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A “Cap” on Medicaid: How Block Grants, Per Capita Caps, and Capped Allotments Might Fundamentally Change the Safety Net

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“Under all three scenarios, most states would face increased costs.”

SUMMARY: Changing the Medicaid program is a top priority for the Republican party. Common themes from GOP proposals include converting Medicaid from a jointly financed entitlement benefit to a form of capped federal financing. While proponents of this reform argue that it would provide greater flexibility and a more predictable budget for state governments, serious consequences would likely result for Medicaid enrollees and state governments. Under all three scenarios promoted by Republicans—block grants, capped allotments, and per capita caps—most states would face increased costs. For all three scenarios, the capped nature of the funding guarantees that the real value of funds would decrease in future years relative to

what would be expected from growth under the current program.

Although the federal government would undoubtedly realize savings from all three scenarios, the impact might lead states to reduce benefits and services, create waiting lists, impose cost-sharing on a traditionally low-income enrollee population, or impose other obstacles to coverage. Nationally, as many as 20.5 million Americans stand to lose coverage under the proposed Medicaid changes. In California, up to 6 million people could lose coverage if changes to the Medicaid program were coupled with the repeal of coverage for the expansion population.

Medicaid has transformed over the past decade from a welfare-linked health insurance program to the nation’s single largest public health insurance program. Medicaid is administered through the states but is jointly financed by state and federal governments. As part of the 2010 Patient Protection and Affordable Care Act (ACA), Medicaid was expanded to include all individuals with incomes below 138 percent of the Federal Poverty Level (FPL). The 2012 Supreme Court ruling made this expansion optional for states. This expansion filled a tremendous coverage gap for single, childless, low-income adults, who had previously been largely shut out of health insurance coverage.

Definitions

Block Grant

States would receive a predetermined lump sum in the form of a grant from the federal government.

Per Capita Cap

The federal government would provide states with a capped amount per Medicaid enrollee.

Capped Allotment

States would receive federal matching funds up to a certain limit.

In 2015, Medicaid covered about one in five Americans (about 62.4 million people).¹ Medicaid is currently an entitlement benefit; all those who qualify receive coverage, and states are not allowed to limit enrollment in any way. Republican lawmakers are concerned about the growth of federal Medicaid spending, which in 2015 consumed approximately 9.5 percent of the federal budget.² These concerns have led to reform proposals aimed at reducing the federal government's role in Medicaid financing.

Current Financing

Under current law, Medicaid is funded by a joint federal-state financing arrangement, although each state administers its own program. Federal financing is guaranteed and open-ended, and matching is based on the Federal Medical Assistance Percentages (FMAP), which use state average per capita income in relation to the national average.³ The FMAP varies by state: in 2017, it ranges from 50 percent in a number of states to 74.63 percent in Mississippi.³ States receive an enhanced match rate for the expansion population. States have certain core requirements for receiving federal matching, including coverage of certain populations and services, without the use of caps or waiting lists. States can also extend coverage beyond federal core requirements. States have flexibility in financing services: they can reimburse providers on a fee-for-service basis using their own reimbursement rates, or they can use managed care to cover enrollees.⁴ Spending per enrollee thus varies considerably across states and by population.⁴

In 2015, total Medicaid spending was \$552 billion, of which the federal government financed 62.8 percent.^{5,6} Average per enrollee costs by state vary significantly. In 2011, the high was \$11,091 (Massachusetts), and the low was \$4,010 (Nevada).⁴ Average per capita costs by group also differ: costs for individuals with disabilities and the elderly are on average seven times greater per capita than spending for children, and four times greater than per capita adult spending.⁴ Relatedly, in 2011, the disabled and elderly population made up about 25 percent of

enrollees, although they accounted for 64 percent of spending.^{7,8}

Policymakers have considered three major Medicaid financing reforms to achieve federal cost savings: Medicaid block grants, capped allotments, and per capita caps (Exhibit 1).

Scenario 1: Medicaid Block Grants

The 2015 House budget resolution proposed converting Medicaid to a block grant.⁶ Traditional federal block grants make lump sum payments to states in the form of a grant. Payment amounts are set through a predetermined formula. There is some federal oversight on how states use this financing. Proposals vary with regard to Medicaid block grant specifics, though most seek to lower federal spending in relation to existing law. Converting federal Medicaid financing to block grants would fundamentally change the Medicaid program, as it would no longer be an entitlement benefit.

