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Medicaid

How Per Capita Caps in Medicaid Would Hurt States

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Moving to Medicaid per capita caps would be a radical change in how the federal government helps states cover the cost of running Medicaid.

The way that Medicaid is currently structured, states run their own Medicaid programs, but they get significant help with funding from the federal government. The federal government "matches" each state's spending, paying at least 50 percent of state costs for traditional Medicaid and considerably more for a Medicaid expansion program.[1] This makes Medicaid a true state-federal partnership.

How would per capita caps be different from how Medicaid is financed today?

Medicaid per capita caps would replace Medicaid's current financing structure. Federal payments for each Medicaid enrollee would be capped. States would still get an extra federal payment for each beneficiary who is added to the program, but that payment would be limited to a preset amount per person.

The details of how the federal government would determine these payment rates could be very complicated (we discuss this complexity later). But the bottom line is that more of the cost of running the program would be shifted to states.

Most federal proposals to establish per capita caps also incorporate large cuts in federal Medicaid spending, which means that even more costs would be shifted to states.

What's wrong with per capita caps?

How the federal government sets the caps could severely reduce state funding

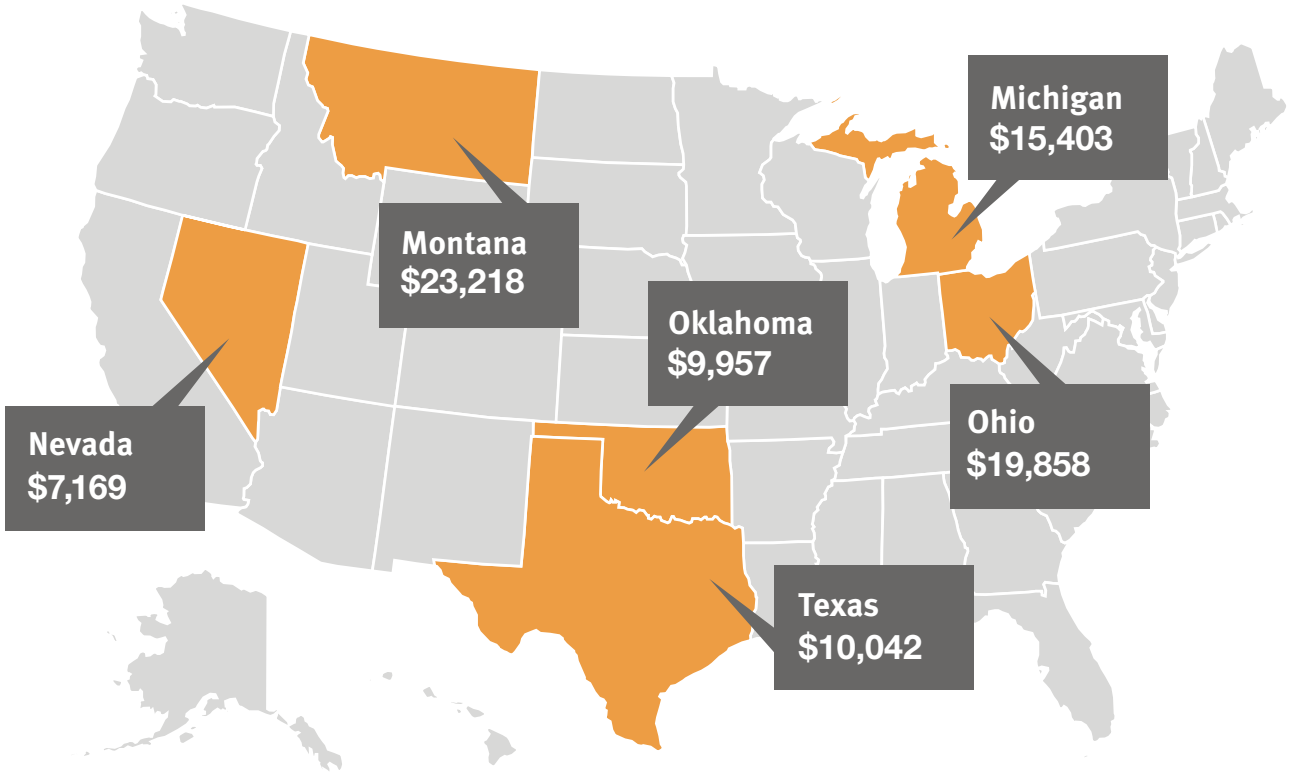
Precisely how the federal government would set these caps is an important detail that would need to be worked out. Caps could be set based on overall national Medicaid spending (a single payment cap). Alternatively, a cap could be set for each state based on that state's Medicaid costs. Or they could be set for different groups of Medicaid beneficiaries, like one cap for children, one for seniors, one for people with disabilities, and so on.

