Dangers of Block Grants and Per Capita Caps in Medicaid Financing

FEBRUARY 2017 | SUZANNE WIKLE

Since 1965, Medicaid has been providing affordable access to health care for children, workers, seniors, and persons with disabilities through a shared state-federal funding arrangement that guarantees a minimum package of health benefits to all who qualify. The 2016 elections have spurred a renewed conversation in Washington about fundamentally changing the financing structure of Medicaid to one based on block grants or "per capita caps." These discussions have intensified quickly and without any evidence that such changes are necessary or in the best interest of patients. The consequences of such a drastic change to Medicaid would be far reaching and cause significant damage to a program that's vital to the vulnerable people it serves. Such changes would place severe fiscal pressures on states and threaten patient access to care. Any discussion about strengthening the program should build on the current successful foundation rather than threatening states' financial stability—and patients' health and well-being—with drastic changes to the program's financing and structure.

Under a block grant, states receive a fixed amount of money from the federal government to administer a program. The total amount of funding and the formula for the allocation of these funds among states would be set by Congress. Typically, block grant formulas are based on factors such as a state's overall population, the number of people living in poverty, or historical levels of spending.

Five consequences of changing Medicaid's financing structure:

1. Funding will not keep up with need, burdening state budgets.
2. Medicaid will no longer respond automatically to economic downturns.
3. States will be under pressure to cut benefits and reimbursements.
4. States may cut eligibility, pitting vulnerable populations against each other.
5. The safety net will be inconsistent across states.

Lessons from TANF and CCDBG

Lessons from two current block grants—the Temporary Assistance for Needy Families (TANF) block grant and the Child Care and Development Block Grant (CCDBG) —demonstrate the key weaknesses of block grants: funding fails to keep up with the costs of services and population growth over time, and funding is unresponsive in times of recession, when more people need help just as state revenue is declining. This pressures states to cut benefits and reimbursements, or to cut eligibility, pitting vulnerable populations against each other. The result is increased disparities in the services available to residents of different states.

TANF

The transition from AFDC to TANF in 1996—and the experience in the two decades since—provides key evidence and cautions about how a block grant structure might change Medicaid. TANF has been flat funded since it was block granted 20 years ago and not adjusted for either inflation or population growth over time. As a result of inflation alone, the value of the block grant has eroded by one-third since its creation. States that have experienced growth in the number of poor children are forced to spread fewer dollars across a larger number of children. Fifteen states receive less than half as much per poor child as they did when TANF was created.[1] States have responded by both cutting benefits—35 states have allowed their TANF benefits to decline by 20 percent or more in real terms—and by serving fewer families—only one in five poor children receives any cash assistance.[2] During the Great Recession that started in 2008, TANF caseloads only grew slightly, and the program played a marginal role in lifting families out of deep poverty. The flexibility to use TANF funds for a range of purposes has only increased the competing demands on a limited pool of funding.

CCDBG

A key benefit lost in the creation of TANF was a guarantee for access to child care assistance. Because Congress expected low-income women to go to work, they initially provided a large increase in funding for CCDBG. Those dollars however have eroded over time—CCDBG's current funding is 10 percent below its 2002 level in constant dollars.[3] States have been left to balance the needs of serving both families receiving TANF and low-income working families by using limited TANF and CCDBG dollars. States have turned to policies such as low eligibility limits, waiting lists, increased co-payments, and lowered provider payment rates to control costs. Payment rates to providers—an important indicator of whether families can access quality child care—have been most affected by stagnant funding. In 2001, 22 states set payment rates at the federally recommended level compared to just 3 states today. [4] Since 2006, nearly 364,000 children have lost access to CCDBG-funded care.[5] Today, only 11 percent of eligible children are able to get help.[6]

Under per capita caps, states would receive a set amount of money per enrollee from the federal government to administer the program. **While responding to caseload increases, per capita caps otherwise share the problems of block grants.** Like block grants, per capita caps are unlikely to keep up with the cost of health care, forcing states to make the same difficult decisions about reduced eligibility or benefits to balance state budgets. Even if adjusted for the overall rate of inflation, funding is likely to fall far short of rising costs caused by an aging population and new advances in medical care. If the capped funding does not reflect the true cost of serving some populations, there will be incentives to deny or limit coverage to the most sick—and thus most costly—populations.

Proponents argue that structural changes to Medicaid are needed to give states more flexibility. This is a flawed argument, particularly because states currently have flexibility in their Medicaid programs. As Governor John Bel Edwards of Louisiana explained, "Under such a scenario, **flexibility would really mean flexibility to cut critical services for our most vulnerable populations,** including poor children, people with disabilities and seniors in need of nursing home and home-based care."

For more information, read the full report http://www.clasp.org/resources-and-publications/publication-1/Medicaid-Financing-Dangers-of-Block-Grants-and-Per-Capita-Caps.pdf

[1] U.S. HHS OFA, "TANF Financial Data," 1997-2015, U.S. Census Bureau CPS March Supplement, "Related Children Under Age 18," 1997-2015.
[2] U.S. Census Bureau, "Income and Poverty in the United States: 2015," September 2016, U.S. DHHS OFA, "TANF Caseload Data 2015", 2016, CLASP, "TANF 101: Block Grant," November 2016.
[3] National Women's Law Center, "TANF and Child Care Assistance: A Weakened Safety Net For Families," 2016.
[4] National Women's Law Center, "Red Light, Green Light: State Child Care Assistance Policies 2016," 2016.
[5] CLASP, "CCDBG Participation Drops to Historic Low," January 2017.
[6] U.S. Government Accountability Office, "Access to Subsidies and Strategies to Manage Demand Vary across States," December 2016.