Supporters of this financing model hypothesize that a reduction in federal spending would lead to innovation in care delivery, more efficient coverage, and more judicious use of Medicaid resources.⁶ Under most block grant proposals, states would likely need to increase their role in financing their Medicaid programs or else limit coverage, benefits, or reimbursement. Federal spending for block grants tends to remain fixed at the original amount, typically only trended forward by inflation, thus decreasing in value over time as the growth of health care costs outpaces the predetermined growth formula. In the case of the Temporary Assistance for Needy Families (TANF) program, a block grant that replaced the Aid to Families with Dependent Children, an open-ended entitlement, actual funding never increased. Across states, TANF funding totals \$16.5 billion, yet funding levels have remained constant since it was block granted; adjusting for inflation, the funding value has declined by 32.5 percent.⁶ The ability to cover families with incomes below 138 percent FPL is therefore heavily impacted: in 1996, 68 out of 100 families in poverty received TANF, compared to 2013, when only 26 out of 100 families in poverty received TANF.⁹

“Under most block grant proposals, states would likely need to increase their role in financing their Medicaid programs or else limit coverage, benefits, or reimbursement.”

Overview of Financing Proposals

Exhibit 1

	Current	Block Grant	Capped Allotment	Per Capita Cap
Coverage	<ul style="list-style-type: none"> Guaranteed coverage for those <133% FPL in expansion states No waiting lists No caps 	<ul style="list-style-type: none"> Not guaranteed Waiting lists or enrollment caps could be instituted by state 	<ul style="list-style-type: none"> Not guaranteed Waiting lists or enrollment caps could be instituted by state 	<ul style="list-style-type: none"> Could allow for changes in enrollment level
Federal Financing	<ul style="list-style-type: none"> Matching payments made to states based on FMAP Guaranteed No cap Changes with enrollment and health care costs 	<ul style="list-style-type: none"> Lump sum payments to states in the form of a grant Payment amounts not based on enrollment, but set through predetermined formula and trended forward 	<ul style="list-style-type: none"> Matching payments made to states up to a certain limit or cap Predetermined growth formula for state allotments 	<ul style="list-style-type: none"> Limit on federal reimbursement per enrollee; caps could be set by national average spending, average state spending, or population group Formula used to set predetermined per capita growth rate Changes in spending not allowed beyond enrollment variation or per capita growth limit
State Financing	<ul style="list-style-type: none"> State matching required; federal spending dependent on state spending 	<ul style="list-style-type: none"> States may not have matching requirements but could be required to show effort of maintaining current spending Once block grant has been depleted, states are responsible for any further spending 	<ul style="list-style-type: none"> State matching required; federal spending dependent on state spending up to cap Once federal matching cap has been reached, states are responsible for any further spending 	<ul style="list-style-type: none"> State matching requirements unclear Once per capita limit has been reached, states are responsible for any further spending
Core Requirements	<ul style="list-style-type: none"> Federal core requirements with state flexibility to expand 	<ul style="list-style-type: none"> Could have some federal oversight 	<ul style="list-style-type: none"> Could have federal core requirements 	<ul style="list-style-type: none"> Could have federal core requirements

Block grants are also vulnerable to budget cuts in times of economic duress. When political will to reduce the federal deficit is strong, it is easier to reduce funding for block grants, as consequences are not usually felt for several years. Traditional block granting does not take into account changes in state population levels or enrollment in Medicaid. During times of economic recession, when many people lose their employer-based coverage and are in need of public support, states would not receive additional federal funding (as is the case now under the open-ended match). With limited federal financing, states could impose caps on benefits and services, enrollment, or waiting lists to control Medicaid spending. As a

result, many individuals would be worse off than they would be if Medicaid remained a need-based program.

When faced with budget deficits, states have turned to freezing enrollment for non-entitlement programs. In 2011, in response to the recession, Arizona froze enrollment for its Medicaid waiver program (which covered single, childless adults) and for KidsCare, the state's Children's Health Insurance Program (CHIP). This enrollment freeze led to roughly 100,000 adults losing coverage and more than 100,000 children being placed on waiting lists.¹⁰ These types of issues could be exacerbated if the federal Medicaid match is removed.

