Medicaid Reform Proposals: The Impact of Block Grants and Per Capita Caps on Medicaid Financing

The idea of converting the federal share of Medicaid financing into a block grant or per capita cap system has emerged in budget reconciliation talks as an attempt to offset spending. In general, under either proposal, the federal government would pay its share of a state's Medicaid costs up to a predetermined amount. This means that states would bear 100% of any medical costs that exceed the block grant or caps. This is a fundamental shift away from Medicaid's current financing structure where the federal government guarantees matching funds to states for any qualifying Medicaid expenditures.

Past efforts to implement block grants/ per capita caps would have led to thousands of individuals losing coverage. The first Trump administration initially sought to implement block grants and per capita caps through legislation seeking to repeal and replace the Affordable Care Act. However, these proposals were met with significant opposition due to concerns over their potential impact on coverage rates, and were ultimately voted down in Congress. A similar proposal appeared in President Trump's FY 2020 budget but was also never enacted. The administration then shifted its approach, promoting both block grant and per capita caps at the state level through Section 1115 waivers under the Healthy Adult Opportunities (HAO) Demonstration, introduced in January 2020. The HAO initiative would have implemented a state-level funding cap (which could be either a per capita cap or a block grant), in exchange for less federal oversight and greater flexibility to reduce coverage, benefits, payment rates, and access to care to stay within the funding cap. The flexibility also extended to "shared savings," enabling states to redirect some of the capped federal funds towards other state priorities. However, the HAO initiative was ultimately rescinded.

The ultimate goal of refinancing Medicaid into block grants/per capita caps is to massively cut the amount of federal spending for Medicaid. Under block grants, states would receive a fixed sum or a "block grant" for Medicaid, either for the entire program or specific parts of it, whereas the per capita cap model would limit federal funding on a per-person basis, allowing funding to grow only with enrollment. While both programs have been discussed, the House Budget Committee recently held a markup on the chamber's proposed budget resolution, and both an accompanying document for the markup and a "menu of options" (p. 21) released by the committee last month include discussion (though no specific bill text has been released yet) of a proposal to implement per capita caps.

Per capita caps aim to control federal spending on Medicaid by establishing a maximum amount that the federal government will pay for Medicaid services. These caps adjust for changes in state population or enrollment based on how Congress chooses to implement them. The caps are typically tied to historical spending levels, using an inflation adjustment factor (the House Budget committee proposal specifically suggests using medical inflation as the adjustment factor).

Regardless of which tool is used, issues arise due to the fact that Medicaid spending and medical inflation have consistently outpaced other inflation measures in recent years. The Congressional Budget Office estimates $907 billion in federal savings from per capita caps, largely because the rate of cap growth would not keep pace with the rising costs of serving beneficiaries and providing necessary services. This leaves states with two options: cover the funding gap with state funds or reduce services, programs, or provider payment rates to manage the shortfall in federal funding. In short, these funding caps are often designed to fail to keep pace with expected growth in costs in order to substantially reduce federal Medicaid spending, with cuts becoming larger over time.

Proponents of the block grant/per capita cap approach have argued that states would gain greater flexibility in designing and managing their Medicaid programs. However, block grants/per capita caps are unlikely to provide any greater programmatic flexibility to states than they already have. States would likely have flexibility related to patient protections that are currently in the Medicaid program, meaning enrollees could be subjected to higher co-pays for medications and services, imposition of premiums, work requirements or other requirements that would limit an enrollee's participation in the program.

Ultimately these proposals are likely to end up costing states and the federal government more money than they save. Medicaid is the nation's largest payer of mental health and substance use services, and despite state and federal efforts to improve accessibility to services, approximately 35% of Medicaid-covered individuals experiencing mental health and substance use challenges report not receiving treatment. Shifting costs to states and limiting access to Medicaid will shift, and in some cases potentially increase, costs to communities by pushing people experiencing such challenges into higher and more costly levels of care such as emergency room visits, hospitalization, and jails.