the number of poor Americans who are uninsured or underinsured.

Per Capita Cap or Block Grant Would Shift Large Costs to States

Under the plan, the federal government would no longer pay a fixed share of states’ Medicaid costs. Instead, it would pay its share of those costs only up to a fixed amount per beneficiary (if the state elected the per capita cap) or up to a single overall amount (if the state chose a block grant). The state would be responsible for *all* costs above the per-beneficiary cap or block-grant allotment.

Per Capita Cap

The plan envisions a per capita cap as the default option for states, starting in 2019. Under the plan, the federal government would impose per-beneficiary caps for each state for four categories of beneficiaries — seniors, people with disabilities, other adults, and children. The initial caps for 2019 would be equal to a state’s actual Medicaid spending per beneficiary in 2016 for those categories, adjusted for general inflation. The federal government would pay its share of a state’s Medicaid costs only up to the caps. States would have to bear 100 percent of medical costs for beneficiaries to the extent those costs exceeded the per-beneficiary caps.

Key to the design of the caps — and the main reason they would produce large federal savings while squeezing state Medicaid programs hard over time — is that the caps would be adjusted only for general inflation (to set both the initial caps and the caps for subsequent years). Health care costs in the United States — in both the public and private sectors — have consistently risen significantly faster than the overall inflation rate, in part because of continued medical advances that improve health and prolong lives but add to costs, such as the new drugs for Hepatitis C. That means that the initial caps for 2019 would be significantly below the expected levels of federal Medicaid funding per beneficiary for that year under current law, and that with each passing year, federal funding per beneficiary would fall farther behind the actual costs of treating Medicaid beneficiaries. More specifically, because health costs outpace the general inflation rate, the caps would rise by an estimated 1.8 percentage points *less* per year over the coming decade than the rate of growth in Medicaid per-beneficiary costs that the Congressional Budget Office forecasts. The resulting federal funding cuts thus would grow steadily larger each year.

The loss of federal funding would be even greater in years when per-beneficiary health care costs rose faster than expected. This could happen, for example, if a new medical treatment were developed that greatly improved patients' health but raised costs, or if there were an epidemic or disease outbreak like Zika (or HIV/AIDS in the 1980s). Today, the federal government and the states *share* in such unanticipated health care costs. Under a per capita cap, states *alone* would bear those costs once they exceeded the cap amount.

Aggravating these problems, Medicaid per-beneficiary spending for seniors is likely to rise substantially over future decades as the baby-boom generation ages and more seniors move from “young-old” age to “old-old” age. People in their 80s or 90s are much likelier than younger seniors to have serious and chronic health problems and to require nursing home and other long-term care; their average health care costs are substantially higher than those of younger seniors. Nothing in the per capita cap proposed today addresses this critical issue, with the result that the cuts the plan would impose on state Medicaid programs would grow considerably deeper as more people moved into “old-old age.”

Block Grant

Unlike with the per capita cap, the plan does not provide any details on how a state's block grant amount would initially be set or be adjusted annually. But as with the per capita cap, the block grant amounts would certainly be designed to provide significantly less federal funding than under current law. For example, past block grants have been based on state's historical spending in a base year, adjusted annually for population growth and general inflation. As noted above, however, health care costs rise faster than inflation. And with the aging of the population, Medicaid enrollment is expected to grow faster than the rate at which the overall population increases.

As under a per capita cap, states would face large and growing federal funding shortfalls, due to faster growth in per-beneficiary costs and the aging of the population. Moreover, under a block grant, states would be responsible for all costs due to higher-than-anticipated enrollment, as occurs in every recession. As the recent recession demonstrated, when people lose their jobs and access to employer-sponsored insurance, many more individuals and families become eligible for Medicaid and enroll.

Total Federal Medicaid Funding Cuts

The plan is silent on its savings target for a per capita cap or block grant. But as noted, the budget plan that the House Budget Committee approved in March called for savings of about \$1 trillion over the next ten years from requiring states to live with a per capita cap or block grant. If all states elected a per capita cap, that would require cuts to federal Medicaid funding per beneficiary of about *50 percent* by the tenth year, relative to current law, with the cuts growing still deeper after 2026. If all states elected the block grant option instead, overall federal funding for state Medicaid programs would be cut about one-third by 2026, relative to current law.

Unraveling of Federal Standards Would Likely Leave Millions More Uninsured and Underinsured

House Republican leaders indicated today that they expect states could compensate for the losses in federal funding under a per capita cap or a block grant by using the added flexibility that would accompany these measures to cut costs without harming beneficiaries. This assertion strains credulity. Medicaid costs per beneficiary already are far below those of private insurance, after adjusting for differences in health status, and have grown more slowly in recent years than costs in both private insurance and Medicare — rising an average of only 1.9 percent per year between 1999 and 2014. Moreover, per-beneficiary costs are expected to continue growing more slowly than costs under private insurance in coming years, as a recent analysis by the Medicaid and CHIP Payment and Access Commission shows.

Moreover, states already have substantial flexibility in how they deliver Medicaid services (see box). For example, over the past two decades, they have expanded the use of managed care — more than three-quarters of beneficiaries are now in some form of managed-care arrangement — and instituted cost-containment strategies in areas like prescription drug spending.

Instead, the new flexibility the House GOP plan would provide is likely to be aimed more at low-income beneficiaries. The flexibility apparently would eliminate various federal beneficiary protections and key federal minimum standards related to who may qualify for Medicaid and which essential health services the program must cover. The new flexibility would enable states to make sizeable cuts directly affecting beneficiaries that states cannot make now, in order to compensate for the sizeable federal funding losses they would suffer. This is another reason the likely result would be millions more uninsured or underinsured people.