“Block grants are also vulnerable to budget cuts in times of economic duress.”

“There are wide-ranging opinions about which groups of adults are deserving of public health insurance, and to what degree.”

Scenario 2: Capped Allotments

Medicaid could also be converted to a capped allotment. For example, CHIP is financed this way. States would receive federal matching funds up to a certain limit, or cap.⁶ This differs from traditional block grants in that state spending is required in order for states to receive the federal match. The grant is dependent on state spending; states could receive less than their specified allotment for the year if they do not spend enough. However, the grant would be prospectively allocated and could allow for state budget stability.

There are few examples of capped allotment programs that might suggest how a similarly structured Medicaid program might work. Although CHIP is a capped allotment program, it should be noted that there is a significant political consensus around giving children access to health insurance coverage. On average, children are also less expensive to cover than adults, particularly adults who are disabled, have chronic health conditions, or are elderly. These factors may be the reason there have historically been continuous sufficient appropriations for these special groups.

In contrast, a capped allotment program for adults would be more politically sensitive. Among conservatives and some Democrats, there are wide-ranging opinions about which groups of adults are deserving of public health insurance, and to what degree. Adults are also more expensive to cover, so if Medicaid financing moves to a capped allotment system, budget shortfalls may be a significant problem for state Medicaid programs.

Further implications can be inferred from the CHIP program. On average, states spent less than their allotment at the start of the program. In subsequent years, states spent more than what the formula predicted, and Congress authorized additional funds to prevent budget shortfalls. In 2009, the CHIP formula was reformed, allowing for contingency funding for states that had

reached their cap.⁶ Overall, states used less than the federal resources allotted; in 2016, only \$13.5 billion of the \$19.3 billion appropriated was used. However, the Medicaid and CHIP Payment Access Commission could not determine whether this was due to states being more prudent with their spending or to the appropriated allotments being higher than necessary.

Scenario 3: Per Capita Caps

The federal government could institute a cap on how much is spent per enrollee (a “per capita cap”). The recent American Health Care Act (AHCA) proposed this reform. Under this model, a federal formula would be used to set per capita growth limits; to ensure savings, these would be set below the expected growth of the current Medicaid program.⁴ States would be expected to fill any gaps through greater efficiencies, increased spending, limits on enrollment, or the provision of so-called “skimpy” coverage. This proposal would allow for changes in enrollment (unlike the block grant proposal). It would not, however, account for changes in spending beyond variation in enrollment and the growth limit.⁴ For instance, changes in spending due to epidemics, increases in prevalence of chronic diseases, and technological advancement that might lead to effective but expensive therapies would not be factored into a determination of per enrollee reimbursement.⁴ If, for example, an effective but expensive cancer therapy were discovered, it is unclear how this would be financed, since federal funds would not adjust to cover the costs. Either the state would have to cover the additional costs, or the burden of payment would fall on a traditionally low-income patient base.

Several factors must be taken into consideration in designing this financing model, including the base per capita cap, the growth rate, and what, if any, state Medicaid program requirements would be tied to federal reimbursement. This last point is key: under this structure, the federal government could relax rules governing

what basic services are covered, as well as what population groups are “deserving” of coverage. In addition, decisions would have to be made on whether to include disproportionate share payments, Medicare premium payments for the dual-eligible population, or partial coverage for certain groups, all within the per capita cap.⁴

How the per capita cap is determined is vital to state reimbursements. The AHCA set per capita allotments by eligibility group. However, other proposals did not take into account specific population groups, such as the disabled or elderly, instead setting allotments uniformly by national or state average per capita spending. Potentially, this means that enrollees with more severe health needs would likely face a deficit unless the state in which they resided elected to bridge the funding gap. In addition, if how much a state spends per enrollee is based on a state-based uniform standard, it is likely that there would be significant and permanent inequality in spending across states. This is because states would be limited in implementing future state-based Medicaid reforms based on their initial agreement for federal reimbursement.⁴

Most proposals set the growth rate below current projections to achieve savings.^{4,11} Although Medicaid per capita spending does not grow as fast as spending from other payers, there is significant variation in growth between states and populations (i.e., some states have populations that are more costly than others and some cover more services than others, making a uniform standard potentially inappropriate).⁴ If the growth rate is tied to the growth of the economy (for example, the gross domestic product), the per capita cap will not increase in times of recession or slow economic growth, when the program is most needed.⁴

