

Medicaid Per Capita Caps

What are per capita caps and how would they work?

To lower government spending on Medicaid, some conservatives have proposed limiting the federal contribution to each enrollee's health coverage.¹ The American Health Care Act, the Republican-backed bill recently introduced into the U.S. House of Representatives as a replacement for the Affordable Care Act (ACA), includes a provision that would transition federal Medicaid funding to a per person basis by 2020.²

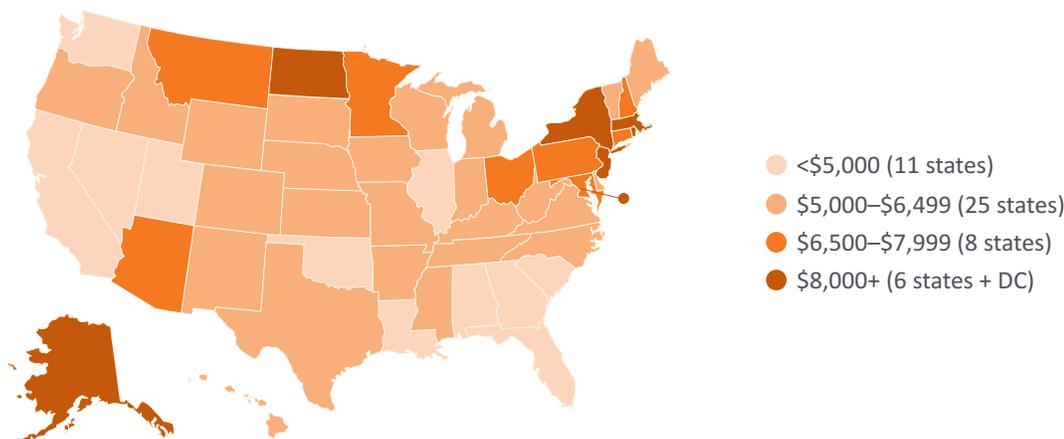
Under the House bill, states would receive payments during the year based on their estimated number of Medicaid beneficiaries and on the per capita cost of serving various groups, such as children, adults, people with disabilities, or the elderly. The principal per capita payment would reflect a state's expenditures "directly" related to health care.³ The House bill also adjusts spending for inflation, based on the medical component of the consumer price index.

While it sets an annual upper limit on federal spending per beneficiary, a per capita cap approach allows for federal funding to increase when enrollment in state's Medicaid program rises during the year.

What's the backstory?

Over the years, Medicaid—the health care program for low-income Americans that is funded jointly by the federal government and the states—has employed a variety of targeted cost-containment measures to control spending. These include reforms to lower outpatient prescription drug costs, expand access to preventive care, and scale up managed care. Together, they have helped keep spending per beneficiary comparable or below Medicare or private insurance levels since the early 1990s.⁴

Medicaid spending per enrollee, 2015



Data: Kaiser Family Foundation, *State Health Facts, Medicaid Spending per Enrollee (Full or Partial Benefit), FY2011*.
Source: S. Rosenbaum, S. Schmucker, S. Rothenberg et al., *What Would Block Grants or Limits on Per Capita Spending Mean for Medicaid?* (The Commonwealth Fund, Nov. 2016).

Medicaid Per Capita Caps (continued)

In 2014, total Medicaid spending rose 8 percent, largely because of the Affordable Care Act's (ACA) expansion of eligibility to people with incomes up to 138 percent of the federal poverty level (about \$16,000 for an individual). Since the federal government fully covered the costs of these new enrollees, its portion of Medicaid spending grew 13 percent, although states' portion increased only 1 percent.⁵

Many conservatives believe federal spending on the Medicaid program is too high. They have called for across-the-board limits on the federal contribution to the states, either by [block-granting Medicaid](#) or by instituting per capita caps.

How would per capita caps differ from current policy?

Medicaid has historically relied on federal funding that rises in tandem with enrollment and states' health care needs—as well as on contributions from states. This flexible funding approach has allowed Medicaid to address health needs arising from economic or societal disruptions: a rise in poverty rates during a recession, the erosion of employer coverage for low-wage workers, longer life spans for people with serious disabilities, and natural or manmade disasters such as Hurricane Katrina or the September 11 terrorist attacks.

In theory at least, per capita caps would be more accommodating than state block grants to a rise in demand for Medicaid coverage. That's because block grants are fixed annual lump sums that do not increase as enrollment rises. But like block grants, per capita caps come with a fundamental trade-off: to save money at the federal level, they must keep spending below projected levels. And that means the burden of covering additional enrollees is shifted to states just as it would be under a block-grant approach. With caps as well as block grants, states face a gap between the costs of providing coverage and the federal funds available to offset those costs.

How would per capita caps affect low-income people, providers, and insurers?

The effects of per capita caps could have significant consequences for people's health care. For example, states might reduce already-low payment rates for doctors and other providers, forcing many out of the Medicaid market and thus limiting enrollees' access to care. This would be especially detrimental to people who need specialized treatment and long-term care.⁶

If the federal government's annual spending updates fail to keep up with rising health care costs, states might reduce payments to Medicaid managed care plans, causing many to cease operations. Or states might narrow Medicaid eligibility to control costs, perhaps even eliminating coverage for high-need, high-cost individuals.

NOTES

¹ This explainer draws from Commonwealth Fund–supported research conducted by the George Washington University's Milken Institute School of Public Health. For further information, see S. Rosenbaum, S. Schmucker, S. Rothenberg et al., [What Would Block Grants or Limits on Per Capita Spending Mean for Medicaid?](#) (The Commonwealth Fund, Nov. 2016).

² T. Jost, "Examining the House Republican ACA Repeal and Replace Legislation," *Health Affairs Blog*, March 7, 2017.

³ Because "directly" is undefined, there is potential room for the U.S. Secretary of Health and Human Services to define the term in ways that exclude legitimate expenditures stemming from clinical innovations. See S. Rosenbaum, "What Does the Draft ACA Repeal/Replace Legislation Tell Us About the Future of Medicaid?" *To the Point*, The Commonwealth Fund, March 2, 2017.

⁴ Medicaid and CHIP Payment and Access Commission, [Report to Congress on Medicaid and CHIP](#) (MACPAC, June 2016).

⁵ *Ibid.*

⁶ S. Rosenbaum, "Medicaid Payments and Access to Care," *New England Journal of Medicine*, Dec. 18, 2014 371(25):2345–47.