The Case for Per Capita Caps
Improving the focus, equity, and accountability of Medicaid

Chris Pope, Manhattan Institute
May 24, 2017
Medicaid Per Capita Caps

- Challenge of cost with management and financing split
- Inequity in distribution between the states
- What are the higher-spending states getting?
- Assessing Per Capita Caps as a reform proposal
Federal program spending/GDP
Medicaid program challenges

• Medicaid is largely a 4th party payment system

• There is no objective “cost” to be covered. States will spend all the funds they are given.

• Medicaid maximization games (reclassifying spending, provider taxes)

• State management frustrates tracking of expenditures

• Allocations to states are the inverse of needs
Medicaid distribution in theory

![Line plot showing the relationship between Federal Medical Assistance Percentage and State economic output per capita.](LINE_PLOT)

- Federal Medical Assistance Percentage: 41% to 76%
- State economic output per capita: $30,000 to $80,000

The plot illustrates a negative correlation, indicating that as state economic output per capita increases, the percentage of Federal Medical Assistance decreases.
Medicaid distribution in practice

Federal subsidy per resident under Poverty Line

$0 $2,000 $4,000 $6,000 $8,000 $10,000 $12,000 $14,000 $16,000

$30,000 $40,000 $50,000 $60,000 $70,000 $80,000

State economic output per capita
Two very different Medicaid programs

<table>
<thead>
<tr>
<th></th>
<th>Alabama</th>
<th>Connecticut</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under Federal Poverty Level</td>
<td>17%</td>
<td>9%</td>
</tr>
<tr>
<td>Federal Medicaid subsidy per capita</td>
<td>$786</td>
<td>$1,253</td>
</tr>
<tr>
<td>Enrolled in Medicaid</td>
<td>18%</td>
<td>21%</td>
</tr>
</tbody>
</table>
A medical safety net under strain?

Medicaid Per Capita Spending (2015)

- Hospital care:
  - $410
  - $520
Limited access to providers?

Medicaid Per Capita Spending (2015)

- Hospital care: $410, $520
- Other medical providers: $320, $622
or LTC for those with equity <$840,000?

Medicaid Per Capita Spending (2015)

- Hospital care: $410
- Other medical providers: $320
- Long Term Care: $307

- Other medical providers: $622
- Long Term Care: $935
The (very modest) goals of Per Capita Caps

- PCCs do nothing to prevent future expansions of benefits or eligibility by future Congresses

- Congress can revise caps in the budget every year

- PCCs give federal taxpayers a say over unilateral attempts by states to expand benefits greatly beyond current spending path

- PCCs establish regular scrutiny and a conversation about priorities, purposes, and opportunity costs in the Medicaid program
The AHCA’s “deep cuts to Medicaid”

• Cap on growth of aggregate per-enrollee payments to states
  • Increases at Medical-CPI for children, expansion adults, and other adults
  • Increases at Medical-CPI+1 for elderly, blind, and disabled
  • Excludes payments for DSH and Medicare cost-sharing

• Caps loosen in recessions as proportion of younger enrollees increases
A few worthwhile tweaks

• Defining “per capita” as “per enrollee” is problematic
  • Enrollment is the main cost-driver of Medicaid in recent years
  • The most fixable part of looming LTC spending boom is on enrollment side
  • Medicaid cost per enrollee is falling as recent expansions have added relatively healthier beneficiaries
  • It is likely very easy for states to game by adding low-cost enrollees
  • Residents under the Poverty Level is a better objective metric of need, and would similarly automatically loosen caps during recessions

• AHCA caps constrain low-spending and high-spending states equally
  • Increasing scrutiny may stop disparities getting worse
  • Locks in advantage for states with more fat in the system
  • Better to have different cap growth rates for states relative to national average payments