As with capped allotments and block grants, it is unclear what federal core requirements would be compulsory for states under per capita caps, and whether additional benefits would be reimbursed by the federal government.⁴

Proponents of this option describe its impact on the federal deficit and control of federal Medicaid spending.⁴ If the growth rate were set below current projections, it would undoubtedly achieve federal Medicaid savings. States would also likely have more flexibility in administering their Medicaid programs, as well as having more predictable budgets. State flexibility could lead to innovative program design, service delivery, and nontraditional service coverage (such as focusing on upstream social determinants), which could result in a more efficient use of resources. This has been observed in some Medicaid waiver programs.

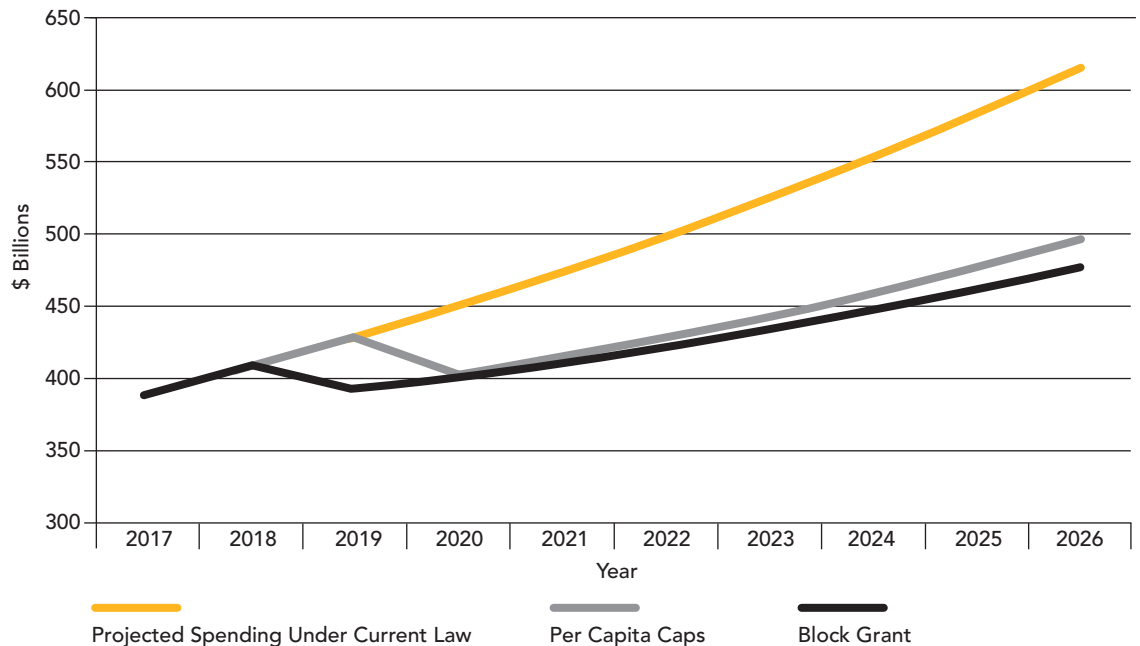
However, as with the capped allotment scenario, there are potential adverse consequences: it could be administratively challenging to implement; it would not allow for changes in spending due to technological advances, cost of medical services, and epidemics or other future increases in disease prevalence; cost increases would likely shift to state governments, beneficiaries, and providers; and states could be limited in future Medicaid reforms.⁴

Determining how much is spent per enrollee nationally could also be difficult. National data have a five-year lag time.⁴ Other factors could lead to a significant gap in federal and state spending or a severely underfunded program. Further, advances in treatment, medical technologies, and pharmaceuticals could increase costs.

Since the per capita cap would not account for these changes, some treatments could be out of reach for Medicaid enrollees or could consume state budgets. Likewise, it is reasonable to believe that per capita caps would be ineffective in controlling epidemics such as HIV/AIDS or hepatitis C, as well as being ineffective in times of natural disasters.⁴

“Enrollees with more severe health needs would likely face a deficit unless the state in which they resided elected to bridge the funding gap.”

