American Academy of Actuaries

Issue Brief

Medicaid Per Capita Caps: Design Considerations and Policy Implications

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Key Points

- As with national health spending as a whole, spending in the Medicaid program, which is financed jointly by federal and state governments, is rising. Such spending trends increase pressure on federal and state budgets, and federal policymakers are considering alternative approaches to financing the Medicaid program that would relieve some of this pressure.
- One approach that has been considered is limiting the annual federal Medicaid contribution to a certain amount per enrollee, either overall or by category. Once the federal per capita cap is reached, all spending would be borne fully by the state.
- The implications of Medicaid per capita caps depend on the specific design features, especially how the initial payment level is determined and how the payment level changes over time.
- Although shifting more of the financial risk to states could encourage states to use their Medicaid dollars more cost effectively, if per capita caps do not keep up with health spending trends, states may need to reduce coverage for optional populations, reduce optional benefits, reduce provider payments, or increase beneficiary premiums and cost sharing.

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The Medicaid program helps improve access to health care, including behavioral health services, for millions of Americans, including low-income families, low-income childless adults, pregnant women, and children, as well as low-income individuals who are aged or disabled, including the majority of those populations who receive long-term services and supports (LTSS). As of October 2024, 72 million people were enrolled in Medicaid,[1] down from a high of 87 million in April 2023 during the COVID-19 public health emergency.[2] Despite the recent decline in Medicaid enrollment, projected Medicaid spending, as with the spending of other health care payers, is expected to grow faster than the economy. Increased Medicaid spending will put additional pressure on federal and state budgets, furthering competition with other policy priorities.

One strategy that federal policymakers have revisited is moving to a per capita cap approach to funding Medicaid, with a goal of reducing Medicaid spending and improving the program's financial sustainability. Per capita caps would limit the federal Medicaid contribution in a state to a certain amount per enrollee. Any spending exceeding the cap would be borne fully by the state.

This issue brief by the American Academy of Actuaries Medicaid Committee updates a 2017 issue brief[3] that examined both per capita caps and block grants. This issue brief focuses on per capita caps and discusses some of the key design considerations and the potential implications of different design decisions. In particular, the brief discusses considerations related to setting the initial federal per capita cap as well as how that cap would change over time.

1 Centers for Medicare & Medicaid Services, "Medicaid and CHIP Enrollment Trend Snapshot," accessed February 27, 2025.
2 Centers for Medicare & Medicaid Services, Center for Medicaid and CHIP Services, "July 2024 Medicaid and CHIP Enrollment Trends Snapshot," July 2024.
3 American Academy of Actuaries, *Proposed Approaches to Medicaid Funding*, March 2017.

Background

Currently, the Medicaid program is financed jointly by the federal government and states.[4] Federal contributions to states for their Medicaid programs are based on a percentage of total program expenditures. This percentage, known as the "federal medical assistance percentage" (FMAP), varies by state based on its per capita income relative to the national average. Current standard FMAP rates for the non-expansion population range from 50% in several states to 83% in U.S. territories other than Puerto Rico.[5] The current FMAP for the Medicaid expansion population is 90%. The federal government sets minimum requirements related to eligibility and benefit coverage. States are also required to ensure beneficiary access to care and must abide by limits on beneficiary premiums and cost sharing.

Beyond the minimum federal requirements for Medicaid programs, coverage of optional populations and benefits varies by state.[6] These differences, along with state differences in provider reimbursement levels and service delivery models (e.g., fee-for-service or managed care), and regional differences in health care costs, provider practice patterns, population mix, and disease burden drive material variations in per capita health care costs.[7] Other factors can also affect federal and state Medicaid funding levels. For instance, state waiver programs can affect federal contributions. States can finance a portion of the non-federal share through the use of provider taxes, managed care organization (MCO) taxes, and intergovernmental transfers.