Say, for example, the federal government decides to set a cap for each beneficiary group based on average national spending for that group. Looking just at the six states in the illustration on page 3, average Medicaid spending on seniors is about $14,000 a year. However, among these six states, the difference between the state with the highest spending per senior and the state with the lowest spending is about $16,000.

If the federal government set its per capita payment for seniors based on average national spending, there would be clear winners and losers. States that are

Establishing per capita caps in Medicaid would radically change the program's current financing structure. Instead of matching state Medicaid spending with at least one dollar for every dollar states spend, federal payments for each Medicaid enrollee would be capped. These caps would likely shift more of the cost of running the program to states.

Medicaid Costs Vary Widely from State to State:
Medicaid Payments per Enrollee for Seniors in Selected States, 2011



Source: Kaiser statehealthfacts.org

below the average, like Oklahoma and Texas, could get much more federal support per beneficiary than they currently do. But states that spend more than the average, like Montana and Ohio, would end up getting much less federal support than they do today. That means they would have to make deep cuts to their Medicaid programs.

On the other hand, the government could decide to set a cap for each beneficiary group based on current state spending for that group. That could produce a system with multiple payment rates per state (and hundreds of payment rates nationwide), which would be complicated for states to administer.[2]

Beyond the administrative complexity, states that spend less because they offer fewer benefits could be permanently "stuck" with a lower cap. If a state wanted to change the benefits it offers in a way that might increase spending, even if it's a short-term spending increase that could improve care and save health care dollars in the long term, the state would have to foot the bill on its own.

Saving federal dollars means cutting funding for states

It's important to keep in mind that one of the purposes of establishing a per capita cap system is to reduce federal Medicaid costs. Therefore, the federal government would either set initial cap rates lower than current federal Medicaid payments, or it would set annual adjustments for inflation below projected levels of medical cost inflation, or both.

Both tactics would cut overall Medicaid funding, which would force states to either make up the difference with their own funds or cut their programs. And if federal inflation adjustments are lower than medical inflation, federal support as a percentage of Medicaid costs would get lower and lower over time, which would pass even more costs to states every year.

If circumstances in a state change, federal funding won't necessarily be adjusted to meet the state's needs

Health care costs and state populations aren't static. For example:

- New drugs or technologies could raise short-term costs but produce long-term savings.
- As populations age, more and more of the seniors in Medicaid will be among the very old, who have higher health care costs than younger seniors.
- A state could experience a public health crisis or natural disaster that requires more Medicaid spending.

In the current Medicaid program, federal support rises or falls in conjunction with state health care spending and the changes that affect that spending. A system of per capita caps won't necessarily have a mechanism for adjusting to new technologies, changes in demographics, a public health crisis, or any other changes in health care spending.

States may lose program flexibility due to funding cuts

States have a great deal of flexibility when it comes to designing their Medicaid programs—that's why every state's program looks different.

It's important to keep in mind that one of the purposes of establishing a per capita cap system is to reduce federal Medicaid costs.

Medicaid spending also varies widely from state to state. There are good reasons for this.

- Some states have chosen to offer more benefits.
- Some states have a higher cost of living, which means health care just costs more.
- Some states have a different mix of services. For example, in one state, most of the long-term care Medicaid pays for might be provided in home- and community-based settings, while another state might rely on nursing home care, which costs more.

States value the flexibility they already have to set benefits to match the needs of their residents.