Exhibit 2

Comparing Projected Future Federal Medicaid Spending to Capped Federal Proposals^{12, 13}

Projection data from the Congressional Budget Office (see endnotes 12 and 13). Growth rates for capped proposals are based on the CPI-U.

“Patient cost-sharing requirements could affect health outcomes and utilization of services, given that most Medicaid beneficiaries are low income.”

Under all three scenarios, most states face increased costs (Exhibit 2) and thus cost-containment choices, as states are required to balance their budgets.⁴ Some states would try to maintain benefits and coverage levels, and in doing so would need to reduce provider reimbursements. This could potentially limit access for Medicaid enrollees, as there are already significant issues with Medicaid provider participation rates due to low reimbursements.¹⁴ Other states may reduce benefits or limit coverage if a per capita cap is implemented, leaving the poor and low-income population underinsured or uninsured. If there is a uniform national cap, it is unclear what will happen for high-cost Medicaid enrollees, such as individuals with disabilities and the elderly, who have greater needs than typical Medicaid enrollees. Still other states may establish work requirements, patient cost sharing, and premium requirements, or use a combination of these approaches to conserve resources. Patient

cost-sharing requirements could affect health outcomes and utilization of services, given that most Medicaid beneficiaries are low-income.¹⁵ Finally, this proposal would have long-term policy implications. States would essentially be locked into their Medicaid per capita funding levels and would be limited in any care delivery innovations that required an upfront investment.

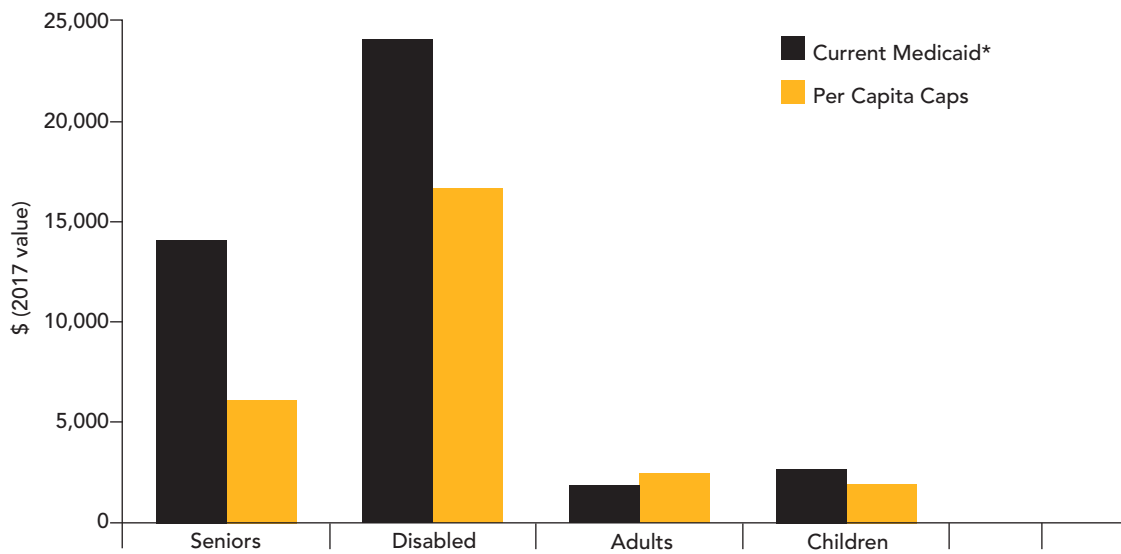
Impact on Federal Spending

All three proposals inherently limit federal Medicaid spending. A 2015 House budget resolution proposed converting Medicaid to a block grant, lowering federal spending by \$732 billion over 10 years.⁶ A 2016 House resolution proposed a capped allotment, which would cut federal funding by roughly \$900 billion over 10 years.⁶

Although details of how these proposals would achieve their cost savings were not clear, the Congressional Budget Office has

Comparing Current Medicaid Spending to Projected Per Capita Caps by Group in California

Exhibit 3



* 2011 California state budget data were used, as these were the most comprehensive data available.

