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Health Policy Brief

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Per Capita Caps In Medicaid. One way to slow the rise of federal spending on Medicaid would be to calculate per capita spending and set an allowable annual rate of growth.

WHAT'S THE ISSUE?

Medicaid, the joint federal and state program that pays for health care and other services for low-income Americans, cost $432 billion in 2011, and Medicaid spending is expected to grow to $795 billion by 2021. Concerns over the program's contribution to fiscal pressures at both the federal and state levels have led some policy makers to urge reforms.

One such proposed reform would be to impose a cap on the amount of federal spending per Medicaid beneficiary, or what's called a "per capita cap," so that any program spending growth would be linked to enrollment, not rising per beneficiary spending. Supporters contend that instituting a system of per capita caps would moderate the growth of federal spending on Medicaid. They describe the approach as a middle ground between the program as it currently operates and other proposals such as block grants, which would more dramatically change the way federal Medicaid funding is calculated.

Critics contend that a per capita cap approach would not necessarily slow the rate of growth of Medicaid spending. If it did, they say, it would do so by shifting the costs to the states, which would face even greater pressures to cut services or limit eligibility, ultimately limiting many poor Americans' access to care. What's more, they contend that setting up a system of per capita caps would be very complex and difficult to administer.

This policy brief examines the issues surrounding per capita caps in Medicaid and explores other policy options for states and the federal government.

WHAT'S THE BACKGROUND?

Medicaid is the largest public health insurance program in the United States, covering more than 54.7 million low-income people in 2011, including approximately 4.8 million elderly; 9.4 million disabled; roughly 13.2 million nondisabled adults, including pregnant women; and 27.2 million children. The federal government sets requirements on many aspects of the program and "matches" contributions that states make toward the program, according to a formula that takes into account income levels in a given state. By law, states cannot deny enrollment to anyone who is eligible to receive Medicaid benefits.

FEDERAL, STATE SPENDING: The federal contribution, called the Federal Medical Assistance Percentage, ranges between 50 percent and 76 percent of the total Medicaid spending in each state, with a larger percentage being paid in states with lower per capita incomes. On average, federal funding accounted for 57 percent of total Medicaid spending in 2012, with state and some local governments paying the rest. Federal spending on Medicaid con-

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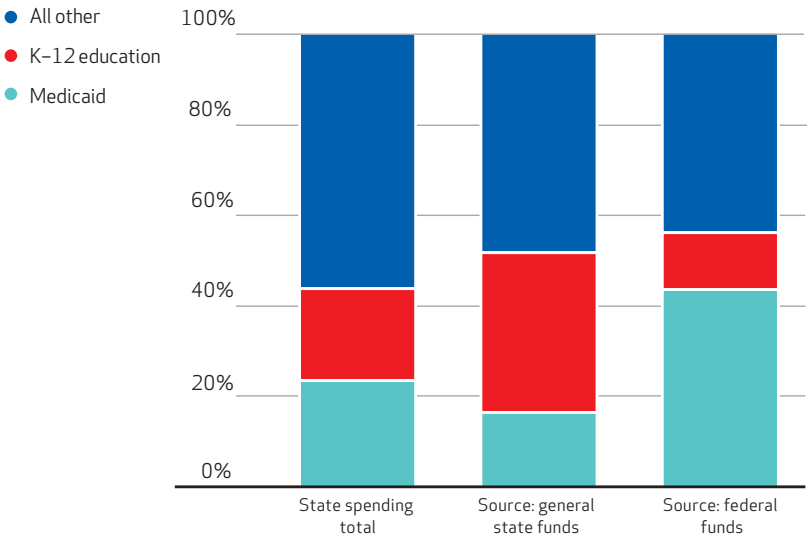
stitutes about 8 percent of the US federal budget. States spend on average 17 cents of every general revenue dollar on Medicaid, making it the second-largest state expenditure following K–12 education (Exhibit 1).