One way that proponents of per capita caps are promoting the idea is by saying that they will give states even more flexibility. How? The federal government would eliminate some of the federal Medicaid requirements for benefits and services. So, while states would be constrained by a set federal contribution per beneficiary, they would know that amount in advance. And since states would have fewer federal requirements to meet, they would be able to manage their Medicaid budgets within those financial constraints.

But if we look at that claim more closely, it is clear that a system of per capita caps could actually take away some of that flexibility. Why? Because per capita caps would be designed to save the federal government money, and that means cutting federal support to states.

Of course, reducing federal payments to states won't make states' health care costs go away—those costs would simply be passed on to states and beneficiaries. State "flexibility" might be limited to deciding which services to cut to fit within a cap that is too low to meet enrollees' health care needs.

The way that the caps are set may not become more transparent

Another way that proponents of per capita caps are promoting the idea is by saying that the way federal Medicaid payments are set will be more transparent than the way they are currently set.

But how the federal government sets per capita caps will undoubtedly be complicated and may be far from transparent. If the cap system ultimately includes processes for adjusting payments to account for changes in state costs, that will be complicated, too: It will be hard to figure out which states should get adjustments and at what level, and it will be hard to figure out how those adjustments would fit into a federal budget that's based on set Medicaid per capita payments.

A system of per capita caps could affect state decisions to expand Medicaid

Moving to a per capita cap could include the Medicaid expansion population—or it might not—depending on the proposal. But let's say that it does. All the issues outlined above would apply. Those issues would also be complicated by the fact that people covered by a

Medicaid expansion haven't previously had Medicaid, or they've had it only for a short time. So, it's hard to know what it will cost to cover the expansion population over the long term. That adds another layer of complexity to the already complex process of setting a fair cap.

Unfortunately, that's only part of the problem. Moving to a per capita cap for the expansion population would totally change the incentive for states to expand.

Under the Affordable Care Act, the federal government picks up virtually all of the cost of expansion to make it easy for states.[3] But under a per capita cap, even if the cap is based on a full federal match, any costs above the cap would have to be picked up by the states. And if the cap included a mechanism to save the federal government money, like a low inflation adjustment, the value of federal help would erode over time. The promise of near full federal support for Medicaid expansion would be gone or severely diminished.

The result? Fewer states would expand Medicaid, leaving a huge gap in coverage that would affect consumers with the lowest incomes.

In addition, several states that have expanded Medicaid have provisions in their expansion laws that automatically end the expansion if federal funding drops below 90 percent. Funding through a per capita cap might trigger those clauses, which would end the expansions in those states.

Per capita caps are just another name for cutting Medicaid.

Switching to a system of per capita caps in Medicaid would likely lead to severe cuts in funding for states, limiting the flexibility they have to design their programs and to respond to circumstances that affect health care spending. It could also make states that have not yet expanded Medicaid less likely to do so.

Endnotes

1 In traditional Medicaid, the federal government pays at least 50 percent of every state's Medicaid costs. The exact federal share for each state is developed using a formula that takes into account the economic variables for each state. Match rates are adjusted annually. In 13 states, the federal government pays 50 percent of state Medicaid costs. In all other states, the federal share is higher, up to a high of 73.58 percent in Mississippi. If a state takes up the Medicaid expansion, the federal government pays a much higher percentage of the costs for those gaining coverage through an expansion. The federal government is picking up all the costs of the Medicaid expansion through 2016. In 2017, the federal share starts to slowly decline until it reaches 90 percent in 2020, where it stays.

2 Assuming that there are separate caps for children, seniors, people with disabilities, pregnant women, parents, and adults without dependent children, there would be 306 cap rates for all the states and the District of Columbia. That's a simplistic breakout of rates. To truly capture differences in the cost of care, rates could be broken out further, making calculations even more complicated.

3 Federal funding for the Medicaid expansion population is 100 percent through 2016, and it gradually lowers to 90 percent in 2020, where it stays.

A selected list of relevant publications to date:

Talking Points: Medicaid and the Federal Deficit (November 2012)

Cutting Medicaid: Ineffective and Harmful (September 2012)

Medicaid's Success: Good Care (August 2012)

For a more current list, visit:
www.familiesusa.org/publications

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