



Medicaid Per Capita Caps: A Cut in Sheep's Clothing

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Introduction

For more than 50 years, Medicaid has efficiently provided health care to low income individuals and families through a unique federal-state partnership, with the federal government contributing a guaranteed amount of each dollar a state spends on Medicaid.¹ On June 22, 2017, Republicans released the Senate version of their health care bill, called the [Better Care Reconciliation Act of 2017](#) ("BCRA"). BCRA, like the House's [American Health Care Act](#) ("AHCA"), proposes to terminate this open-ended federal-state partnership through the use of the use of [per capita caps](#) ("caps").² Medicaid caps divorce funding from states' actual expenditures, replacing a funding guarantee with an artificial cap, and forcing states to massively cut health care. While full analysis of BCRA's economic impact on states is not yet available, BCRA's cuts to Medicaid will be deeper than AHCA's in the long run.³

Medicaid caps, like the one in BCRA, have been repeatedly dangled in front of federal legislators as a way to slash funding to states under the guise of giving states more flexibility without being upfront about the true costs.⁴ Yet fundamentally altering the funding structure of Medicaid to a per capita cap will forever put states at risk for severe cuts and substantial inequities. **The evidence is unmistakable: While BCRA and other per capita cap proposals put forward in recent years differ in details, they all led to same result — a gargantuan cut in federal money to states and arbitrary funding inequities between states.**

Republicans have tried to impose caps before: in 2016, they attempted to impose a cap through a proposal called "A Better Way" ("ABW"). Design differences among these proposals do not change their devastating outcomes. Regardless of the base year or inflation index picked, Medicaid caps like BCRA, AHCA, and ABW permanently codify massive and inequitable cuts in federal funding. Once such fundamental changes are enacted, Medicaid will always be vulnerable: Congress can continually adjust the growth rate to impose even bigger cuts.⁵

I. Medicaid Caps Slash Funding for States

AHCA cuts a colossal \$834 billion in federal funding to states by both imposing caps and functionally eliminating Medicaid expansion.⁶ Although the Congressional Budget Office's analysis is not yet available for BCRA, it is likely that the Medicaid cuts will be even deeper. Cuts are par for the course for Medicaid cap proposals. A conservative estimate found ABW would cut \$841 billion to states.⁷ Finessing the details of per capita caps by using different rates of inflation does not change the fundamental fact that caps lead to cuts.

To put these cuts in perspective, under AHCA, twelve states would have to increase their current state Medicaid spending by 25% or more to make up for the losses. West Virginia would have to increase spending by \$4 billion – a 34% increase.⁸ BCRA's cuts are expected to be even bigger. Many states – including West Virginia – are *already* dealing with severe budget crises. Adding historic Medicaid cuts onto those deficits will be cataclysmic.

The proposed growth index in BCRA and prior proposals have all been lower than historic Medicaid growth rates. Using a growth index tied to the Consumer Price Index (ABW), a combination of CPI and CPI-Medical for different groups of beneficiaries (AHCA), or the CPI-Medical for a set number of years and then dropping down to CPI for perpetuity (BCRA) artificially ties growth to consumer spending rather than to actual health care costs. Further, limits on growth rates put states at risk for 100% of any new costs not included in the baseline year. These new costs can arise from the development of new vaccines, prescription drugs, or treatments; from epidemics or the outbreak of new diseases or illnesses; from an aging population; from natural disasters; and from states' up-front investments in technology or infrastructure intended to improve care delivery or save money in the long run.

II. Medicaid Caps Impose Disproportionate and Inequitable Cuts on States

The massive cuts under BCRA and AHCA **will hurt all states**. The pain, however, is not distributed equally; some states will lose more than others. This is because caps:

- lock in historic spending patterns;
- fail to account for variability in state growth rates;
- do not compensate for increased need in traditionally low-income states; and
- fail to compensate states that have relied on increased funds from Medicaid expansion.

