

# Issue Brief

## KEY POINTS:

- Moving to block grants or per capita caps would shift more funding risk to states, and they will need flexibility to modify components of their Medicaid programs to stay within their budgets.
- Sustainability of Medicaid under block grants or per capita caps funding methods will depend upon appropriate initial allocation of funds to each state and adequate growth rates of those funds.
- If block grants or per capita caps limit the federal share of the current program, states will need more flexibility in their programs to manage their share of the program costs while balancing the needs of beneficiaries and other stakeholders. This may add more administrative burdens to both the federal government and the states.



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## Proposed Approaches to Medicaid Funding

Under certain recent legislative proposals offered to address, in part, replacement of the Affordable Care Act, policymakers are considering modifying the funding structure of the Medicaid program<sup>1</sup> from one based on a percentage of total program expenditures to one that caps or limits federal funding to states. This document addresses key design elements of block grants and per capita caps in relation to program sustainability. It does not consider appropriateness of covering certain populations. Table 1 (page 2) provides a comparison to the current structure of several options.

In addition to their impact on federal reimbursement and budget, depending on their design, these proposals have the potential to significantly impact state budgets, Medicaid enrollees, providers, Managed Care Organizations (MCOs), and other health care system stakeholders. Key design elements discussed in this document include the following:

1. Approach to setting state caps;
2. Treatment of Medicaid expansion populations;
3. Growth rate methodology;
4. Program flexibility provided to states; and
5. Continuing actuarial soundness requirements.

<sup>1</sup> Medicaid is a state-operated, state-/federal-funded public health care program that covers more than 70 million Americans.

**Table 1: Comparison of Federal Funding of Current System, Per Capita Caps, and Block Grants**

	<b>Current System</b>	<b>Per Capita Cap by Enrollee Category</b>	<b>Single Per Capita Cap</b>	<b>Block Grant</b>
<b>Federal share</b>	Percentage based on state's per capita income <sup>2</sup>	Amount defined per program enrollee (state/national) by type (e.g., child, disabled adult, elderly adult, other adult)	Amount defined per program enrollee either by state or nationally	Aggregate amount allocated per state
<b>Savings/costs resulting from changes in total enrollment</b>	Shared between state and federal governments	Shared between state and federal governments	Shared between state and federal governments	Assumed by state
<b>Savings/costs resulting from changes in enrollment mix<sup>3</sup></b>	Shared between state and federal governments	Shared between state and federal governments	Assumed by state	Assumed by state
<b>Changes in per capita costs (if costs exceed a specified threshold)</b>	Shared between state and federal governments	Assumed by state	Assumed by state	Assumed by state

## Approach to Setting State Caps

Medicaid costs are shared between the federal and state governments; however, Medicaid programs are state-operated and reflect state-specific policy decisions. While the federal government sets a floor with mandated covered populations and benefits, there are significant variations across states with respect to coverage of optional populations and benefits, levels of provider reimbursement, and service delivery models (e.g., fee-for-service or managed care). These differences, along with additional regional differences in health care costs and provider practices, drive significant variations in per capita health care costs. One study shows federal fiscal year 2011 Medicaid per capita cost variations of nearly 3:1.<sup>4</sup>

While the federal share is higher for states with lower per capita incomes, states with higher per capita incomes generally have richer coverage and thus higher per capita costs.<sup>5</sup> If state caps are developed based on historical costs, discrepancies across states will be memorialized in future funding without a periodic rebalancing of the per capita cost amounts. This approach could be considered to reward states with richer programs while limiting the ability for states with leaner programs to expand coverage or increase provider reimbursement rates. The approach would also inadvertently penalize states with the most efficient programs, because states with historically less efficient programs would presumably have greater opportunities for savings to avoid state budget

<sup>2</sup> Percentage varies by state based on per capita income for non-expansion groups; for expansion groups, federal share is 95 percent for CY2017, reducing to 90 percent beginning in CY 2020.

<sup>3</sup> For example, if a growing proportion of the covered population is disabled, thus driving up the average per capita cost.

<sup>4</sup> Robert Wood Johnson Foundation, State Health Reform Assistance Network Issue Brief: "[Data Points to Consider When Assessing Proposals to Cap Federal Medicaid Funding: A Toolkit for States](#)," Feb 13, 2017.

<sup>5</sup> Urban Institute Health Policy Center, "[Block Grants and Per Capita Caps the Problem of Funding Disparities among States](#)," September 2016.

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overruns. More efficient states may be better equipped but have fewer opportunities for savings.

