



What Does a Cap on Federal Funding Mean for Utah's Medicaid Program?

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How We Got Here

- **February 2019:** SB 96 passes.
 - Partially expand coverage up to only 100% FPL
 - Incorporate a per capita cap on federal funding for Medicaid.
- **April 2019:** Implementation of the “Bridge Plan” to expand Medicaid up to 100% FPL with a 70/30 Federal match, capping enrollment and imposing various work-related documentation requirements.
- **Later this Spring:** The state will request a waiver for a “Per Capita Cap Plan,” which will replace the 70/30 Federal match with a per capita cap and a 90/10 federal match. It will also impose a cap on Medicaid enrollment.
 - SB96 supporters claims re: what CMS will allow looking uncertain.

What does this “Per Capita Cap Plan” mean for Utah’s Medicaid Program?



No More Guarantee that Federal Funding Will Match State Spending

- A Medicaid per capita cap is just that—a cap on what the federal government will pay the state to cover its Medicaid enrollees.
- It would end the 50-plus year federal guarantee of matching the state's actual Medicaid spending and replace it with a capped, pre-set amount and pre-set growth rate.
- Right now, federal support *automatically* changes to match a state's spending, and needs. Federal support increases if a state's costs go up.
- Per capita cap:
 - Base amount based on current spending
 - Inflation rate, likely set below real growth rate of costs.

What a Cap on Federal Funding Is Fundamentally About

1. Who Bears the Risk as Health Care Costs Increase?
 - Federal Government?
 - Utah Taxpayers?
 - Low-income people and their medical care providers?

2. What Other Core Medicaid Protections Does Utah “Waive”?
 - Quid Pro Quo—Federal Government caps liability, allows state to make Medicaid cuts that are otherwise not allowable.
 - What will these cuts be?
 - Capping enrollment beyond cap on partial expansion?
 - Cutting Benefits?
 - Other cuts to eligibility?

The State Is on the Hook to Cover Costs

- Changing federal funding structure to a per capita cap passes risk and costs on to states.
- If federal funding is less than what the state currently receives for its Medicaid program, the state will have to choose:
 - Cut coverage and benefits for children, seniors, people with disabilities, and working families;
 - Cut other funding priorities to make up for the gap in federal funding.
 - Raise taxes to make up for the gap in federal funding.
- With less federal funding, the real “flexibility” that states will have is in deciding what to cut.

State Experiences with Capped Medicaid Funding

- Puerto Rico:
 - Funding capped in statute, does not keep up with health care costs.
 - Impact is catastrophic, getting worse
 - Physicians leaving
 - Hospitals struggling
 - Huge lack of fiscal and provider capacity to deal with natural disaster in 2017
- Rhode Island, Vermont
 - Caps approved at very end of Bush administration
 - Very loose caps, no core elements of Medicaid waived
 - Sweetheart deal to entice two states to sign on
- States often have a cap in “normal” Medicaid waivers, but these operate differently.

What we know about Trump Administration Intent on Capped Medicaid Funding

1. 2017 Repeal and Replace bills had artificially low inflation rates, booked enormous and compounding federal Medicaid cuts from per capita caps.
2. Every Trump Administration proposed budget since the failure of Repeal and Replace has included huge, compounding savings from Medicaid per capita caps.
 - This included budget proposal released several weeks ago
3. Key driver is Mick Mulvaney
 - Now both budget director and Chief of Staff
 - Huge believer in cutting Medicaid via caps
 - Strongly opposed to enhanced match for partial expansion

What about Enrollment Caps?

- Possible state strategy to “manage risk” of per capita caps.
- This means eligible people are denied Medicaid.
- Risk of health care costs shifted to:
 - Poor and Near-Poor people
 - Hospitals
 - Clinics
 - Nursing Homes

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