Medicaid Financing:

Dangers of Block Grants and Per Capita Caps

Lessons from TANF and CCDBG

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Introduction

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. The 2016 elections have spurred a renewed conversation in Washington about fundamentally changing the financing structure of Medicaid, in particular ending the current guarantee of a minimum package of benefits to all qualifying individuals by putting a limit on federal funding to states. Two types of financing changes have been discussed: block grants and per capita caps.

Such changes would place severe fiscal pressures on states and threaten patient access to care. Other federal block grant programs that have undergone such drastic restructuring—particularly the change with 1996's "welfare reform" from Aid to Families with Dependent Children (AFDC) to the Temporary Assistance for Needy Families (TANF) program—demonstrate that services are greatly diminished, funding fails to keep up with need, and the block grant is unresponsive in times of recession. All of these consequences leave states with untenable choices. The Child Care and Development Block Grant (CCDBG), which is comprised of both a discretionary funding stream, subject to the annual federal appropriations process, and a mandatory funding stream, similarly demonstrates shortcomings and has been challenged to provide adequate child care assistance to eligible families.[1] Per capita caps, which would provide states with a set amount of dollars per Medicaid enrollee, avoid some of the hazards of block grants, yet they would also undermine the core guarantee of comprehensive medical insurance.

What are block grants?

Under a block grant, states receive a set amount of money from the federal government to administer a program. Block grants would be a drastic change from the current Medicaid financing structure, which automatically responds to need. With block grants, states would face difficult decisions that would lead to decreased eligibility and benefits for the people who receive their health care through the program.

If Medicaid is converted to a block grant, states would receive a finite amount of money from the federal government for providing Medicaid services, rather than the current structure that "allows federal funds to

flow to states based on actual costs and needs as economic circumstances change."[2] The total amount of funding would be established by Congress, with the allocation of these funds among states determined by a formula devised by Congress. While we do not yet have any specific formula proposals to evaluate, they are typically based on factors such as a state's overall population, the number of people living in poverty, or historical levels of spending.

TANF, currently the largest block grant program at $16.5 billion a year, is designed to help needy families achieve self-sufficiency. It is also the one example of a program that was converted from an individual benefit—where all people meeting the eligibility criteria were legally entitled to receive assistance—to a block grant. 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.

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, and 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.[3]

Five consequences of changing Medicaid's financing structure:

1. Funding will not keep up with need, burdening state budgets.

If Medicaid financing is changed to a block grant or per capita cap, there is significant risk that states would not receive enough funding to keep pace with the rising cost of health care while simultaneously continuing to provide the same coverage, benefits, and payments to providers. As a result, state policymakers would be forced to decide how to make up the difference and/or Medicaid recipients would lose services or eligibility. Erosion in Medicaid funding is detrimental not only to those without other affordable health care options, but also to doctors, other health care providers, hospitals, nursing homes, and managed care organizations that all receive Medicaid funding to provide services.

Such an erosion is exactly what has happened with TANF, which 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 fallen 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.[4] States have responded by both cutting benefits and serving fewer families.

While funding for CCDBG actually grew in the early years after welfare reform, it later remained flat and then experienced minimal increases in baseline funding. CCDBG's current funding of $5.7 billion remains 10 percent below its 2002 level in constant dollars.[5]

Eroding federal funds will significantly impact state budgets. Total Medicaid spending (state and federal combined) comprises about one-quarter of state budgets, and federal dollars account for over half of this spending. Therefore, a reduction in federal Medicaid funding over time through block grants will place pressure on state budgets, causing ripple effects throughout other areas of state budgets and jeopardizing their fiscal stability.[6]

2. Medicaid will no longer respond automatically to economic downturns.

Shifting financial risks to states is especially damaging during economic downturns. Unlike the federal government, which can run a deficit, nearly all states are legally required to balance their budget each year. When state tax revenues drop during recessions, federal dollars can help alleviate state budget crises. Without federal support that responds to increased need, states would be forced to cut eligibility and/or benefits at a time when more people are in need.