Similar to overall healthcare spending, Medicaid spending has grown over the past two decades. Medicaid enrollment and total Medicaid spending have generally grown in tandem (Figure 1). According to data from the National Health Expenditure Accounts, Medicaid spending grew from $200 billion in 2000 to $872 billion in 2023, an average annual increase of 6.6%. Over the same period, Medicaid enrollment grew from

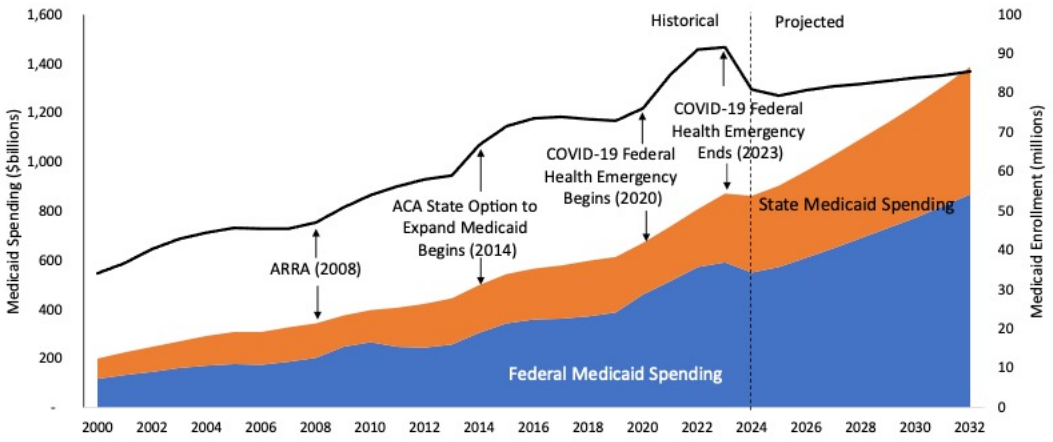
4 Here and throughout, the term "state" includes states, the District of Columbia, and U.S. territories.
5 Federal Register, Department of Health and Human Services, "Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2025, Through September 30, 2026," November 2024.
6 KFF, "Medicaid & CHIP," accessed February 27, 2025.
7 Rhiannon Euhus and Priya Chidambaram, "A Look at Variation in Medicaid Spending Per Enrollee by Group and Across States," KFF, August 16, 2024.

34 million to 92 million, an average annual increase of 4.4%. The average annual increase in Medicaid per enrollee expenditures during this period was 2.1%, lower than that of Medicare (4.5%) and private health insurance (5.2%).

The federal share of Medicaid spending has increased from 58% in 2000 to 68% in 2023. Federal legislation and other actions have contributed to increases in Medicaid enrollment and spending as well as increases in the share of Medicaid funding borne by the federal government, at least temporarily. These actions include:

- The American Recovery and Reinvestment Act of 2009 temporarily increased the FMAP during a period of economic hardship[8];
- The Affordable Care Act (ACA) gave states the option to expand Medicaid, beginning in 2014, to people with incomes up to 138% of the federal poverty level at an enhanced FMAP[9]; and,
- During the COVID-19 Public Health Emergency, the FMAP was increased temporarily on the condition that states not perform eligibility redeterminations and actively disenroll Medicaid members.[10]

Figure 1. Annual Medicaid Spending and Enrollment, 2000-2032



ARRA=American Recovery and Reinvestment Act of 2009; ACA=Affordable Care Act
Source: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group

8 American Recovery and Reinvestment Act of 2009 [P. L. 111-5, 123 Stat. 115]
9 Patient Protection and Affordable Care Act of 2010 [P.L. 111–148, Mar. 23, 2010 (124 Stat. 119), as amended through P.L.118-42, enacted March 9, 2024], 42 U.S.C. 157.
10 Families First Coronavirus Response Act [P.L. 116-127, March 18, 2020], as amended through the Coronavirus Aid, Relief, and Economic Security Act [P.L. 116-136, March 27, 2020].

The end of the COVID-19 Public Health Emergency in 2023 resulted in a reduction in Medicaid enrollment and spending, as eligibility redeterminations resumed. From 2025 to 2032, the CMS Office of the Actuary projects only 1.0% annual enrollment growth. Per enrollee Medicaid spending is projected to grow faster than in previous years (5.2% annually), comparable to per enrollee spending growth for Medicare (5.7%) and private insurance (4.8%). During this period the federal government's share of Medicaid spending is projected to be 63%, down from a peak of 71% in 2022.