indicated that the majority of savings would come from limiting the proposed Medicaid growth rate to a rate lower than what is actually expected.⁶ In doing so, states would increasingly lose federal dollars over time. Modeling of Rep. Paul Ryan's 2016 "Better Way" plan and the AHCA, both of which included per capita caps, resulted in similar cuts of \$841 billion and \$457 billion over 10 years, respectively.¹⁶ The loss of federal financing would undoubtedly lead to fewer persons covered under Medicaid; one estimate of the 2012 Ryan proposal showed that converting Medicaid to a block grant would result in a loss of coverage for 14.3 million to 20.5 million Americans after the tenth year of implementation.¹⁷ When combined with an expansion repeal, this number would increase by 37.5 million, which would be a 50 percent reduction in enrollment.¹⁸

Impact on California

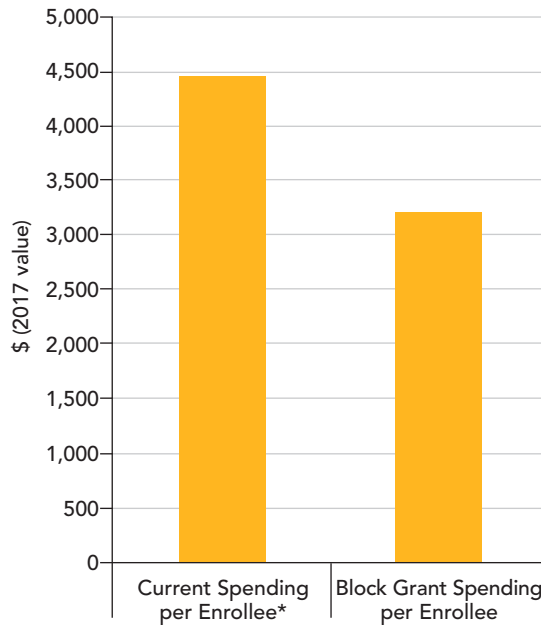
Altering the funding structure of Medicaid to a block grant, per capita cap, or capped allotment would have profound impacts on the financial capacities of the state of California to cover all eligible populations. The amount of financial allocation the state government receives, depending on the type of changes made, will impact the amount the state can spend on covering those currently enrolled in Medicaid, including children, adults, the elderly, and the disabled.

In the case of one proposed version of per capita caps, in just the first year of implementation Medicaid spending would be reduced for all populations except for the young and the healthy (Exhibit 3).^{19, 20} The projected federal Medicaid spending, in the form of per capita caps, illustrates the amount of spending available per enrollee by eligibility category.

“Altering the funding structure of Medicaid would have profound impacts on the financial capacities of the state of California to cover all eligible populations.”

Exhibit 4

Comparing Projected Future Federal Medicaid Spending to Capped Federal Proposals



* 2011 California state budget data were used, as these were the most comprehensive data available.

“The real value of funds would decrease more in future years for all three proposed reforms.”

If the California Medicaid program were to be block granted, in one proposed version the amount of available spending would decrease by 32 percent in the first year alone, from \$4,468 to \$3,226 per enrollee (Exhibit 4).^{19, 20} The projected federal Medicaid spending in the case of block grants represents the lump sum available for California’s Medicaid population, as opposed to the case of per capita caps, where the federal funding received would vary by eligibility category.

Projection data are not available for capped allotments at this time. However, funding would be expected to be lower than the present value, with similar impacts on the state’s ability to cover those eligible under Medicaid. Importantly, the real value of funds would decrease more in future years for all three proposed reforms.

While it is unclear at this time how many Californians would lose coverage under the proposed GOP financing reforms, one 2012 block grant estimate showed that if this were to be combined with ACA repeal, about 6 million Californians would lose Medicaid coverage after the tenth year of implementation.¹⁸

Conclusion

Although the Republicans’ efforts to repeal and replace the ACA with the ACHA were thwarted in early 2017, the GOP continues to consider Medicaid financing reform a priority. New legislation is in the works to revise the AHCA. Elements of a revised bill might include reduced essential benefits, the ending of protections for those with preexisting conditions, and expanded concepts of high-risk pools. The three scenarios outlined above to “cap” federal spending have long been popular with conservatives. Regardless of which scenario they choose, the result will fundamentally change the Medicaid program from an entitlement program based on need to an underresourced option for the many who may, or may not, be able to qualify for services.

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