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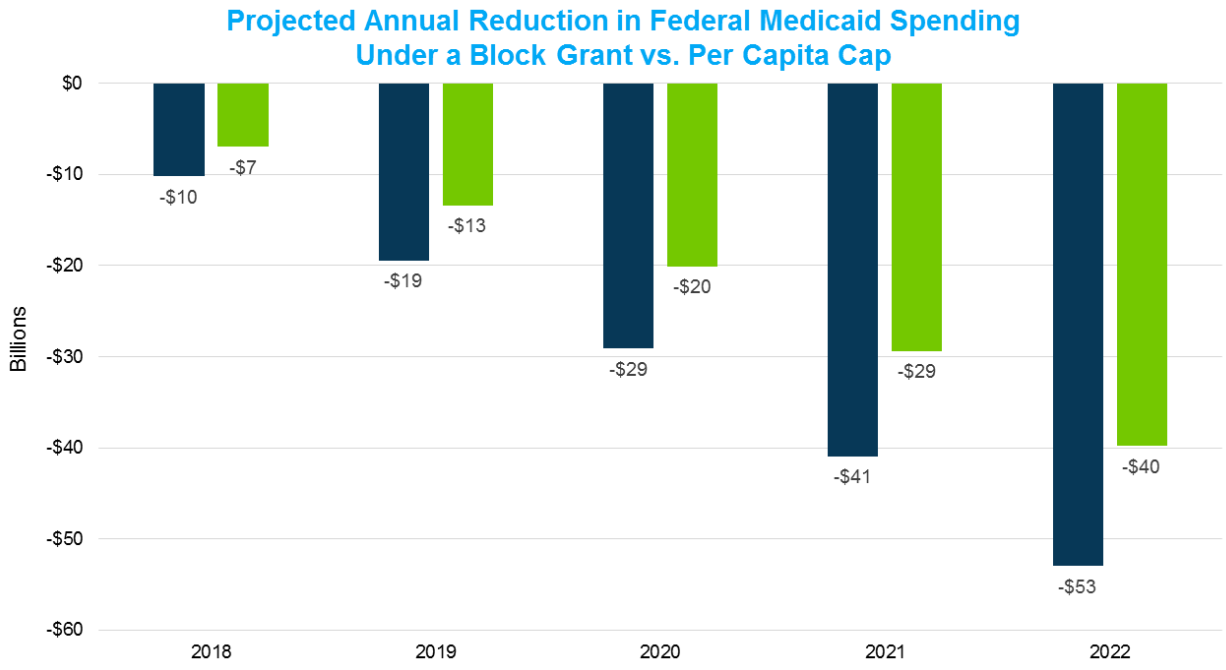
CAPPED FUNDING IN MEDICAID COULD SIGNIFICANTLY REDUCE FEDERAL SPENDING

Analysis shows Medicaid block grants and per capita caps could result in state budget gaps

New research from Avalere finds that moving to capped payments in Medicaid—either by block grants or per capita caps—could dramatically reduce federal spending on the program. According to the Avalere analysis block grants would result in $150 billion less in federal Medicaid spending over five years, while per capita caps would save the federal government $110 billion over five years.

Several of the Affordable Care Act (ACA) replacement plans proposed by the new Congress would reform Medicaid and move to a block grant or per capita cap system. Currently, the federal government pays a percentage of states' total spending on Medicaid. Under Medicaid block grants, states would receive a fixed amount of money from the federal government for their Medicaid program; whereas, a per capita cap entails a fixed amount of funding per beneficiary.

"Medicaid block grants and per capita caps serve as vehicles to control federal spending on the program and put more of the decision-making on things like covered services and program eligibility in the hands of the states," said Dan Mendelson, president at Avalere. "The details of block grant and per capita caps are critically important in determining the distribution of funding across states, plans, and providers."



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The details of how lawmakers structure a potential Medicaid funding cap (e.g., growth rates, allowances for historical spending and mechanisms for quality payments) will have a significant impact on states. For instance, states that spend more per enrollee will fare worse under per capita caps. States that experience large increases in enrollment will struggle in a block grant scenario.