Medicaid's response to the Great Recession was exactly what we expect of the safety net. The program responded by providing health care for millions of Americans who lost employment and often their access to employer-provided insurance. Between December 2007 and December 2009, Medicaid enrollment grew by 14 percent and, because Medicaid spending is directly related to enrollment, spending also increased. This increase was because the long-standing successful funding formula allows for fluctuations in enrollment and does not cap spending. The ability of Medicaid to respond to economic pressures preserves not only access to health care for those most in need, but also jobs at every level of the health care industry.

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Unlike Medicaid, TANF did not respond during the recession to the increasing needs of American families by providing a basic safety net. In fact, TANF caseloads did not immediately grow along with the sharp increase in national unemployment, and the program only played a marginal role in lifting families out of deep poverty during the recession. In three states—Georgia, Indiana, and Rhode Island—TANF caseloads actually decreased during the recession.[7]

3. States will be under pressure to cut benefits and reimbursements.

If a block grant limits federal funding of Medicaid, states would struggle to cover the same number of people with a limited pool of funding. This would put pressure on them to cut their Medicaid budget by instituting higher co-payments or other cost-sharing arrangements, or by dropping or reducing coverage for certain benefits (e.g., early intervention therapies for young children). The current Medicaid structure for matching federal dollars requires states to meet minimum standards for benefits, which includes such services as developmental screenings for children and nursing care for seniors who are unable to be cared for at home. A block grant structure will likely eliminate federal requirements for minimum benefits, giving states discretion to reduce benefits in response to cuts in federal funding. Another option for states is reducing provider payments, which could lead to fewer doctors being willing to care for Medicaid patients and, in turn, limit access to health care.

A decrease in assistance is exactly what happened with TANF. The value of cash assistance awarded to families has substantially decreased over the last 20 years, during which 35 states have allowed TANF benefits to decline by 20 percent in purchasing power, and 17 states have not adjusted their nominal benefit amounts. As a result, recipients have had to bear inflation-adjusted declines of more than 30 percent. Another consequence of not adjusting TANF for inflation is that states must cover the full cost of any increases in benefits.[8]

CCDBG also demonstrates that block grants lead to reduced benefits and payments. While the recent reauthorization of CCDBG established additional rules for the program, states retain flexibility to set many key policies. Restrictive eligibility policies are one way of controlling costs in a capped program. As of 2016, state-determined income eligibility for CCDBG was lower as a percent of poverty in 26 states, and 25 states required higher parent co-payments as a percentage of household income when compared to 2001. 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.[9]

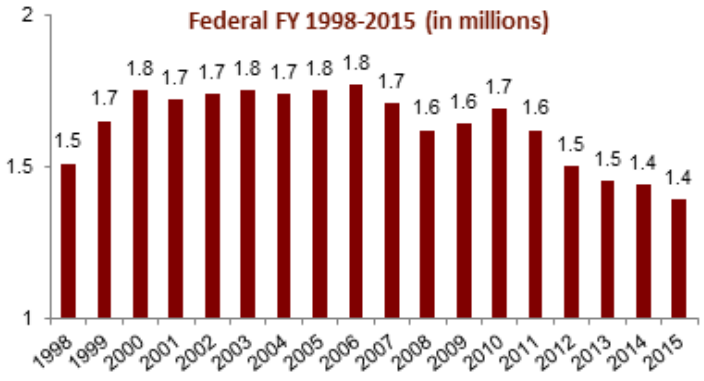
4. States may cut eligibility, pitting vulnerable populations against each other.

Converting Medicaid to a block grant would likely undermine the basic eligibility requirements of the program. The current Medicaid structure requires states to cover certain populations, such as low-income pregnant women, children, seniors, and persons with disabilities. Under a different financing structure, these minimum standards would likely be eroded or left entirely to states' discretion. For example, states may be allowed to deny coverage for some populations or establish waiting lists.

Cutting eligibility due to fiscal pressures will force states to choose which vulnerable populations to cover. Right now, low-income children and pregnant women are guaranteed coverage, just as low-income seniors and individuals with disabilities are guaranteed nursing care. In determining whom to serve, states would likely consider the cost of covering different populations or the political engagement of populations. For example, seniors and persons with disabilities are the most expensive to cover and therefore a likely population to lose coverage. However, seniors are politically engaged and therefore may be a more challenging population to cut. And while children are the least expensive population to cover, they are not an active political constituency, which could jeopardize their coverage. These debates will play out in state legislatures across the country; while different states may make different choices, some groups are likely to lose coverage everywhere.

