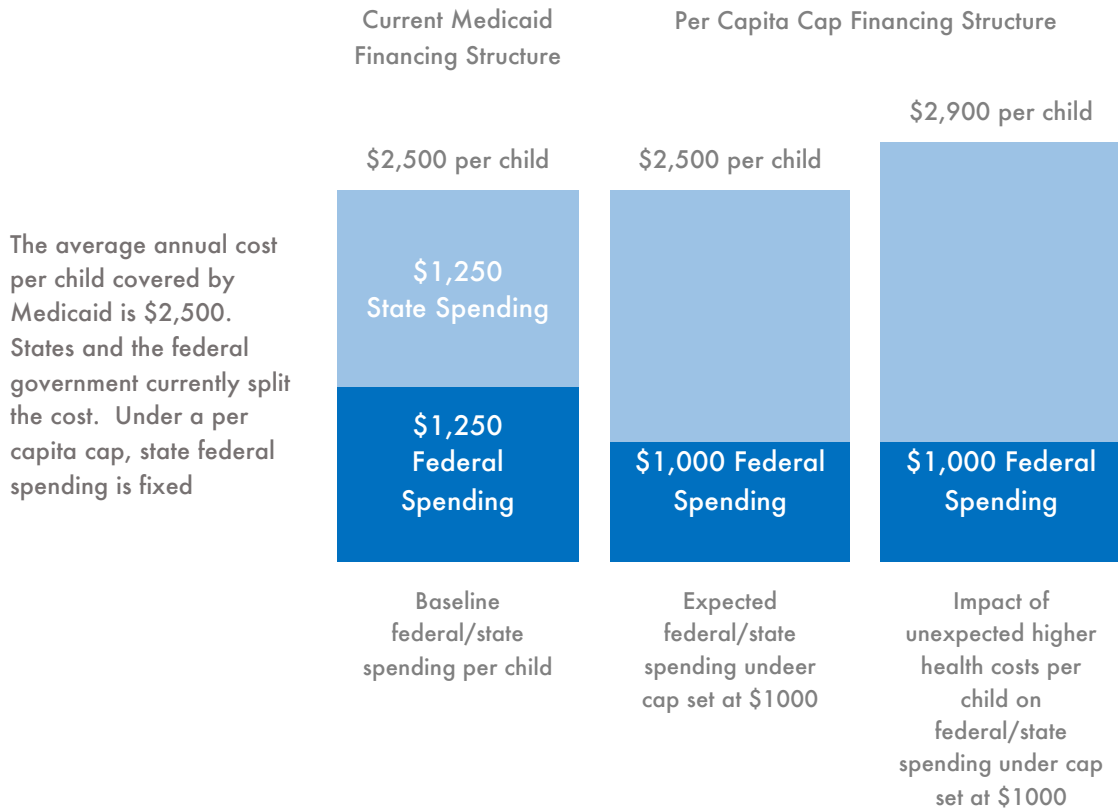




On June 22, Speaker of the House Paul Ryan (R-WI) unveiled the GOP’s latest Obamacare replacement plan. On the Medicaid front, Ryan is again promoting a “per capita cap” on federal Medicaid expenditures to shrink federal Medicaid spending and score budget savings. While this approach has been previously discussed as an alternative to a Medicaid block grant, the effect of per capita caps would be equally devastating for the vulnerable populations that rely on Medicaid, including primarily, low-income children, seniors, and the disabled. Like a block grant, a per capita cap serves only to cut federal costs by setting arbitrary limits on federal Medicaid spending. Not only would a per capita cap jeopardize the Medicaid entitlement by underfunding states, it would force serious cuts in benefits and services for the vulnerable populations Medicaid is designed to protect.

HOW DO MEDICAID PER CAPITA CAPS WORK?

The overall intent of a per capita cap is to reduce federal Medicaid expenditures. While the details will vary depending on the particular proposal, in general, per capita caps reduce Medicaid costs by segmenting out the various populations that rely on Medicaid (e.g., children, adults, the disabled, senior citizens) and then setting an overall cap on the federal support that will be provided for each subpopulation. The savings are derived by increasing annual per-beneficiary payments at a slower rate than the projected rate of growth of per-beneficiary costs under the current Medicaid system. Under this scenario, states would be reimbursed up to the capped amount for each of the defined subpopulations regardless of how much their care actually costs.