Increased Medicaid spending puts additional pressure on both the federal and state budgets, furthering competition with other policy priorities. On average across all states, the state portion of Medicaid is the top expenditure item and Medicaid spending (including both state and federal funding) comprises 30% of state expenditures.[11] For the federal government, Medicaid expenditures make up 9% of all expenditures.[12]

Overview of Per Capita Caps

Moving to per capita caps would limit federal Medicaid contributions. There are several approaches to determining the per capita cap, including one that is FMAP-based. Under such an approach, the federal contribution for each state would continue to be the FMAP-based share of total Medicaid spending in each state, but would be limited to a certain amount per enrollee (the cap).[13] The per capita cap could be based on all enrollees or could vary by Medicaid enrollment category. Above the cap, the state would bear the full costs. If Medicaid spending is such that the federal contribution falls below the per capita cap, the federal and state contributions would simply reflect the FMAP as under the current funding system.

A per capita cap approach can be structured to encourage cost containment. It can also be structured to allow states more flexibility regarding how they use their federal funds, so the program can be geared to further address the particular needs of their Medicaid population. Other considerations in the design of per capita cap arrangements could include the potential impact on Medicaid program enrollment, covered benefits, access to services, provider reimbursement, and state and local budgets, to name a few.

11 National Association of State Budget Officers, "2024 State Expenditure Report: Fiscal Years 2022-2024," 2024.
12 Congressional Budget Office, "The Budget and Economic Outlook: 2025-2035," January 2025.
13 KFF, "Overview of Medicaid Per Capita Cap Proposals," June 2016.

Through section 1915(b), 1915(c) and 1115 waiver programs, states currently can propose variations to their Medicaid programs that include per capita spending limits. Under the waiver programs, states are able to target specific areas of need and identify targeted areas for cost containment within their respective populations. For instance, the 1915(c) Home and Community Based Waiver limits expenditures for home- and community-based services on a per capita basis based on the amount for an average nursing home member.

Under a per capita cap approach, the federal contribution to the state is limited. As such, more of the financial risks are shifted from the federal government to the states, depending on the specific design features. Because the federal contribution to states is currently based on a percentage of total program costs, the financial risks associated with changes in total enrollment, changes in the enrollment mix, and changes in per capita enrollee costs are shared between the federal and state governments. Per capita caps can be designed to control for one or more of these variables (e.g., per capita caps can vary by enrollment category), but the financial risks associated with varying Medicaid expenditures beyond those would be shifted to states (Table 1).

Table 1. Comparison of Risks Borne by Federal and State Governments Under Different Funding Approaches

	Current System	Per Capita Cap by Enrollee Category	Overall Per Capita Cap
Federal share	Standard FMAP ranges from 50% to 83% based on state's per capita income (non-expansion population)[14]; 90% for expansion population	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
Savings/costs resulting from changes in total enrollment	Shared between state and federal governments	Shared between state and federal governments	Shared between state and federal governments
Savings/costs resulting from changes in enrollment mix	Shared between state and federal governments	Shared between state and federal governments	Costs exceeding the cap are assumed by state
Changes in per capita costs (if costs exceed a specified threshold)	Shared between state and federal governments	Costs exceeding the cap are assumed by state	Costs exceeding the cap are assumed by state

Setting per capita caps that vary by enrollee category would continue to partly shield states from the risks of higher enrollment or shifts to more expensive eligibility categories, but states would assume all the risk if per capita costs exceed the federal per capita cap. This increased risk could cause states to limit future service additions or provider reimbursement increases, or even reduce current program benefits and provider reimbursements, if per capita caps do not keep up with health care cost trends.

14 Federal Register, op. cit.

If per capita caps are set overall, regardless of eligibility category, states would also assume the risk of changes in the enrollment mix and could experience extra costs if the average cost profile of Medicaid members due to enrollment mix is higher than expected. For example, if a growing share of Medicaid enrollees are disabled, average per capita costs would increase because the cost of enrollees in disabled categories is materially higher than those in non-disabled enrollee categories.[15]

Key Program Design Features

The impact of per capita caps on state and federal budgets, as well as other stakeholders, depends on the details of how the cap is structured. Key parameters include how the initial per capita cap is determined and how that level will change over time.

Setting the initial per capita cap.

