A Closer Look at the Threat to Medicaid

A series of fact sheets designed to help advocates understand how deficit reduction and the fiscal cliff threaten the future of Medicaid.

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What's Wrong with Per Capita Caps in Medicaid?

What's a Medicaid per capita cap?

A per capita cap is one of the proposals being discussed in Congress as a way to reduce federal spending for Medicaid. Such a cap would replace the current Medicaid financing structure, under which the federal government provides "matching" funds to each state's Medicaid spending. The share of each state's costs paid by the federal government—the match rate—varies from state to state but is never lower than 50 percent. Depending on the specific proposal, the per capita cap might also replace the planned financing for the Medicaid expansion under the Affordable Care Act: Starting in 2014, for states that expand Medicaid, the federal government is initially slated to pay 100 percent of costs for the people newly eligible because of that expansion, with that percent eventually going down to 90 percent, where it should stay.

How would a per capita cap be different from what we have today?

Federal per-beneficiary payments to states would be capped. States would still get extra federal payments for each additional beneficiary in the program, but the federal help would be limited to a pre-set amount per person. Because one of the purposes of a per capita cap would be to reduce federal Medicaid costs, either the initial cap rate would be lower than current federal payments in Medicaid, annual increases would be less than growth due to medical cost inflation, or both. In other words, one way or another, the cap would cut Medicaid.

How would the cap be set?

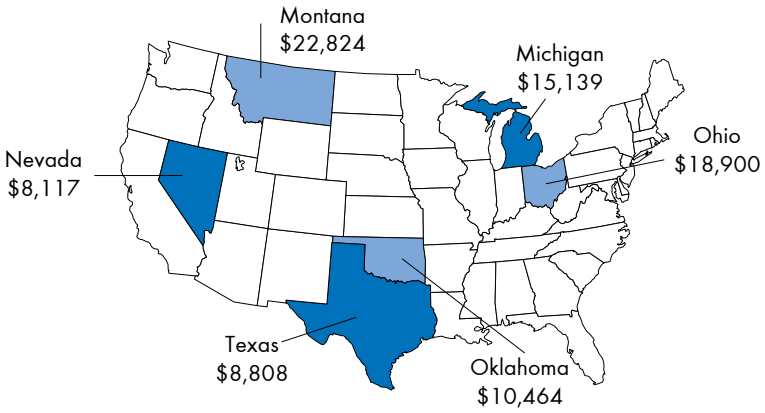
That's a detail that would need to be worked out. Payment caps could be set based on overall national Medicaid spending (a single payment cap), or it could be set for different groups, like one cap for children, one for seniors, one for people with disabilities, and so on. Alternatively, a cap could be set for each state based on that state's historic Medicaid costs.

What's wrong with per capita caps?

First, there's the question of how to set the caps.

Medicaid spending varies widely from state to state. There are reasons for this. Some states offer more benefits. Some have a higher cost of living, which means health care just costs more. Some 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 in another more nursing home care might be used.

Medicaid Costs Vary Widely from State to State:
Medicaid Payments Per Enrollee 2009, for Seniors in Selected States



Source: Kaiser statehealthfacts.org

Say, for example, that the decision is to set caps by beneficiary group, based on the average national spending across the states. Looking just at the six states in the illustration, the 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 is also about $14,000. If the federal government set its per capita payment based on the average spending across states, there would be clear winners and losers. States that are below the average, like Texas and Oklahoma, could get much more federal support per beneficiary than they currently do. But states that spend more than the average would end up getting much less federal support than today. They would have to make deep cuts to their Medicaid programs.

Or say the decision is to set caps by beneficiary group based on current state spending. You'd probably have a system with hundreds of payment rates.[1] But beyond the administrative complexity, states that spend less because they offer

fewer benefits could be permanently "stuck" with a lower cap. Changes in benefits that might increase spending—even if just in the short term—would have to be footed by the state.

- **Then there is the question of building in savings.**

  One of the purposes of moving to per capita caps would be to reduce federal Medicaid costs. That means either setting the caps lower than current costs from the start, or setting annual inflation adjustments below projected medical inflation, or both. Either is a cut to Medicaid that passes costs on to states. If inflation adjustments are lower than medical inflation, federal support as a percent of Medicaid costs would get lower and lower over time, passing more costs to states every year.

- **There's also the question of what happens if something changes.**

  Health costs and populations aren't static. For example, new 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 old-old, who have higher health care costs than younger seniors. Unlike the current program, where federal support rises or falls in conjunction with state costs, per capita caps don't have any mechanism for adjusting for new technologies, changes in demographics, or any other changes in health care costs.

- **This would affect take-up of the Affordable Care Act's Medicaid expansion.**

  Whether moving to a per capita cap would include the Medicaid expansion population or not would depend 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 the expansion haven't previously been covered by Medicaid, so it's hard to know what it will cost to cover them. That adds another level of complexity to the already complex process of setting a fair cap rate.

  But 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. 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. If the cap included built-in savings, like a low inflation adjustment, the value of federal help would erode over time. The promise of near full federal support would be gone. Fewer states would expand Medicaid, leaving the Affordable Care Act with a huge gap in coverage at the lowest income levels.

- **And don't be so sure this will be more transparent.**

  One of the ways per capita caps are being sold to states is to say that they will be more transparent. But setting rates will be complicated and may be far from transparent. If the system ultimately includes processes for adjusting payments to account for changes in state costs, that will be complicated, too. It will undoubtedly be hard to figure out which states should get adjustments and at what level, and how that would fit into a federal budget that's based on set Medicaid per capita payments.

- **States may just be saddled with more costs, as opposed to more flexibility.**

  Another way that per capita caps are being sold is by saying that they will give states more flexibility. States will only get a set federal contribution per beneficiary, will know that in advance, and will have to manage costs accordingly, presumably with fewer federal requirements for benefits and coverage. But states already have a great deal of flexibility in Medicaid—that's why every state's Medicaid program looks different. Per capita caps could actually take some flexibility away. Per capita caps would be designed to save the federal government money and that means cutting federal support to states. Just reducing federal payments won't make 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.

Per capita caps are just another name for cutting Medicaid.

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[1] Assuming a rate for children, seniors, people with disabilities, pregnant women, parents, and non-parental adults, there would be 306 rates for all the states and DC. That's a simplistic break-out of rates. To truly capture differences in the cost of care, rates could be broken out even further, making calculations more complicated.

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