**DEFINING SUBPOPULATIONS.** To implement a per capita cap, policymakers would first have to reach agreement on the subpopulations for which caps would be set. Payment caps could be set for different subpopulations nationally, like a national flat amount per child, per person with disabilities, or per senior citizen, etc. Alternatively, a cap could be set for each state based on that state’s historic Medicaid costs per subpopulation – thereby creating 51 individual and disparate caps (each state and the District of Columbia) across the country. The number and types of subpopulation categories would vary depending on the details of a particular proposal. For example, should pregnant women have their own cap? Does a child with cancer count as a “child” or someone with “disabilities”? There are a variety of strategies policy makers would consider as they carve up the Medicaid population.

While creating more subpopulations would arguably allow the per-beneficiary allotment to be better matched to that groups’ needs, a large number of subpopulations would add to the complexity of the caps’ implementation, diverting health care dollars from patient services to a new administrative bureaucracy. The creation of many subpopulations within and across states would also require significant federal oversight of state accounting practices. For example, federal Medicaid officials would have to pay close attention to how states assign enrollees into the various subgroups to be able to achieve expected savings.

**SETTING CAP AMOUNTS.** For policymakers, one of the most challenging aspects of developing a per capita cap policy would be to reach agreement on the formulas that would establish the caps for each subpopulation in each of the 50 states and D.C. In theory, a single formula could be devised to meet the competing interests of the states, but in reality it would be extremely difficult to design a set of caps that would be agreeable for all states, as health spending varies widely across the country. Under the current system, Medicaid allotments take a variety of factors into account to be sure states are able to meet the needs of their citizens. For example, historically states have had flexibility to set their own payment rates, determine benefits packages (including flexibility on amount, scope, and duration of services), and address other concerns specific to their unique health care environments (e.g., reimbursement for transportation services or telemedicine costs in rural states, etc.). While a national cap would simplify implementation, the variation in existing Medicaid support across the states would create a set of winners and losers that would make consensus on a uniform cap virtually impossible to reach.

On the other hand, a state-by-state system of caps would require the creation of a new administrative bureaucracy to manage compliance because there would be 51 different caps for every subpopulation established. In addition, the imposition of these caps would be arbitrarily determined and the disparities in health costs across states that existed in the particular year for which the cap is set would be locked in forever. If a state happened to improve payment rates to providers or had done a poor job of tackling health care fraud in that single year, these added costs – both good and bad – would provide the state with a higher cap rate into eternity. Meanwhile, a state that was planning a provider payment increase or had been effective in reducing health care fraud would be forever penalized with a lower cap rate. The inevitable “formula fight” between the states over fair payment rates is one of the reasons that previous per capita cap proposals had been considered briefly in the 1990s but were quickly abandoned. Those who worked on the per capita cap concept during the Clinton Administration found it impossible to come up with fair cap levels across states and subpopulations that would be agreeable to states.

For example, a state with historically lower spending per Medicaid beneficiary would argue for a national cap and say they should not be penalized for having run a more frugal and efficient Medicaid program. In contrast, a state with historically higher spending per Medicaid beneficiary would argue for individual state caps to recognize the needs and differing health care environments in each state that account for cost variations.

It is important to highlight that once a cap has been established, the amount of funding the federal government would provide per beneficiary in each category would be fixed and remain the same, no matter how much it actually costs to care for these patients. Thus, if the average initial federal cost per child in a one state is \$1,000 and \$1,500 in another, the federal government might provide a capped amount of \$100 million to deliver health care to 100,000 kids in the first state and \$150 million for the same number of kids in the other state. Needless to say, Members of Congress from the first state would argue the cap amount should be set at the national average and both states should thereby receive \$125 million, while Members from the higher cost state would strongly object to a permanent 17 percent cut in funding for their Medicaid children. It is hard to imagine that any state would agree to such a cut especially given the widespread complaint that Medicaid already underpays providers even without capped allotments.

## **WHY ARE PER CAPITAL CAPS BAD FOR CHILDREN AND OTHER VULNERABLE POPULATIONS?**

**PER CAPITA CAPS THREATEN THE MEDICAID ENTITLEMENT.** In order for Medicaid to remain an entitlement, federal financing must be available to cover all individuals who meet state-specific eligibility requirements. While per capita caps would maintain existing eligibility definitions, they would impose arbitrary limits on the amount of federal support available to states to fund this care. Specifically, the federal government would no longer cover a proportionate share of each state's overall Medicaid costs based on the federal matching rate and instead would cover a fixed amount per beneficiary, regardless of the actual costs of care. While nominally preserving the Medicaid entitlement, ultimately, per capita caps would force major "back-door" changes to the Medicaid entitlement that would restrict or eliminate the benefits and services that protect the health of vulnerable populations.