All Medicaid programs must cover physician and hospital services, laboratory tests, and x-rays. The federal government also requires states to cover certain groups of people, such as pregnant women, children in households below specific income levels, and people who are elderly or disabled and receiving Supplemental Security Income. Many states also cover additional "optional" services and populations. Optional services constitute about one-third of total Medicaid spending and include prescription drugs, dental services, rehabilitation, and other therapies. Among optional populations, which states may or may not cover, are low-income adults without dependent children and the elderly and people with disabilities who do not receive Supplemental Security Income. As Medicaid is currently structured, the program's total spending can grow over time for numerous reasons: increasing enrollment, rising costs for standard services, or beneficiaries needing more complex and therefore more expensive services.

Starting in 2014, states have financial incentives under the Affordable Care Act to expand Medicaid coverage to adults under age 65 with incomes up to 138 percent of the federal poverty level (which in 2013 is about $15,856 for an individual and $32,499 for a family of four). During 2014–17 the federal government will pay states 100 percent of the total cost for enrolling these newly eligible people. This federal contribution will gradually decline to 90 percent of the total costs by 2020 and thereafter. This so-called enhanced match is substantially higher than the current match for other beneficiaries. Partly as a result, federal Medicaid spending is projected to grow from about $251 billion in fiscal year 2012 to $572 billion in fiscal year 2023 (Exhibit 2).

EXHIBIT 1

State Medicaid Spending and Source of Funds, 2011



SOURCE National Association of State Budget Officers, "State Expenditure Report," December 2012.

COUNTERCYCLICAL: Medicaid is a countercyclical program, meaning that when the economy declines, unemployment increases, and more people lose income or private health insurance coverage, Medicaid enrollment rises, and Medicaid spending injects money back into the economy. As a result, spending typically goes up at the same time that overall tax revenues are going down.

Before the most recent recession, Medicaid enrollment had held steady for several years. Then it jumped from 45.6 million in 2007 to 54.8 million in 2011, while total spending grew from $326.2 billion to $407.7 billion.

During the two most recent downturns, the federal government stepped in to help states cover the higher Medicaid costs by increasing its share of total spending. In 2011 the extra federal support for Medicaid expired, and states' spending on Medicaid shot up 22.2 percent on average. In response to increasing Medicaid costs, most states have become aggressive in implementing Medicaid cost-control strategies. Medicaid tops the list of fiscal issues that state legislatures plan to tackle in 2013, according to a recent survey conducted by the National Conference of State Legislators.

Longer term, Medicaid spending, like other health care spending, is expected to consume a larger share of the economy over time. The Centers for Medicare and Medicaid Services estimates that total Medicaid spending as a share of the gross domestic product (GDP) will grow from about 2.7 percent in 2010 to almost 4 percent in 2020.

BLOCK GRANTS: Proposals to reform Medicaid and limit spending growth have emerged in the context of the broader debate over federal budget deficits. For example, House Budget Committee chair Paul Ryan (R-WI) has proposed converting the program into a system of block grants to states. Under the proposal, the fixed grants of federal dollars to the states

2.7%

Spending growth per enrollee
From 2006 through 2010, Medicaid spending per enrollee grew 2.7 percent per year, compared to annual Medicare spending growth at 4.5 percent and private health insurance at 4.2 percent.

would be indexed to grow with inflation and population growth over time. Yet, unlike traditional Medicaid, block grants would not increase as costs and enrollment increased. As a result, the more people who enrolled, the less funding there would be for each beneficiary—unless states made up the difference or changed enrollment requirements. Budget resolutions, including this proposal, were passed by the Republican majority in the House in both 2011 and 2012 but were not taken up in the Senate. A similar proposal was included in the House budget plan for fiscal year 2014, which the House passed on March 21, 2013.