CCDBG and TANF have no guarantee to serve all eligible children. The share of poor children receiving cash assistance has declined dramatically since TANF replaced AFDC. Today, only one in five poor children receives cash assistance.[10] Due to declining federal and state investments, CCDBG is currently reaching the smallest number of children in its history (see Figure 1). Total CCDBG spending declined by 18 percent in constant dollars from 2008 to 2014.[11] Since 2006, nearly 364,000 children have lost access to CCDBG-funded care.[12] Today, only 11 percent of eligible children are able to get help.[13] As child care investments have not kept pace with rising costs, subsidy values have declined by about 20 percent.[14]

Figure 1. Average Monthly Number of Children Served in CCDBG in the United States Federal FY 1998-2015 (in millions)



Source: HHS administrative data. FY 2015 data are preliminary.

5. The safety net will be inconsistent across states.

Medicaid programs are not identical across states now, but should Medicaid become a block grant, the difference in access to health care among states could become stark. Current law requires Medicaid to cover certain minimum benefits as well as certain populations. Under a block grant model, these minimum standards could be eliminated, essentially leaving it up to the states to decide who should receive health care and what services will be covered. As funding erodes and states continue to make choices about limiting eligibility or coverage, the differences in Medicaid coverage among states will be amplified.

The financing structure of TANF has created such inconsistencies across states. The TANF block grant is based on how much states received under AFDC in the years prior to welfare reform. This has locked into place sharp disparities in how much states receive per poor child. These gaps have gotten even larger due to differences in population growth among states. The funding inconsistencies over the 20 years of TANF have been particularly alarming: in 1996, some states received as much as 8 times more per poor child than others; today this gap has increased to 12 times more.[15]

The combination of disparate state funding and high state flexibility has created vast inconsistencies in the safety net system across the country. For example, the share of poor children receiving cash assistance ranges from almost 66 percent in California to 3 percent in Louisiana.[16] TANF monthly cash assistance benefits for a family of three vary from $923 in Alaska to $170 in Mississippi.[17]

Similarly, state flexibility has created huge variation in states' child care subsidy programs and policies related to health, safety, quality, and access. Eighteen states have reduced their average monthly number of children served by more than a quarter since 2006, including four states that are now serving 50 percent fewer children.[18] In a study of racial and ethnic differences in access to CCDBG, CLASP found great variation by state across racial and ethnic groups—with eligible Latino and American-Indian and Alaskan Native children having the least access.[19]

Per capita caps are not a viable alternative

Another Medicaid financing option being floated is per capita caps, a mechanism under which states would receive a set amount of money per enrollee from the federal government to administer the program. Per capita caps are not a viable alternative to block grants because they hold many of the same pitfalls as block grants. Moreover, per capita caps have never been used in a public benefit program, and there are no details of how this financing structure would work. It is unclear whether each enrollee would be allocated the same capped funding or whether the amount would vary among populations, such as higher amounts for seniors or persons with disabilities. 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.

"Flexibility would really mean flexibility to cut critical services for our most vulnerable populations…"

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. States will either need to tap their own general revenue or deny services, such as for prescription drugs or other life-saving treatment.

Consequences to States and Enrollees	Block grants	Per capita caps
Funding will not keep up with population growth	X	
Funding will not keep up with rising costs of health care	X	X
Funding will not respond to economic downturns	X	Uncertain
States will be under pressure to cut benefits and reimbursements	X	X
States may cut eligibility, pitting vulnerable populations against each other	X	Uncertain
States' safety-net programs will vary widely	X	X