**PER CAPITA CAPS ARE A BAD DEAL FOR STATES.** While per capita caps do adjust for population changes, they also impose an overall hard limit on federal spending like a block grant would. Thus, the impact on states would be similarly devastating. The fact is that no matter how the formulas are set by Congress, per capita caps represent an enormous cost shift to states and localities. Right now states receive federal matching support for Medicaid based on the total number of people who meet Medicaid's eligibility requirements and the cost of delivering care to that population. Under a per capita cap, the total level of federal support for the costs of care would be cut while the Medicaid eligibility criterion remains the same.

In short, under a per capita cap, the federal government would shift 100 percent of the risk and costs to states for any spending above the arbitrarily set limit – regardless of whether a state or the nation experiences a medical epidemic (e.g., like AIDS in the 1990s or Ebola, measles, or spikes in flu cases); natural disasters (which typically lead to higher rates of injury, disability, and illness); or a medical breakthrough (such as a cure for cancer or Alzheimer's disease).

At best, a per capita cap would freeze current Medicaid allotments and shift 100 percent of the costs above the federally-imposed cap to the states. States that experience a Medicaid funding shortfall because costs exceed the cap would have no good options to make up the difference. They would have to use their own money to shoulder the cost of providing health care to poor people or limit services, cut provider payment rates, or reduce benefits. The bottom line is per capita caps would seriously underfund Medicaid at the state and local levels, with a devastating impact on the children and families who rely on Medicaid for their health care.

**MEDICAID IS ESSENTIAL TO STATE ECONOMIES.** Medicaid's federal-state partnership is essential for state economies. It is the largest source of federal funds to states and it fuels state economic activity. The federal government matches state spending in Medicaid at least dollar for dollar and, according to the Kaiser Family Foundation, these federal Medicaid matching funds are the largest source (48 percent in 2014) of federal funds to states. Medicaid not only ensures a health care safety net for low-income populations, it also plays a key role in creating jobs and raising revenues for hospitals, nursing homes, clinics, pharmacies, and other providers, and bolsters economic activity well beyond the health sector.

According to the Kaiser Family Foundation, Medicaid is the second largest program in most state budgets after elementary and secondary education, with states spending approximately 18 percent of their own funds on the program on average. Those who support per capita caps frequently inflate Medicaid spending data to make it appear that Medicaid is a drain on state economies. They do so by adding the federal support they receive to their state-share calculation, even though those are not state funds.

**PER CAPITA CAPS DISADVANTAGE CHILDREN.** Per capita caps are particularly troublesome for Medicaid's child population because the cap for children, given their relatively inexpensive coverage costs, would likely be far lower than for other Medicaid populations. With a low cap for children, states would have less "wobble room" to adjust their spending and would be less likely to adopt new initiatives to improve access to care or delivery of services for kids. For example, states would have little incentive to increase payment rates for pediatric providers or take advantage of scientific breakthroughs for kids via new medical procedures, devices, or drugs, if adoption of such initiatives would have to be paid for using state-only funds.

**PER CAPITA CAPS RESULT IN RATIONING OF CARE FOR THE SICKEST AND MOST NEEDY PATIENTS.** Per capita caps would have grave implications for individuals with serious illnesses or chronic conditions and children with special health care needs because the cost for their care, which is significantly higher than that for other Medicaid beneficiaries, would certainly exceed any cap that is set. States would be left with a substantially higher fiscal burden for the sickest and most vulnerable Medicaid beneficiaries. This would create dangerous and perverse incentives that could jeopardize care for high-cost patients. For example, if the state has a cap of \$1,000 per child but the cost of an individual child with cancer or in need of heart surgery is hundreds of thousands of dollars, the incentives to ration care for these children would be very high and could potentially be life-threatening.

**PER CAPITA CAPS ARE AN ADMINISTRATIVE BURDEN.** In addition to the complexities of determining subpopulations and establishing formulas that are agreeable across the states, per capita caps would also require the creation of new administrative systems at both the state and federal levels to ensure that states apply the caps in an appropriate manner. Previous efforts to establish per capita caps in Medicaid during the 1990s showed that unless a massive new compliance system is incorporated into the policy, the Congressional Budget Office (CBO) would not score Medicaid savings from per capita caps. In the previous effort, CBO predicted that states would game the caps in order to draw down the maximum amount of federal funds. In order to avoid gaming, the federal government would have to build complex enforcement mechanisms that would require new federal and state bureaucracies to oversee the implementation of the caps. This would not only place additional burdens on states, it would also require significant new resources for this purpose, further eroding anticipated Medicaid savings.