Under AHCA, the following states will suffer more than their fair share of the inequitable cuts: **Alaska, Arizona, California, Colorado, Connecticut, Delaware, Hawaii, Illinois, Kentucky, Maryland, Massachusetts, Minnesota, Nevada, New Hampshire, New Jersey, New**

Mexico, New York, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, Vermont, and Washington.⁹

a. Per Capita Caps Harm States by Ignoring States' Future Needs and Permanently Freezing Spending Patterns

Caps harms states by locking them into a one-time “snapshot” of their spending – freezing inequities in spending, and thereby federal reimbursement, for perpetuity.

Medicaid is an extremely flexible and state-specific program. Some states traditionally spend less on Medicaid. In some cases, this is because of differences between state programs, such as increased efficiency and innovation, slimmer optional benefit packages, or simply because the cost-of-living is lower than average, and therefore the cost of providing health care is less in that state.¹⁰ In other cases, differences in Medicaid spending are simply a function of annual fluctuations. A state may spend a little less in one year due to a state budget shortfall and then increase funding in the next year due to political changes or increased revenues.

States that have lower than average spending in the cap's “base year” risk being frozen at low spending levels forever, without any flexibility to choose to offer more benefits or reinvest savings gained through efficiency or innovation. Proposals have been floated to choose a new base year every few years. This “rebasings,” however, is not the “reset button” it is made out to be. Once a cap is implemented, states have heavy incentives to underspend the ceiling every year. Resetting new ceilings based on post-cap spending levels could lead to even more restrictive caps and increasing cuts in federal support. In this way, rebasing creates the risk of a “[one-way ratchet](#)” instead of a safety valve.

To implement a cap, Congress must pick a base year from which to calculate growth. AHCA will freeze spending in 2016, while ABW would have frozen funding in 2019. BCRA lets a state choose a time period to freeze it at some point between 2014 and 2017, by allowing states to pick eight consecutive quarters from which to calculate future spending. The base year influences *which* states will lose the most, but any caps based on a snapshot in time will cause *all* states to permanently and substantially lose out on the opportunity for more funding. Caps turn short-term state budget spending decisions into permanent long-term spending ceilings.

This kind of “snapshot” of spending increases inequities across states, because Medicaid spending varies dramatically among states. Total federal Medicaid expenditures per enrollee by eligibility group vary across states by a factor of at least 2 to 1. Spending on subgroups of beneficiaries varies even more between states, which is significant because BCRA, AHCA and other cap proposals apply different growth indexes to different subpopulations.¹¹

Medicaid expenditures for the aged span from a high of \$44,752 per person in Delaware, to a low of \$8,623 in South Carolina. Under a cap, South Carolina would be stuck forever at its relatively low spending level, even as its older adult population continues to age and needs more services. Similarly, per capita spending for a child in Vermont is \$4,612, but only \$2,984 in New Hampshire. If a cap like AHCA were imposed, a child in Vermont would forever get almost twice as much allotted to the state for her care than her neighbor living across the border in New Hampshire, irrespective of what either state needs to meet future needs.¹²

b. Caps Harm States By Ignoring Variability in the Growth of Costs

Not only does a cap lock states into a one-time snapshot of spending, but it also fails to account for the fluctuations across states in the rate that Medicaid costs grow (“growth rate”). The effect of growth rate variations across states can be dramatic. For example, if a Medicaid cap like AHCA’s had been in place from 2001-2011, more than half of the states would see a funding drop in federal Medicaid funds of more than 10%. At least four states would have faced cuts of 20% or more.¹³ Furthermore, the risk to the states is asymmetrical: if the state spends less under the cap in one year, the state does not get extra funds to roll over to the following year. Even a state that, on average, matched the growth index for the cap over a ten year span would lose funding in some years, because the growth in annual Medicaid costs fluctuate by year.¹⁴