Supporters argue that block-granting Medicaid, combined with greater flexibility for states to tailor benefits to match their citizens' needs, would give states incentives to control costs. Critics argue that block grants would end the entitlement nature of the program because states would be pressured to reduce benefits or tighten enrollment requirements. (See the Health Policy Brief published January 12, 2012, for more information on Medicaid reform proposals.) Block-grant proposals are also criticized for doing nothing to address the continued growth in costs that affect all sectors of health care, including Medicaid.

WHAT'S THE PROPOSAL?

The per capita cap approach would limit the amount the federal government spends per beneficiary but not necessarily the amount of total spending. This approach has been advocated by some as a compromise between the current program and the block-grant approach because it allows federal spending to increase as enrollment increases. The approach is not new. President Bill Clinton included a Medicaid per capita cap in his 1997 budget proposal, but it was not adopted. Per capita caps are currently used in many Medicaid demonstration projects to ensure that federal spending does not exceed a specified amount.

Here's how a per capita cap would work. First, total spending and the total number of beneficiaries would both be calculated for a given base year. Then the number representing total spending would be divided by the number of beneficiaries to calculate the initial amount spent per person, or per capita amount. For future years, this per capita amount would then be adjusted by a measure of inflation—for example, the Consumer Price Index (CPI), which measures the change in prices consumers pay for goods, such as food, housing, transportation, and medical care. Finally, this new inflation-adjusted per capita amount would be multiplied by actual current enrollment to compute the total federal Medicaid spending for a specified time period.

Under this methodology, total Medicaid spending could grow only if enrollment increased. In theory, this approach would give states an incentive to control other factors that lead to increased spending, including providing care in higher cost settings, such as emergency departments and nursing homes.

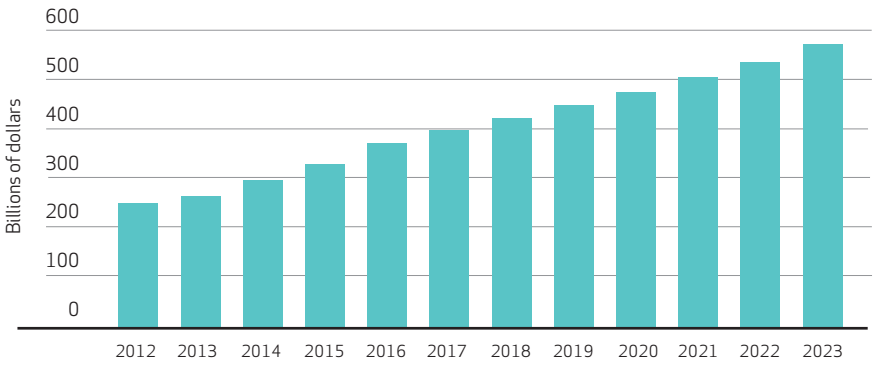
WHAT ARE THE ISSUES?

No specific legislative proposals to enact a per capita cap in Medicaid have been introduced in Congress, but informally, several approaches are being discussed. To assess them, the methodology and metrics used are critical.

• **Populations.** Per capita caps might be applied to the entire population of Medicaid beneficiaries, or as the Clinton administration proposed, caps could be calculated for spending for specific subpopulations, such as nondisabled children, the elderly, the disabled, or nondisabled adults. This approach recognizes the substantial cost differences in providing care to different groups of beneficiaries. For example, in 2011 Medicaid spent an average of $6,982 per beneficiary. However, the average spending per child was only $2,851, while the program spent $17,958 per person with a disability and $15,931 per elderly person. Exhibit 3 simulates the impact on federal spending of a single cap as compared with the impact of population-specific caps.

EXHIBIT 2

Federal Medicaid Spending Projections, 2012–23



SOURCE Congressional Budget Office, "The Budget and Economic Outlook: Fiscal Years 2013 to 2023," February 2013. **NOTE** Spending for 2012 is actual.

"Outcomes of a per capita cap approach would also vary greatly depending on which measure of inflation is used to allow for growth of the cap."