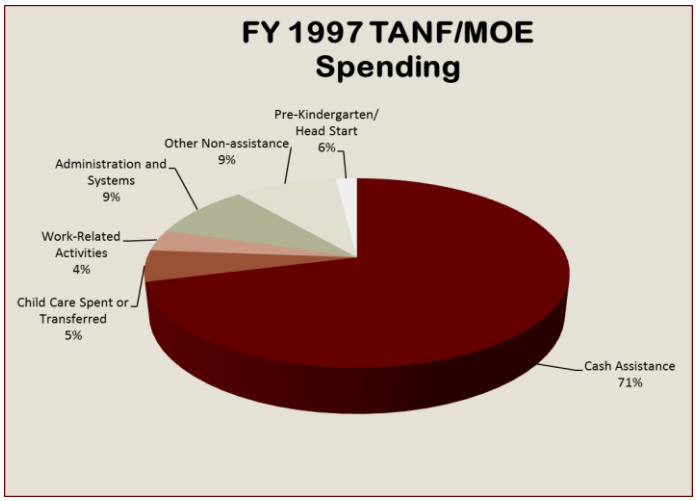
Block grants and per capita cuts do not provide true flexibility

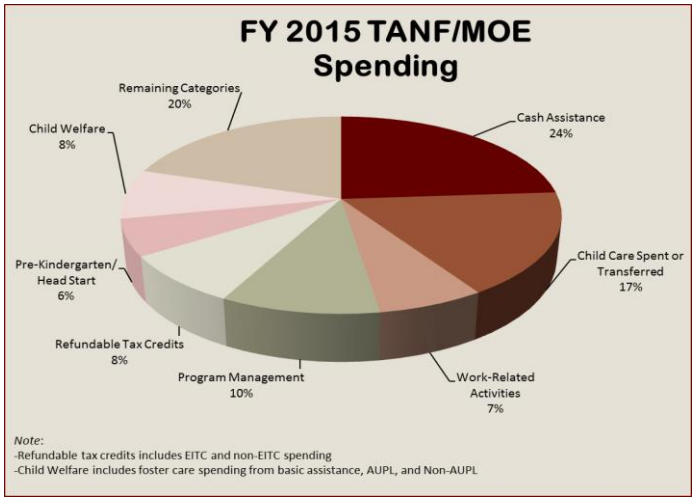
Proponents of structural changes to Medicaid argue that they are needed to give states more flexibility. This is a flawed argument, particularly because states currently have flexibility in their Medicaid programs. States can apply for waivers from the federal Centers for Medicare and Medicaid Services (CMS) to cover more benefits, increase eligibility limits, or try innovative models for care. Any waiver

must be deemed “budget neutral,” meaning that it will not increase federal spending. Waivers are evaluated by CMS on four criteria: increasing access to care, increasing and stabilizing provider networks, improving health outcomes, and increasing program efficiency. Given the latitude states already have, the current use of the term "flexibility" by those pursuing significant structural changes to Medicaid should be viewed with caution.

As Governor John Bel Edwards (D) of Louisiana explained, “Under such a [block grant] 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.” Massachusetts Governor Charlie Baker (R) feels similarly and said, “We are very concerned that a shift to block grants or per capita caps for Medicaid would remove flexibility from states as the result of reduced federal funding. States would most likely make decisions based mainly on fiscal reasons rather than the health care needs of vulnerable populations.”[20]

Second, without protections for recipients, flexibility only increases the competing demands on a limited pool of funding. Under the guise of “state flexibility” states have used TANF block grant dollars and the required state "maintenance of effort" (MOE) contribution to meet other state needs. Because the uses of TANF are so broad, some states have capitalized on the program's flexibility to redirect funds to a wide variety of activities such as college scholarships for middle-income students. TANF funds are commonly used to pay for programs with real benefits to low-income families like child care subsidies and child welfare programs. While these are crucial supports for low-income families, in many cases states have supplanted other funding sources that would otherwise have paid for these programs. As a result, significantly fewer dollars go directly to families as cash assistance. In fiscal year (FY) 1997, 71 percent of TANF/MOE spending was dedicated to cash assistance for families. In FY 2015, only 23 percent of TANF/MOE spending went to cash assistance for families.[21]





This experience should serve as a cautionary tale for those who hope that increased flexibility in Medicaid would allow states to expand funding to address social determinants of health, such as housing or other anti-poverty efforts. Given limited funding, it is highly unlikely that states would support such activities, and if they did, it could only be funded by cutting core health care eligibility, benefits, or payments.