A principal decision is how to initially set the per capita cap for each state and how those initial payments would vary among states. A fairly straightforward method would be to use historical data on state Medicaid spending and project it forward using adjustments based on expected changes in enrollment, enrollment mix, and per capita costs to reflect the initial year of the new approach. For instance, if the underlying historical data reflect continuous coverage requirements during the COVID-19 public health emergency, adjustments may be needed to reflect the higher acuity of enrollees that remain in Medicaid after coverage redeterminations resume. The state's FMAP could then be applied to the applicable amount—either the overall per capita cap or the per capita cap by category.

Under such an approach, the federal contribution would be similar to what they would have paid under the current method, as long as per capita costs are similar to expected. Unless a pathway is available to allow for deviation from the initial per capita cap (either through continued use of waivers or other approaches), federal financial support would likely not be available to states that are looking to enhance their Medicaid programs from the program design in place when initial caps were established.

15 Medicaid and CHIP Payment and Access Commission, *MACStats: Medicaid and CHIP Data Book*, Exhibit 19, "Medicaid Benefit Spending Per Full-Year Equivalent Enrollee by Eligibility Group and Service Category," December 2024.

There are important considerations under this or similar methods of determining the initial cap. In particular, the federal government could use different levers to dial up or down the cap, as well as how the caps might differ among states. Different variations would have different effects on both federal and state spending. Some potential examples include:

- Building in federal savings. Applying the current FMAPs to projected per capita Medicaid spending would result in no change in expected federal spending for Medicaid in the short-term. Building in federal government savings through a lower FMAP or explicit savings in reduced projected trends would lessen budgetary pressures from the federal perspective. The explicit savings would also shift more costs to the states, which would increase the state's budgetary pressures, but could also encourage an increased state focus on cost efficiency. However, those states that are already more cost efficient in their Medicaid spending may find it more difficult to find additional opportunities to lower their spending.

- Basing initial per capita caps on historical state spending. Using historical state spending to determine initial per capita caps would preserve the differences in state Medicaid spending that arise from state variations in the coverage of optional populations and benefits, eligibility criteria, provider reimbursement levels, service delivery models, and state population characteristics and health care needs. This would be advantageous to states that have high per capita costs and disadvantageous to states that align with federal minimum requirements, limiting their ability to expand coverage eligibility or increase provider reimbursement rates.

- Basing initial per capita caps on national average per capita spending. Basing per capita caps on national per capita spending averages rather state-specific spending averages would smooth the federal spending contributions among states. Because of the large variation among states in their Medicaid program design as well as in other factors that impact state-specific per capita costs, the effects of moving to a national average per capita cap would vary by state. In particular, such an approach would create more of a constraint in states with higher-than-average spending, because the per capita cap would be lower than the state's per capita costs. Lower resources for these states would put them under more budgetary pressure. Some factors may be in a state's control (e.g., use of payment methods that encourage cost effective care), but states have less control over the characteristics and health care needs of their residents.[16] As a result, states receiving reduced federal contributions may need to cut their programs in some way. Per capita caps based on national per capita spending would have less of an effect on states with lower-than-average per capita costs, because these states would be less likely to exceed the cap.

16 The majority of Medicaid enrollees are enrolled in a managed care plan and states continue to explore ways to implement value-based payment structures. See Elizabeth Hinton and Jada Raphael, "10 Things to Know About Medicaid Managed Care," KFF, May 1, 2024.

- Basing initial per capita caps on a national FMAP. Basing the per capita cap on a national FMAP applied to projected expenditures rather than a state-specific FMAP would result in lower per capita caps in lower-income states, running counter to the goals of providing increased financial support to these states. It would also result in higher per capita caps in higher-income states, which may already have more resources available to fund their Medicaid programs.

Another consideration when determining the initial per capita cap is how the Medicaid expansion population is treated. As noted above, the ACA gave states the option to expand Medicaid coverage at an enhanced FMAP (currently 90%). Currently, 40 states plus the District of Columbia have expanded Medicaid. Twelve of these Medicaid expansion states have trigger laws that would end expansion or require other changes to the program if the FMAP for the expansion population were to fall below 90%.[17] Whether the implementation of per capita caps would trigger such laws depends on how the per capita caps are determined, including whether FMAPs are reduced from their current levels. Although the trigger laws may insulate states from increased financial burden, many enrollees would lose coverage.