The opportunity to expand Medicaid coverage to nondisabled adults in 2014 could add additional complexities to setting population-specific caps. Because few states now cover this population, it is difficult to estimate what the additional per person costs would be. By law, the federal government will cover 100 percent of the Medicaid costs for the newly eligible population in 2014 and 2015. Some governors and state legislators have questioned whether states can rely on the federal government to meet this funding commitment. Imposing a cap on federal spending might reduce incentives for states to cover this population, leaving more people without coverage and access to care.

Another key detail is whether caps could be set based on a national average of per capita spending or on state-specific spending. Each of these approaches would lead to different outcomes. Because Medicaid programs differ from state to state, Medicaid spending per person also varies. According to the Kaiser Family Foundation, the average national payment per enrollee in 2009 was $5,527, but actual payment per enrollee ranged from a low of $3,527 in California to a high of $9,577 in Connecticut. If a cap is based on individual states' spending levels, states with higher per capita spending would in effect have a higher cap—and therefore would have more options to meet beneficiaries' needs within the cap. However, if a cap is based on national averages, those states currently with lower-than-average spending would have greater room to maneuver once a higher funding level was established.

• **Base year.** The selection of the base year would also be very important. The combination of enrolled population, payment rates, and covered services in that year would determine how much spending would be available in future years. Spending levels from a base year marked by recession would likely reflect a narrower range of services or lower payment rates. On the other hand, setting a base year during a time of improving economic conditions could well reflect more generous benefits and higher payment rates. Using per capita costs from the recent years of recession and weak economic growth would in effect lock in cuts to provider payment rates or reductions in benefits that states made as enrollment and costs increased.

• **Inflation.** Outcomes of a per capita cap approach would also vary greatly depending on which measure of inflation is used to allow for growth of the cap. Some proposals use a growth rate that is tied to a broad measure of inflation, such as the CPI. Others might tie their cap to growth in the overall economy as measured by GDP. However, annual health spending typically grows faster than the CPI and GDP. For example, between 2011 and 2020 overall health spending per person is projected to increase by 5.2 percent annually, while GDP per person is projected to increase by only 3.9 percent annually during the same period. Therefore, if the comparatively slow growth in GDP is used to calculate per capita Medicaid funding, that money won't go as far as it once did, leaving states and beneficiaries to bear the burden as the underlying cost of health continues to grow at a faster rate. To address this concern, it would be possible to use a measure of inflation that is tied specifically to the cost of health care, but this in turn would reduce any potential savings that the cap was originally created to achieve.

WHAT'S THE DEBATE?

As mentioned above, advocates of a per capita cap believe that such an approach would have several benefits—chief among them slowing the growth of overall Medicaid spending. They

EXHIBIT 3

Simulated Impact on Federal Spending from New Medicaid Enrollees: Single Per Capita Cap versus Multiple Population-Specific Caps

			Total federal spending for new enrollees		
Beneficiary group	Total average spending in 2011 ($)	Federal share[a] ($)	Number of new enrollees	Single per capita cap ($)	Population-specific caps ($)
All	6,982	3,980	20	79,600	77,550
Children	2,851	1,625	10	39,800	16,250
Nondisabled adults	4,362	2,486	5	19,900	12,430
People with disabilities	17,958	10,236	3	11,940	30,708
Elderly	15,931	9,081	2	7,960	18,162

SOURCE Amanda Cassidy, author, using 2011 Medicaid spending numbers. **NOTE** Calculations do not include an inflation index. [a]57 percent of average spending.

argue that by capping the amount that states receive to provide care for each person, states will have a new incentive to provide guaranteed basic services much more effectively and efficiently than they do under today's system, where there is no cap on the funding they receive. They also argue that at the same time, per capita caps would still allow states to increase enrollment during poor economic times; then overall Medicaid spending would rise to match those enrollment increases.