Alternatively, state caps could be set to allocate federal funding based on a more equitable set of benefits, covered populations, and provider reimbursement levels. Without an increase from current levels in overall federal funding, this could result in significant disruption in states with richer programs by redirecting funds to states that historically may not have been interested in utilizing available funds to expand covered populations or benefits.

## Treatment of Medicaid Expansion Populations

Under the Affordable Care Act, states had the option to expand Medicaid coverage to adults with incomes up to 138 percent<sup>6</sup> of the federal poverty level who would have otherwise been ineligible. As of February 2017, 31 states plus the District of Columbia had opted into this expansion. The federal share for the cost of this group (95 percent in 2017, phasing down to 90 percent by 2020) is considerably higher than the federal match rates for the non-expansion populations.

While the expansion population is low-income, some consider this group to be less vulnerable than other populations traditionally covered by the Medicaid program, such as children, elderly and disabled adults, and pregnant women. Not including this funding into the program going forward, however, could result in discontinuation of coverage for the more than 14 million adults covered through Medicaid expansion.<sup>7</sup> On the other hand, continuing this funding only for the states that opted to expand coverage will further increase funding inequities across states. Alternative approaches include increasing federal spending to provide equity across states, or reallocating existing funding in an equitable

manner. Another option would be to allow states the flexibility to access funding for lower income levels.

## Growth Rate Methodology

The growth rates used to increase block grants or per capita caps over time are a key design component that will drive both federal savings and the impact on states and other stakeholders. Health care costs over the long term have historically outpaced economic indicators such as gross domestic product (GDP) and consumer price index (CPI). This growth is driven not just by utilization and unit cost increases, but also by new treatments, such as the costly new biological drugs recently made available, and unexpected events such as natural disasters or pandemics like H1N1 influenza. If growth rates in federal funding do not keep up with health care cost changes, it will likely be difficult for states to sustain their current programs without material changes. Efforts to close budget gaps including eligibility and benefit changes may reduce Medicaid spending but they will not completely reduce spending; the cost of care will be transferred to providers, insurers, employers, and to the individuals who seek needed care.

Additionally, there are several factors which drive variation in health care cost trends by state which should be considered in analyzing the impact of setting a single national trend rate. These include:

**Benefits covered**—Cost increases vary by service type (pharmacy, for example, tends to have higher trends than many other service categories) and covered services vary by state.

**Population mix and disease burden**—States vary in their demographic mix by age, gender, socioeconomic status, and other characteristics. States also vary with respect to the disease burden and health risk of their populations; for example, diabetes prevalence in Southern states is significantly higher than the national average.<sup>8</sup>

6 Healthcare.gov, “[Federal Poverty Level](#)” (Accessed March 16, 2017.)

7 Kaiser Family Foundation State Health Facts “[Medicaid Expansion Enrollment](#),” January - March 2016.

8 Centers for Disease Control and Prevention, “[Diabetes Data and Statistics](#),” January 12, 2017.

**Prospects for economic growth or recession**—Medicaid enrollment and funding are sensitive to growth and recession, and the need for funding often grows as a state's ability to fund it diminishes. Medicaid will need to compete with other programs for reduced funds during a recession, especially if federal funding does not increase with enrollment growth.

**Geographic variations in care delivery**—Any growth rate set at a national level, even if it varies by beneficiary or service category, will not align by geography. Geographical variations in the average cost and trends of services can be significant. Practice patterns, such as the likelihood of inpatient admission or pharmacy regimens, as well as the mix of provider types and payment arrangements, also vary.

**Current levels of cost-effectiveness programs and management**—To the extent there is an expectation that restricting the federal growth level will encourage states to improve the efficiency and effectiveness of their Medicaid programs, there will also be concern that states which have already moved into managing the delivery of care will have less ability to find additional savings. Growth rates that expect savings, but do not attempt to reflect the current management effectiveness in states, likely are not achievable in all cases.

## State Flexibility

Today, states must comply with specific Medicaid program requirements to receive federal funding. Because moving to block grants or per capita caps would shift more funding risk to states, the states will need the flexibility to modify components of their Medicaid programs to stay within their budgets to avoid having to either raise additional revenue through taxes or assessments or reallocate funding designated for other state programs to

Medicaid. States do not have unlimited funding for their Medicaid programs, so not allowing flexibility creates a financially unsound funding mechanism for Medicaid programs. Possible areas of flexibility include those described below.