Determining how per capita caps would change over time.

How federal payments change over time will affect payments to states, which in turn can affect both federal and state program sustainability. In general, if the change in per capita caps does not keep pace with increased Medicaid spending, states will bear an increasing financial responsibility. If per capita caps increase faster than Medicaid spending, the per capita cap would not be a limiting factor and the federal contribution will continue to reflect the current method of payment—the FMAP share of total Medicaid spending.

Considerations for determining the change in the per capita cap include:

- Per capita caps could be rebased on a periodic basis to reflect changes in per capita spending, enrollment changes, or other factors. Under this approach, states could face unanticipated costs depending on whether actual spending was higher or lower than expected, but those differences would not be cumulative. That is, the total spending estimates could be reset each year (or on a periodic basis) using more recent experience. This method would keep federal and state funding shares relatively constant.

17 See Jennifer Tolbert, Clea Bell, and Robin Rudowitz, "Medicaid Expansion is a Red and Blue State Issue", KFF, November 27, 2024.

- Per capita caps could be changed over time using an economic index such as the growth in gross domestic product (GDP) or the consumer price index (CPI). Medical spending typically outpaces GDP and CPI. Increases in medical spending can also exceed CPI for medical care, which reflects price increases but not increases in utilization or other factors. As a result, using one of these indices could result in federal payments that increasingly diverge from Medicaid spending over time, potentially increasing pressure on state budgets.

- Changes in Medicaid spending are affected not only by enrollment changes and price and utilization changes, but also by the introduction of new treatments, such as new biological drugs, and unexpected events such as economic downturns, natural disasters, and pandemics. The federal government has historically stepped in during national economic or healthcare crises to support the Medicaid program, such as when it increased the FMAP rate during the COVID-19 public health emergency. Continuing to help states during unusual events such as these would help ensure the Medicaid program can meet the needs of enrollees. Otherwise, state efforts to close budget gaps could include reducing eligibility and benefits, which would shift the costs of care to health care providers and to the individuals who seek needed care.

Summary

The increase in national health spending is affecting all sources of health insurance coverage, including the Medicaid program. Rising Medicaid spending is putting pressure on federal and state budgets. Policy changes under consideration by policymakers include changing the way federal Medicaid contributions to states are determined, such as shifting them from a percentage of total Medicaid spending to limiting federal contributions to a per capita cap. Such an approach could shift more of the financial risk from the federal government to states, meaning states could face additional costs depending on how actual spending compares to the per capita cap. States experiencing higher costs may be forced to make program cuts. The implications of per capita caps on federal and state payments and related budgetary pressures depend on how the per capita caps are designed. In particular how the initial per capita cap is set and how it changes over time.

Setting the initial per capita cap is complicated by considerable variations in Medicaid spending by state, due to differences in state coverage of optional populations, provider payment levels, and health care delivery models, as well as regional differences in health care costs, provider practice patterns, population mix, and disease burden. Using historical data and the FMAP to determine the initial level would result in a federal payment similar to what would have been paid under the current method. Different variations would have different effects on state and federal budgets.

How the per capita cap changes over time is as important as setting the initial payment. In general, if the change in the cap does not keep pace with increases in Medicaid spending, states will bear an increasing financial responsibility, which could lead to program cuts. Resetting the cap each year (or on a periodic basis) to reflect more recent experience would keep federal and state funding shares relatively constant.

Potential goals of changing the federal funding approach to Medicaid may be to alleviate federal budgetary pressures and to encourage states to use their Medicaid dollars more cost effectively. To do so, states may be able to further adopt care management and value-based care provider payment methods. But increased financial pressure on states could lead them to reduce coverage for optional populations, reduce optional benefits, reduce provider payments, or increase beneficiary premiums and cost sharing. The latter two could jeopardize compliance with federal requirements to ensure patient access to care.

Importantly, while this issue brief focused on how any proposed changes to Medicaid funding approaches could affect federal and state budgets, other stakeholders would also be affected, including, but not limited to, Medicaid enrollees, health care providers, and managed care organizations.