Policy Summary: Per Capita Caps

Proposals Under Review

House Republicans, including Rep. Brett Guthrie (R-KY), the Chairman of the House Energy and Commerce Committee, have expressed interest in exploring alternatives to the Federal Medical Assistance Percentage (FMAP) as a means of reforming Medicaid financing. Among other cost saving proposals under review, per capita caps would limit the amount of funding the federal government would contribute per Medicaid beneficiary. Congressional action is needed to implement per capita caps.

Estimated Ten-Year Savings (2025-2034) - House Republicans' Estimate: Up to $900B; CBO Estimate: Up to $893B, if per capita caps were applied to all Medicaid eligibility categories, with the cap trending forward to account for inflation. [1]

Background

Medicaid is jointly funded by federal and state dollars. This model utilizes federal funds (federal share) to match a percentage of state spending (non-federal share) on Medicaid services, with the matching rate varying based on each state's per capita personal income (PCI) level.

Per capita caps represent a proposed method where federal contributions are limited to a fixed amount per beneficiary, with the aim of controlling overall Medicaid expenditures by setting predetermined limits. Per capita caps reduce federal funding by tying spending limits to an annual growth factor that falls short of the actual expected growth in costs. Per capita caps establish a maximum federal contribution for each enrolled individual regardless of actual service costs, leaving states responsible for covering any expenses incurred beyond the cap. Under a per capita cap, states receive a fixed federal contribution per beneficiary, establishing a limit on federal funding while potentially allowing for certain additional funding mechanisms to support critical services. These mechanisms may include Medicaid Waivers, Disproportionate Share Hospital (DSH) payments, and funding special demonstration projects. Caps offer more flexibility than block grants by adjusting funding based on the number of enrollees, making them somewhat less restrictive.

There can be a wide range of design and implementation approaches for per capita caps that would have varying impacts on coverage and access to care for Medicaid beneficiaries. For example, caps could be applied across all enrollment groups or may be targeted to specific groups within the Medicaid program, such as expansion populations, which include low-income adults aged 19 to 64 with incomes up to 138% of the federal poverty level (FPL) and childless adults. Under per capita caps, states might seek to limit enrollment in certain categories to control costs, raising important questions about access to care for vulnerable populations. Some proposals limit per capita caps to the growth rate of general inflation, as measured by the consumer price index (CPI-U). Other proposals use the medical consumer price index (CPI-M), which typically grows faster than the CPI-U.

Historical Traction

During the first Trump administration, the 2017 American Health Care Act (AHCA) proposed a per capita cap system for Medicaid funding where each state would have a single overall per capita allotment divided

into five enrollee categories. Allotments were based on average per capita spending from three years prior, trended forward by CPI-M and multiplied by the number of enrollees in the year enacted. Certain expenditures were excluded, including DSH and safety-net funding for non-expansion states, while non-DSH supplemental payments (e.g., UPL, 1115 waiver payments) were included. Excluded populations included CHIP enrollees and Indian Health Services. The bill passed the House in 2017 by a close vote but was then withdrawn, in part due to opposition from key stakeholders.

Despite interest from some states, per capita caps have faced significant opposition from various stakeholders, arguing that per capita caps could lead to reduced funding for essential services, limit access to care for vulnerable populations, and shift costs to states without ensuring adequate federal support.

Key Model Components

The impact of per capita caps will vary by state based on a range of factors, including how previous cost containment actions impact base year expenditures, actual cost growth for specific eligibility categories, cost trends for specific services disproportionately needed by Medicaid populations, and opportunities for new Medicaid reforms or cost cuts in the future.

- **Base year expenditures**
  - *Current proposal assumption:* Although not specified, it can be assumed that base year is no earlier than FFY2026.
- **Inflationary rate**
  - *Current proposal assumption:* Projections are assumed to use CPI-M as the inflationary rate, which may not fully capture Medicaid-specific trends.
- **Target populations**
  - *Current proposal assumption:* A single cap covering all Medicaid spending, without differentiation across beneficiary groups or services.
- **Exclusions**
  - *Current proposal assumption:* The current proposal does not include details on exclusions.
  - Under a per capita cap, certain costs can be excluded including DSH costs and IT investments.

Scenarios Under Review

- **Caps on the Entire Medicaid Program**
  - Proposed to control overall federal Medicaid spending, this approach sets a single cap across all populations within a state.
- **Caps on Medicaid Expansion Populations Only**
  - Introduced to curb federal spending on the Affordable Care Act's Medicaid expansion, this cap targets enrollees who tend to have lower per capita costs but whose inclusion has significantly increased overall expenditures.