Conclusion

Current discussions about structurally changing the financing of Medicaid have intensified quickly and without any evidence that such changes are necessary or in the best interest of recipients. The consequences of such a drastic change to Medicaid would be far reaching and cause significant damage to a vital program for children, seniors, and persons with disabilities. Access to care for vulnerable populations would be diminished, states would be left holding the bag for increasing medical costs, and providers and other health industry jobs would be at risk.

Simply put, neither turning Medicaid into a block grant nor initiating per capita caps on spending will provide states with choices that improve access to care. Rather, such changes will shift all the financial risk to states, which would be forced to respond to rising needs without additional assistance from the federal government. The current structure has worked for more than 50 years by sharing the responsibility between states and the federal government. This system allows Medicaid to respond to economic downturns without jeopardizing state budgets, while also ensuring that states are held accountable for minimum eligibility and benefits criteria. Medicaid is a successful program with a proven record of improving lives. Any discussion about strengthening the program should build on this 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.

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[1] The Child Care and Development Block Grant (CCDBG) is also known as the Child Care and Development Fund or CCDF. CCDBG's structure is unusual because it is comprised of multiple funding streams: mandatory, matching, and discretionary. Each state receives a Mandatory allotment based on a formula set in 1996, and may draw down Matching funds up to a cap if it contributes required state Match and Maintenance of Effort fund. Discretionary funding is subject to the annual federal appropriations process and does not require a state match.

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[3] Karen Schulman and Abbie Starker, "Temporary Assistance For Needy Families and Child Care Assistance: A Weakened Safety Net For Families," National Women's Law Center, 2016, http://nwlc.org/wp-content/uploads/2016/11/TANF-Child-Care-Fact-Sheet-11.4.16.pdf.

[4] U.S. Department of Health and Human Services Office of Family Assistance, "TANF Financial Data," 1997-2015, https://www.acf.hhs.gov/ofa/programs/tanf/data-reports. U.S. Census Bureau Current Population Survey March Supplement, "Related Children Under Age 18," 1997-2015.

[5] Hannah Matthews and Christina Walker, *Child Care Assistance Spending and Participation in 2014*, CLASP, 2016, http://www.clasp.org/resources-and-publications/publication-1/CC-Spending-and-Participation-2014-1.pdf.

[6] Medicaid and CHIP Payment and Access Commission, "Medicaid's Share of State Budgets," https://www.macpac.gov/subtopic/medicaids-share-of-state-budgets/.

[7] Elizabeth Lower-Basch, "TANF 101: Cash Assistance," CLASP, November 2016, http://www.clasp.org/resources-and-publications/publication-1/TANF-101-Cash-Assistance.pdfhttp://www.clasp.org/resources-and-publications/publication-1/TANF-101-Cash-Assistance.pdf.

[8] Ibid.

[9] Karen Schulman and Helen Blank, "Red Light, Green Light: State Child Care Assistance Policies 2016," https://nwlc.org/wp-content/uploads/2016/10/NWLC-State-Child-Care-Assistance-Policies-2016-final.pdf. As of February 2016, one state (Oregon) set its payment rates at the federally recommended level. In March and June 2016, West Virginia and South Dakota raised their rates to this level respectively.

[10] Bernadette D. Proctor, Jessica L. Semega, and Melissa A. Kollar, "Income and Poverty in the United States: 2015," U.S. Census Bureau, September 2016, http://www.census.gov/content/dam/Census/library/publications/2016/demo/p60-256.pdf. Office of Family Assistance, "TANF Caseload Data 2015", Administration for Children and Families, U.S. Department of Health and Human Services, https://www.acf.hhs.gov/ofa/resource/tanf-caseload-data-2015. Elizabeth Lower-Basch, "TANF 101: Block Grant," CLASP, November 2016, http://www.clasp.org/resources-and-publications/publication-1/TANF-101-

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[12] Christina Walker and Hannah Matthews, "CCDBG Participation Drops to Historic Low," CLASP, January 2017, http://www.clasp.org/resources-and-publications/publication-1/CCDBG-Participation-2015.pdf.
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[14] U.S. Department of Health and Human Services, FY 2017 Administration for Children and Families Justification of Estimates for Appropriations Committees, 2016, https://www.acf.hhs.gov/sites/default/files/olab/final_cj_2017_print.pdf.
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