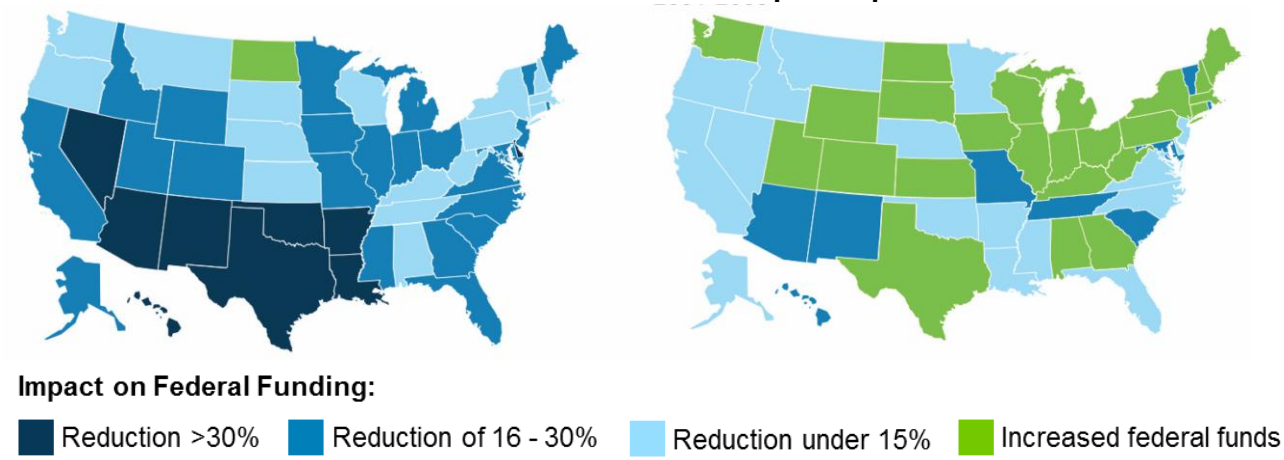
How would capped Medicaid spending impact individual states?

To illustrate how the different impacts these two approaches can have on states, Avalere modeled how state Medicaid funding from the federal government would have changed under each scenario from 2001 to 2008. Under the Medicaid block grant model, one state, North Dakota, would have experienced an increase of 11 percent in federal funding. The remaining states and D.C. would have faced a reduction in federal funding ranging from 4 percent (Wisconsin) to 62 percent (Arizona). In terms of the per capita cap model, twenty-four states would have received an increase in federal funds. The remaining 26 states and D.C. would have experienced a reduction in federal funding all under 30 percent.

Percent Change in 2008 Federal Funding

Block Grants

Per Capita Caps



"The Medicaid block grant model is more limiting to states because it constrains both spending growth and enrollment growth," said Caroline Pearson, senior vice president at Avalere. "The per capita cap model allows for greater flexibility and better absorbs marketplace fluctuations like financial downturn; however, it can still result in an overall loss of federal funding for state Medicaid programs. States may respond to block grants or per capita caps by cutting enrollment, limiting benefits, or reducing payment rates to providers and plans."

Under the ACA, federal funding of Medicaid is currently open-ended. The federal government contributes a fixed share of each state's actual spending. Under both scenarios, states are likely to benefit from greater flexibility to structure their programs. Should either of these concepts be implemented, their level of impact on states will be determined by their current federal match rate, Medicaid expansion and eligibility criteria, scope of benefits, role of managed care, and use of provider taxes.

METHODOLOGY

Avalere used CMS projections of Medicaid spending from the 2016 Medicaid Actuarial Report and the National Health Expenditure Accounts by state of residence. For projections of the growth rate factors, Avalere relied on the 2016 Medicaid Actuarial Report and the National Health Expenditure Projections, 2015 – 2025. Our models assume Medicaid growth rate tied to inflation (CPI).

Avalere used overall per enrollee Medicaid spending to simulate a per capita cap policy. An actual per capita cap policy would likely make adjustments for different types of Medicaid enrollees (e.g., children, adults, disabled, aged). Adjustments for type of enrollee would likely reduce the magnitude of the variation in effects across states.

Avalere's simulations assume no changes in spending or enrollment by states. Instead, the simulations estimate the potential funding gaps if states continued to operate their existing Medicaid programs in the same manner. It is likely that states would alter their programs under a change in federal funding policy.

Avalere's historical simulations start in 2001, with a base year of 2000 for determining initial federal funding levels. State level simulations stop in 2008 to avoid measuring, in addition to federal caps, the effect of the American Recovery and Reinvestment Act (ARRA) and the Affordable Care Act (ACA) increasing the average federal matching rate.

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