Some cost drivers are relatively predictable. As one example, HIV/AIDS rates of diagnoses are growing most rapidly in Nevada, the southeast United States, and some states with large urban populations. Providing health care for individuals with HIV/AIDS is expensive.¹⁵ It is predictable that Medicaid spending associated with HIV/AIDS treatment will rise in **Florida, Georgia, Louisiana, Maryland, Mississippi, Nevada, New Jersey, New York, North Carolina, South Carolina, Texas, and the District of Columbia**, compounding the harm caused by AHCA’s unprecedented cuts.¹⁶

Other cost drivers are completely unpredictable. The 2001 attack on the World Trade Center led to an increased need for mental health and medical care in its aftermath, which New York quickly addressed through a new Medicaid waiver.¹⁷ The [opioid overdose epidemic](#) has led to a 20% increase in overdoses in 2016, increasing the need for overdose-reversal medication like naloxone, and the need for medication-assisted treatment like Buprenorphine as well as an overall increased need for substance use disorder treatment. In [West Virginia](#), Medicaid pays for 45% of all buprenorphine prescriptions in the state. If an exigent need forces a state to spend more on health care than is permitted by the cap, that state is on its own; no federal assistance will be available once the state hits its cap. States experiencing emergencies lose the opportunity for potentially hundreds of millions or billions of dollars in federal assistance.

Some fluctuations have more mundane causes. Costs rise when a state increases provider payment rates necessary to attract sufficient qualified providers. The impact, however, is the same: Medicaid caps fail to account for increases in spending that are not related to increased enrollment, and they harm states by not accounting for these fluctuations.

Not only do growth rates fluctuate over time, buy it's typical that a state that spends less than average one year tends to spend more (grow a bit faster) in the following years.¹⁸ This tendency is important because if a state happens to be in the low-spending part of the cycle in

the selected base year, it is more likely to be hurt by the cap. Medicaid caps will hit these states twice, first by having their spending frozen at historically low levels, and then by being forced to live under a growth index that is less likely to keep pace with actual growth. If a cap like the one under AHCA had been imposed from 2001-2011, states with below-median per beneficiary costs would have been forced to absorb 85% of estimated federal spending reductions.¹⁹ States with the lowest current spending, and therefore more likely to require faster growth in the future, include **Alabama, Georgia, South Carolina, Florida, Illinois, Oklahoma, Utah, and Nevada.**²⁰

c. AHCA Penalizes Poorer States That Expanded Medicaid

Medicaid, by design, gives poorer states more federal assistance. The federal share of Medicaid costs is based on a state’s per capita income so the poorer the state, the higher the federal matching rate, also known as Federal Medical Assistance Percentages (FMAP).²¹ States that expanded Medicaid also get a higher FMAP for that population as an incentive to expand coverage. A low-income state with both a high FMAP for its regular Medicaid population and the enhanced FMAP for newly eligible adults faces a disproportionate reduction in federal funds under AHCA.

Table 1 Expansion States with Low FMAPs Harmed by Caps²²

State	FMAP	Percentage of increase needed in state spending to make up for AHCA funding gap.	Percentage of Increase needed in State Spending to Make up for funding gap caused by A Better Way
National	N/A	16%	30%
New Mexico	71%	55%	82%
Kentucky	70%	52%	82%
Oregon	64%	48%	71%
Nevada	65%	38%	58%
West Virginia	72%	34%	62%
Montana	66%	34%	62%
Arizona	69%	30%	49%

Because BCRA and AHCA both impose a cap and eliminate expansion funding, all states will face massive federal cuts that will be impossible to fill (even if they did not expand), but low income states that have also expanded Medicaid will be hurt the most, as they will be forced to increase state spending even more to fill federal funding gaps. These low income expansion

states include: **New Mexico, Kentucky, Oregon, Nevada, West Virginia, Montana, and Arizona.**