For example, under the House plan, states apparently could:

- **Shift Medicaid beneficiaries into individual-market plans.** States would be permitted to use Medicaid funds to pay the premiums for private coverage for beneficiaries (instead of providing coverage directly), without any assurance that such coverage is affordable for a beneficiary or provides a comprehensive array of benefits that meet vulnerable beneficiaries' health needs. Of note here, other aspects of the House Republican plan would roll back the Affordable Care Act's market reforms and consumer protections that enable people to buy individual-market coverage that is affordable and meets minimum coverage standards. Under the House plan, insurers could heavily restrict or eliminate benefits such as maternity care and prescription drugs and could impose annual benefit limits. They also could impose substantial deductibles and other cost-sharing charges. Even if states chose to supplement the individual-

market coverage, for example by picking up some deductibles and co-payments and some benefits that private insurance did not cover, many current Medicaid beneficiaries would likely end up with higher costs and skimpier coverage.

- **Establish a work requirement and terminate coverage for people deemed non-compliant.** The plan would allow states to require that all “able-bodied adults” otherwise eligible for Medicaid demonstrate they are working, searching for work, or in an education or training program in order to qualify for Medicaid coverage. This could result in people with various serious barriers to employment — people with mental health or substance use disorders, people who have difficulty coping with basic tasks or have very limited education or skills, and people without access to child care or transportation — going without health coverage. Most people with Medicaid coverage who can work do so. But for people with barriers such as these, such a requirement could actually *reduce* their ability to work steadily by putting health coverage out of reach and thereby causing them to have more (or more serious) health problems.
- **Begin charging premiums for most adults.** Federal rules prohibit Medicaid premiums for beneficiaries with incomes below 150 percent of the poverty line. That’s because research has found that premiums disproportionately lead poor households to forgo enrollment and remain uninsured. The plan announced today, however, would allow state Medicaid programs to begin charging significant premiums at levels that research suggests would likely reduce poor people’s access to care.
- **Use waiting lists or cap enrollment.** States would be able 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 as low as 40 percent or 50 percent of the poverty line in many states. This could leave significant numbers of eligible low-income people uninsured — a particular risk for working families during economic downturns when more people lose their jobs and become eligible for Medicaid. Under current law, all eligible individuals who apply for Medicaid must be allowed to enroll.
- **Eliminate or restrict benefits now protected under federal minimum standards.** For “optional” eligibility groups, including children with incomes above 138 percent of the poverty line, states would be allowed to drop certain benefits they are now required to provide. For example, states would no longer be required to provide such children with a comprehensive pediatric benefit known as EPSDT (Early Periodic Screening, Diagnostic, and Treatment), under which children enrolled in Medicaid receive both regular check-ups and coverage for all medically necessary treatments that the check-ups find a child needs. Private insurance typically doesn’t provide such comprehensive pediatric coverage.

EPSDT ensures that low-income children have access to preventive care. It is especially important for children who have complex health care conditions and need advanced medical treatments.

States Using Considerable Medicaid Flexibility to Improve Health Care Delivery and Lower Costs

Contrary to claims by proponents of a per capita cap or a block grant that current Medicaid rules inhibit state reforms,* states already have — and use — their considerable flexibility under Medicaid to streamline health care delivery, improve health, and lower costs.

States are beginning to coordinate physical and behavioral health care services as well as social services. They are also moving to integrate services for their most vulnerable beneficiaries by improving communication and data sharing across health care providers and systems to provide effective health services in a timely way. These efforts are improving health outcomes and making Medicaid more efficient by bridging the gap between health care and other services, such as housing assistance.

For example:

- Missouri has established “health homes” that coordinate care for beneficiaries with chronic physical health conditions or a diagnosed serious mental illness. Early data from the program show a significant drop in emergency department visits and preventable hospitalizations.
- Tennessee is one of 44 states participating in the Money Follows the Person program, which helps Medicaid beneficiaries transition from nursing facilities to their own homes, the home of a caregiver, or a community-based residential facility. Tennessee’s program has produced significant state savings by reducing unnecessary nursing facility stays.
- A Wisconsin hospital is testing a new way to integrate health services for children with complex medical needs, a growing group with high health care costs. Participants are significantly more likely to report that their health needs are being met.
- Oregon has established accountable care organizations — groups of providers and other entities that partner to provide a range of health care services in a coordinated way — to integrate hospital-based services with primary care, behavioral health care, and other social supports. The initiative has produced significant declines in emergency department visits and preventable hospital admissions.

* For more, see 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>.

States that elect the block grant could institute even more draconian cuts. They would appear to be given unfettered flexibility with respect to most of their beneficiaries. The only condition would be that they would have to continue providing certain services for seniors and people with disabilities whom federal law requires states to cover; federal law generally requires states to cover low-income seniors and people with disabilities who are enrolled in the Supplemental Security Income program, the income limit for which is about 75 percent of the poverty line in many states. Other low-income people who are elderly or have disabilities would not be protected.

Due to these numerous, far-reaching changes, millions of low-income people would likely wind up uninsured or underinsured. This includes not only many people who have gained coverage under health reform’s Medicaid expansion and would eventually lose their current coverage under the House plan, but also tens of millions of people who rely on Medicaid outside of the expansion.