By contrast, critics of the per capita cap approach argue that it would do very little to limit the underlying growth in the cost of care. Instead, they say, this approach would lead states to restrict eligibility and reduce either covered benefits or provider payment rates—all of which would limit already vulnerable beneficiaries' access to care. Their arguments include the following points:

- Because Medicaid is one of the largest components of state budgets, states already have incentives to manage costs. During the recent recession, many states already took steps to limit Medicaid spending. It is unclear how much more states could do to greatly reduce spending without reducing benefits, restricting enrollment in Medicaid, and ultimately limiting access to care.

- A system of per capita caps could end the entitlement nature of Medicaid, which essentially gives each qualified beneficiary a guarantee of access to certain health care benefits. As the cost of providing those benefits increases, federal spending also increases to keep pace. However, under a per capita cap, federal spending could not rise to reflect changes in health care practice that may lead to increased costs, such as from a new drug or medical technology. The only way that total spending could grow under a per capita cap would be if enrollment grew—regardless of whether technological breakthroughs raised the cost of providing care.

- Some analysts question whether a per capita cap would even save the federal government money. Much of the growth in Medicaid spending over the past decade has been due to increases in enrollment. In recent years, Medicaid spending has grown because the number of Medicaid enrollees has grown, even as spending per enrollee has grown at a slower pace than total Medicaid spending.

What's more, Medicaid per enrollee spending has also grown more slowly than Medicare or private insurance per enrollee spending. From 2006 through 2010 Medicaid spending per enrollee grew 2.7 percent per year, compared to annual Medicare spending growth at 4.5 percent and private health insurance, at 4.2 percent. Between 2011 and 2020 Medicaid spending per person is projected to grow at the same rate as GDP per person, which suggests that there is little opportunity for the federal government to save money through per capita caps.

Some analysts argue that instituting a per capita cap may be the right approach but only within the context of larger delivery system reforms that some states are pursuing. Oregon, for example, has negotiated a waiver with the Centers for Medicare and Medicaid Services (CMS) that stipulates that state spending on Medicaid will grow at two percentage points a year less than the overall national per capita Medicaid spending growth projected by the Office of Management and Budget. Oregon officials expect to achieve these cost savings by moving to a new health care delivery model that builds on the patient-centered medical home concept, increasing the use of home care services and reducing hospitalizations.

But a cap adopted by a state as part of a waiver, as in Oregon's case, would be different from a general nationwide per capita cap in several ways. For example, under a waiver, states are able to negotiate a cap tied to the expected savings of the specific reform efforts in the state; that is different from having to find ways to achieve mandated savings targets. In addition, a waiver such as Oregon's is time limited. If the arrangement turns out not to be successful, the state may be able to negotiate a new arrangement with CMS or return to its former financing arrangements—whereas a nationwide per capita cap on the Medicaid program that proved problematic would probably need to be amended legislatively by Congress.

"Medicaid spending, like other health care spending, is expected to consume a larger share of the economy over time."

WHAT'S NEXT?

Whether a Medicaid per capita cap will emerge as part of negotiations on the federal budget, or entitlement reform efforts, isn't known. In 2012 Rep. Bill Cassidy (R-LA), a physician and member of the House Energy and Commerce Health Subcommittee, introduced a bill (HR 5979) that included a per capita cap, but the House took no action on it. Implementing a cap was also floated during budget negotiations in late 2012, but no specific proposal was offered either by members of Congress or by the White House.

Changes in federal spending will continue to be debated in 2013 as Congress grapples with 2013–14 budgets and other fiscal concerns. The Obama administration considers any changes in Medicaid to be off the table during these negotiations, since it wants to avoid making major changes in the program as the Affordable Care Act is fully implemented and states wrestle with whether and how to proceed with the Medicaid expansion. However, Republicans in Congress are likely to continue to press for broader entitlement reforms and may push to make a per capita cap approach part of future discussions. ■

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