d. Medicaid Caps Harm Other States that Expanded Medicaid

AHCA also harms states that, due to expansion, successfully enrolled new Medicaid beneficiaries but still otherwise have a low FMAP for the non-expansion population. These states will experience a dramatic decrease in the reimbursement rate for their expansion population. For example, Alaska’s FMAP for its expansion adults would decrease by 44%. By comparison, for the same population, Kentucky’s reimbursement rate would only decrease by 22%, since Kentucky’s FMAP for the non-expansion population is higher than Alaska’s.²³ The same concept applies to all Medicaid cap proposals. Due to their successful implementation of Medicaid expansion, **Colorado, New Jersey, and Washington** would all experience a federal cut of 20% or more under AHCA. The same states would be harmed under ABW, with overall cuts of 25% or more. Under these two proposals, using different base years and growth indexes, these same states are harmed by the combination of imposing caps and eliminating Medicaid expansion. These states will be forced to choose between cutting health care for large numbers of individuals, or absorbing a huge loss of federal funding.

Table 1 Expansion States with Low FMAPs Harmed by Caps²⁴

State	FMAP	AHCA: Percent decrease of federal funding	ABW: Percent decrease of federal funding
National	N/A	10%	18%
Colorado	50%	20%	27%
New Jersey	50%	21%	28%
Washington	50%	20%	27%

III. Conclusion

Medicaid caps have been repeatedly proposed, most recently in BCRA. Significantly, the details of the base year or growth index used under various Medicaid cap proposals do not meaningfully change the outcome. Proposed caps all lead to massive cuts in funding, and substantial inequities between states. Caps turn short-term state budget decisions into permanent ceilings without regard for a state’s future needs. Caps also cannot accommodate the widely variable growth rates among different subpopulations in different states. Last, caps impose the biggest burdens on low income states and states that relied on federal incentives to expand Medicaid. Medicaid caps are not a new or innovative idea; they are a recycled gimmick that will slash funding to states and dismantle the 50-year partnership that has successfully provided health care to so many Americans.

ENDNOTES

¹ See generally Teresa A. Coughlin, et al., Kaiser Family Found., [What Difference Does Medicaid Make? Assessing the Cost Effectiveness, Access, and Financial Protection Under Medicaid for Low-Income Adults](#) (May 2013) (comparing cost of low income beneficiaries in Medicaid compared to their expected costs in private insurance); Medicaid and CHIP Payment and Access Comm'n. (MACPAC), [Report to Congress on Medicaid and CHIP](#) at xiii (June 2016) ("Medicaid spending overall is expected to grow at a slower rate than Medicare and private insurance—growth in spending per enrollee has been lower than or comparable to Medicare and private insurance since the early 1990s.").

² American Health Care Act of 2017, H.R. 1628, 115th Cong. (2017).

³ Office of the Speaker of the House, [A Better Way: Report from the Health Care Reform Task Force](#) (June 22, 2016) at 26 (proposing a growth index of CPI, and a base year of 2019); American Health Care Act of 2017, H.R. 1628, 115th Cong. (2017) (proposing a growth index of the Consumer Price Index for Medical Care (CPI-M) for all beneficiaries for the first three years, then CPI-M for adults and children, and CPI-M +1% for people with disabilities and the aged, and a base year of 2016). BCRA proposes of CPI-M + 1% for people with disabilities and the aged for 2020 to 2024, and CPI-M for kids, adults, and the expansion population for 2020 to 2024. After 2024, the growth index drops to CPI for all beneficiary categories.

⁴ Per capita caps proposals have been proposed and defeated numerous times. See e.g. Medicaid Accountability and Care Act of 2012. H.R. 5979, 112th Cong (2012); Rep. Fred Upton and Sen. Orrin Hatch, [Making Medicaid Work](#) (May 1, 2013).

⁵ Kelly Whitener, Georgetown Univ. Health Policy Inst., Ctr. for Children and Families, [Dialing for Dollars](#), Say Ahhh! Blog (May 18, 2017).

⁶ *Id.* at 8; Cong. Budget Office, [Cost Estimate, H.R. 1628 American Health Care Act of 2017, As passed by the House of Representatives on May 4, 2017](#), at 13 (May 24, 2017).

⁷ John Holahan, et al., Urban Inst., [The Impact of Per Capita Caps on Federal and State Medicaid Spending](#) (March 2017) at 8.