**Eligibility**—Currently the federal government requires states to provide Medicaid services to any person who meets specific eligibility requirements related to their own or their household's income and their age, condition (such as pregnancy), or situation (such as caregivers for Medicaid eligible children). For states to control costs under a block grant program, they may need the flexibility to modify eligibility parameters or to limit the number of people they enroll in the program.

**Benefits**—Currently the federal government requires states to cover a set of mandatory benefits within their Medicaid programs. Federal matching is also allowable for other optional benefits that can be covered by the state. To increase the ability of states to maintain costs within their budgets, the federal government may need to adjust the set of mandatory benefits.

**Provider payments**—Another lever states have to reduce program costs is reducing payment rates to providers. Under the current system, states must ensure that rate reductions do not result in inadequate access to care for beneficiaries.

**Provider access**—Currently the Centers for Medicare and Medicaid Services (CMS) sets specific requirements around access to providers within a state's Medicaid program to ensure that Medicaid beneficiaries have reasonable access to necessary services. The access requirements can include time and distance to specific provider types or general access to certain provider types such as children's hospitals. In order to meet these requirements, states or their MCOs often must

pay certain types of providers' rates well in excess of the Medicaid fee schedule. Additionally, the access requirements restrict the state's ability to limit the network to the providers who produce higher quality, lower cost outcomes. Increasing the flexibility of states to tighten networks to the most cost-effective providers would allow states to better manage their budget.

**Delivery system**—As health care is evolving, health care payers are exploring new ways to pay providers for the delivery of services. Specifically, there is currently interest in reforming fee-for-service payment structures to value-based payment structures. The alternative methods for paying providers are intended to pay for higher quality of services and better patient outcomes instead of paying for the volume of services. Allowing states the flexibility to implement and expand these delivery systems would help the states to work within their Medicaid budgets. States may also react to their increased financial risk by passing some of that risk to willing providers.

**Premiums and cost sharing**—Currently the federal government limits the premium and cost sharing amounts states can impose on beneficiaries. Some studies have shown that involving beneficiaries in the financial aspects of their medical programs can curb unnecessary utilization and reduce program costs.<sup>9</sup> However, if not designed carefully, additional cost sharing for the Medicaid population could pose barriers to beneficiaries receiving needed care. States may need the ability to manage costs and enrollment by charging premiums to certain populations and implementing cost sharing for potentially avoidable services.

## Actuarial Soundness

Currently, more than 60 percent of Medicaid enrollees are covered through Medicaid MCOs.<sup>10</sup> To ensure these MCOs are compensated in a reasonable, appropriate, and attainable manner for the services they provide, federal law requires actuarial soundness of the capitation rates they receive from the state.

Payment of actuarially sound capitation rates to MCOs helps ensure that:

- Obligations to the public are met;
- Payments are appropriate for both the state and the federal government;
- The rates promote program goals such as quality of care, improved health, community integration of enrollees, innovation in the delivery of care, and cost containment, where feasible; and
- Medicaid service providers are paid rates that encourage them to participate in the Medicaid program.

For MCOs to continue providing services under the block grant or per capita cap model, the requirements for actuarial soundness of the capitation rates would need to continue. Payment of rates above or below levels necessary to induce MCOs to participate in the Medicaid program do not serve the public interest. Capitation rates that are above such levels unnecessarily increase the cost of the Medicaid program to the public. Rates that are below those levels are unsustainable in the long term and may cause MCOs to exit the Medicaid program. This leads to breaks in continuity of care for beneficiaries, potentially lowering quality of care and increasing costs.

9 Rand Corporation, "[Determining the Effects of Cost Sharing in Health Care](#)," January 20, 2014.

10 Centers for Medicare and Medicaid Services, "[Medicaid Managed Care Enrollment and Program Characteristics, 2014](#)," Spring 2016.

## **Conclusion**

Great care and consideration must be taken in the design of any alternative funding program for Medicaid. Sustainability of Medicaid under these alternative funding methods will depend upon appropriate initial allocation of funds to each state and adequate growth rates of those funds. These must be established in a thoughtful and fair manner to avoid inequities between the states. Also, the federal government currently places strict guidelines on state Medicaid programs in exchange for unlimited funding of the federal share of program costs. If block grants, per capita caps or another funding method that limits the federal share replaces the current program, states will need more flexibility in their programs to manage their share of the program costs while balancing the needs of beneficiaries and other stakeholders. These flexibilities, however, may add more administrative burdens to both the federal government and the states. These costs should be considered in any analysis of the impact of changing to these alternative funding methods.

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