Leadership Council of Aging Organizations

ISSUE BRIEF

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Medicaid Per Capita Caps

Restructuring and cutting Medicaid to reduce the deficit is a priority for some in Congress. One of the suggestions is capping Medicaid payments to states on a per-beneficiary basis. A per capita cap, like a block grant, would spell danger for our country's most vulnerable citizens.

A September 2011 poll showed that the 76% of respondents oppose cutting Medicaid to reduce the deficit, the least popular option.[1] The public understands that millions of Americans, from middle class seniors to children in poverty, rely on Medicaid in their everyday lives. More than a quarter of all older Americans and people with disabilities depend on Medicaid.[2] Fundamentally altering Medicaid's structure, particularly with the goal of finding significant savings, will likely force states to cut essential services and reduce access to care for these important populations.

No Matter the Design, Per Capita Caps Force Disproportionate Cuts

Lawmakers could design a per capita cap proposal a number of different ways. At the most basic level, a proposal would cap the level of federal funding to a state based on the number of Medicaid beneficiaries in the state. Lawmakers seeking to generate savings from the plan would design the proposal so states would necessarily receive fewer funds over time, with deeper cuts every year as funding fails to match inflation. Unlike the current Medicaid structure, a state experiencing higher than usual Medicaid spending per enrollee would no longer receive matching federal funds above its cap.

Per capita cap plans base the first year of federal funds on states' historical Medicaid spending. Some proposals cap funding by enrollee population in each state, such as children, seniors, people with disabilities and adults, thereby creating as many as 200 new complex funding formulas. Cuts will likely most heavily fall on seniors and people with disabilities who are the most expensive recipients of Medicaid, making up nearly two-thirds of spending.[3] States may also try to offset rising costs for one group by cutting provider rates or benefits for other groups, or try to game the system by determining a person's classification not by his or her needs but by what would best advantage the state financially, which would harm beneficiaries.

A Cut to Medicaid by Any Name is a Cut

A per capita cap would not be a boon to states, as governors understood when they opposed such a proposal in 1997.[5] Instead, like with block grants, these proposals are straight forward cuts to Medicaid, reducing the dollars flowing to the states. They are not focused on improving the program, but instead put cuts over beneficiaries' needs. States will not be able to make up for the funds lost with administrative improvements; Medicaid is already a lean program with little fat. Instead they will turn to cutting services and eligibility.

Implementing Caps Could Create Funding Disparities Between States

States vary widely in their funding levels per beneficiary, due to different costs of living and Medicaid option choices. For example, in 2010, Montana New Mexico and Ohio each spent over $18,000 per senior while Georgia, Nevada and Florida spent less than $9,000.[4] If current rates were frozen, states with low spending would start off with little room to cut and could be penalized for their efficiencies. If all states were forced into one average per capita cap, states would have incentives to cut services for their most expensive populations – seniors and people with disabilities.

Medicaid Waivers Already Allow Administrative Improvements

States already have the ability to apply for budget-neutral waivers to improve their state Medicaid programs. While many cite administrative savings from Rhode Island's Medicaid cap, most of these savings could have come from a non-capped waiver.[6] Under its waiver, Rhode Island actually can receive more federal funding per beneficiary than it would have otherwise, while per capita caps would reduce that level. In fact, the waiver process gives states more flexibility to negotiate rates and rules than they might under a per capita cap.

Caps Will Not Reflect Changing Costs and Populations

Any cap and limited growth rate designed to slow Medicaid funding will likely lead to greater cuts than initially projected. Medical costs are unpredictable, reflecting new demand and innovations. If national medical costs rise faster than projected, states will be forced to make further cuts. Additionally, even though funding may be capped by population group, changes within that group will cause costs to rise. For example, some states will be more likely to eventually have more beneficiaries in their 80s and 90s, leading to a more expensive senior group than they have today. Similarly, states that chose to take up the critical Medicaid expansion in the Affordable Care Act face uncertain costs for this new population. While the new population may cost less, states may also see costly new patients with chronic mental health conditions. States would be locked into a cap despite this important unknown. Setting caps on current Medicaid enrollee spending per state and per population eliminates the program's current advantage of changing as the populations' needs change.

Cutting Medicaid Does Not Address Rising Health Care Costs, Only Shifts the Burden

Per capita caps do not address the underlying causes that lead to rising projected cost for federal health services. Federal health care benefits are not the problem. For example, while some point to recent increases in Medicaid enrollment, these trends were caused by the recession and growth has already slowed and states are reporting lower costs.[7] In order to demonstrate savings, per capita cap proposals set Medicaid expenditures to grow slower the overall health care inflation. Because private health care costs would continue to rise, a per capita cap would lead to hardships for states as already low Medicaid funding buys fewer services. The best way to slow federal health care spending is to encourage economic growth and carefully address the underlying symptoms that have led to higher health care costs for everyone. Per capita caps do neither, instead they would force seniors and their families to take on an even greater burden in shouldering higher health care costs.

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[1] Bloomberg News National Poll, September 9-12, 2011. http://thinkprogress.org/health/2011/09/14/319322/pollcutting-medicaid-is-the-least-popular-option-for-deficit-reduction/

[2] Families USA, "Cutting Medicaid: Harming Seniors and People with Disabilities Who Need Long Term Care," May 2011. http://familiesusa2.org/assets/pdfs/long-term-care/Cutting-Medicaid.pdf

[3] Kaiser Family Foundation. Distribution of Medicaid Payments by Enrollment Group. http://kff.org/medicaid/state-indicator/payments-by-enrollment-group/

[4] Kaiser State Health Facts, Medicaid Payments Per Enrollee, FY2010. http://www.statehealthfacts.org/comparemaptable.jsp?ind=183&cat=4

[5] Pear, Robert. "Governors Oppose Clinton Proposal for Medicaid Cap." The New York Times. January 31 , 1997. http://www.nytimes.com/1997/01/31/us/governors-oppose-clinton-proposal-for-medicaidcap.html?pagewanted=all&src=pm

[6] Cross-Call, Jesse. "Claimed State Savings from Rhode Island's Medicaid Cap Heavily Overblown, Report Shows." Center on Budget and Policy Priorities. March 12, 2012. http://www.cbpp.org/cms/index.cfm?fa=view&id=3703

[7] " Medicaid Today; Preparing for Tomorrow A Look at State Medicaid Program Spending, Enrollment and Policy Trends" Kaiser Commission on Medicaid and the Uninsured. October 25, 2012. http://www.kff.org/medicaid/8380.cfm