⁸ *Id.*

⁹ *Id.* at 15-16. This analysis is based on Urban Institute's analysis of the projected percentage change in total spending under each proposal. It does not take into account harm caused by state-specific lost opportunities, health risks, or other factors. For a more detailed analysis of states' risk factors under caps, see Robin Rudowitz, et al., Kaiser Family Found., [Factors Affecting States' Ability to Respond to Medicaid Cuts and Caps: Which States are Most at Risk? \(June 2017\)](#).

¹⁰ As the Congressional Budget Office noted, an unintended consequence of per capita caps may be that efficient states are harmed more by per capita caps than inefficient states. Cong. Budget Office, [Options for Reducing the Deficit](#) at 225 (Dec. 2016) ("[S]tates that have made efforts to operate their programs efficiently to keep costs low would receive caps that reflected that efficiency and were, all else equal, lower than the caps of states with inefficient programs. Therefore, those efficient states would have less flexibility to reduce spending to comply with the caps while inefficient states would have more flexibility.").

¹¹ John Holahan and Matthew Buettgens, Urban Inst., [Block Grants and Per Capita Caps The Problem of Funding Disparities among State](#) at 8, table 2 (Sept. 2016).

¹² Kaiser Family Found., [Data Note: Variation in Per Enrollee Medicaid Spending](#) (June 2017).

¹³ Rachel Garfield, et al., the Kaiser Family Found., Data Note: [What if Per Enrollee Medicaid Spending Growth Had Been Limited to CPI-M from 2001-2011?](#) at 4 (March 2017).

¹⁴ Loren Adler, et al., Brookings, [Effects of the Medicaid Per Capita Cap Included in the House-Passed American Health Care Act](#) at 8 (May 2017).

¹⁵ Ctrs. for Disease Control & Prevention, [HIV in the United States by Geographic Distribution](#) (March 7, 2017); Kaiser Family Found., [Medicaid and HIV](#) at 3 (Oct. 2016) (in 2011, annual per capita spending on HIV positive beneficiaries was almost 5 times that of Medicaid beneficiaries overall).

¹⁶ Kaiser Family Found., [Factors Affecting States' Ability to Respond to Federal Medicaid Cuts and Caps](#), Table 5.

¹⁷ Jocelyn Guyer and David Rosales, Manatt Health, [Medicaid's Role in Public Emergencies and Health Crises](#) at 2 (April 2017).

¹⁸ Adler, et al., *supra* note 14.

¹⁹ *Id.* at 2.

²⁰ Katherine Young, et al., Kaiser Family Found., [Medicaid Per Enrollee Spending: Variation Across States](#) (Jan. 2015).

²¹ Every state has an FMAP assigned to it. This rate is the percentage of each dollar a state spends on Medicaid that the federal government contributes. This rate is generally calculated on a formula that is based on the state's per capita income. The poorer a state's residents, the more help the state receives from the federal government for each dollar spent on Medicaid. See generally Kaiser Family Found., [Medicaid Financing: An Overview of the Federal Medicaid Matching Rate](#) (Sept. 2012).

²² Kaiser Family Found., [Federal Medical Assistance Percentage \(FMAP\) for Medicaid and Multiplier for FY 2017](#) (June 2, 2017); Holahan *et al.* at 12-13 (table 5).

²³ Alaska receives at least a 90% FMAP for the expansion population. For other populations, the FMAP is 50%. The change from 90% to 50% represents a 44% decrease in funding (the decrease in funding is derived by dividing the amount of decrease divided by the original FMAP). Kentucky, like Alaska, receives at least a 90% FMAP for the expansion population. However, Kentucky's FMAP for other populations is 70%. The reduction of 90% to 70% represents a 22% decrease in funding for that population.

²⁴ Kaiser Family Found., [Federal Medical Assistance Percentage \(FMAP\) for Medicaid and Multiplier for FY 2017](#) (June 2, 2017); Holahan *et al.* at 10-11 (table 4).