Numerous administrative questions would certainly arise and how these issues are decided would have enormous financial ramifications for both the federal government and the states. For example, if a per capita reimbursement amount for a child in a state is \$1,200 per year, do states get \$100 per month for that child? If so, what if a child enrolls into the program near the end of the month or disenrolls before the end of another month? Do the states and the federal government have to calculate a prorated amount for every single Medicaid beneficiary across the country? What constitutes enrollment for purposes of the per capita cap allotment? Is it at the time of application, eligibility approval, or assignment to a health plan? If a healthy child becomes disabled, do they move into that new category or is that risk assumed in the child subpopulation? How is the population of people with disabilities defined? Is a child with a mild form of hearing loss or severe asthma considered disabled and how do you define "mild" and "severe"? These are just a few of the issues that make per capita caps complicated to devise and implement.

**PER CAPITA CAPS UNDERMINE POPULAR CONSUMER PROTECTIONS.** At a time when there is near universal support for the provisions of the Affordable Care Act (ACA) that eliminated caps on coverage, such as the ban on annual and lifetime coverage limits, now is not the time to reimpose such restrictions on Medicaid enrollees. In addition, instability in Medicaid funding streams would be particularly disruptive for states that are continuing to manage ACA implementation, especially those that have taken up the Medicaid expansion.

**PER CAPITA CAPS HAVE BEEN TRIED AND FAILED.** In the mid-1990s, President Bill Clinton and Senate Democrats, working in a good faith to tackle the budget deficit, expressed their willingness to consider a proposal that would establish per capita caps as an alternative to the Medicaid block grant proposal being promoted by then-Speaker Newt Gingrich. As lawmakers attempted to iron out the details of a per capita cap policy, a host of issues, including the problems discussed above, as well as an inability to reach agreement with CBO on savings and a realization that this approach would be harmful to Medicaid beneficiaries, showed this approach to be untenable and it has been rejected by Democrats ever since. Indeed, in 1997 Democrats refused both per capita caps and block grants during negotiations over the Balanced Budget Act and lawmakers instead relied on other avenues for Medicaid savings, such as spending reductions through the Medicaid Disproportionate Share Hospitals (DSH) program.

While Democrats were willing to put all options on the table to reduce the deficit, it quickly became clear to staff that per capita caps would create a formula fight across states that would have a devastating impact on the populations Medicaid serves. It was determined that per capita caps were not a viable solution. Nearly two decades later, as families continue to recover from the recession, Medicaid remains a vital source of coverage for low-income children and families. The array of problems inherent with the imposition of arbitrary caps in the form of either block grants or per capita caps remain the same today as they were when proposed back in 1997.

**MEDICAID IS ESSENTIAL TO PROTECT CHILDREN'S HEALTH.** Medicaid plays an essential role in securing the health and well-being of almost 32 million children (MACPAC, FY 2012). Together with CHIP, Medicaid has been enormously successful in providing access to health services to more than 40 percent of our nation's children. From vaccinations, well-child check-ups, and chronic disease management, to oral health, vision care, and prenatal care for expectant mothers, Medicaid ensures that children get the services they need to grow, develop, and go to school ready to learn. By every measure, Medicaid is an essential lifeline for children, who constitute approximately 46 percent of the beneficiaries, but only about 21 percent of the costs.

Instead of the federal government imposing a massive oversight bureaucracy upon states that would significantly increase administrative costs and create an adversarial relationship with state governments, a better solution would be for federal and state governments to work more closely as partners to seek the delivery of more efficient and less costly health care services; to root out waste, fraud, and abuse; and to reduce duplicative administrative expenditures (e.g. relying on out-dated systems to verify income and residency status for the same family in different programs). By working together, better health care delivery at lower costs can be achieved.

As policymakers consider proposals to improve our nation's healthcare systems, it is short-sighted to cut the very programs that are critical for the health and well-being of children and other vulnerable populations. Limiting federal Medicaid funds will only result in dramatic cost-shifting to states, families, health care providers, and localities. Slashing Medicaid to score budgetary savings simply does not make sense. Our nation has made enormous strides in improving access to coverage for low-income children and other vulnerable populations. This progress must not be reversed.