# Block Grants are Bad for Kids

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Since 1965, Medicaid has provided America's children a crucial safety net. As the nation's single-largest health insurance provider for children, Medicaid finances care for one in three children, two in three low-income children, and four in ten of the nation's births.[1] As part of their response to reduce government spending, Congressional Republican leadership has proposed a deficit-reduction plan that would cap federal Medicaid spending and transform it into a block grant program. This plan would represent a fundamental transformation of how Medicaid operates.

Today, the federal government's financial contribution to state Medicaid programs is tied to the total amount a state spends, which rises and falls with fluctuating enrollment and program costs. Under a block grant, by contrast, states would be responsible for 100 percent of program costs above the federal cap. In exchange for this added financial burden, a block grant is typically perceived as allowing states greater flexibility in managing their programs. States facing rising costs without corresponding federal matching funds, could narrow eligibility guidelines, scale back benefits, and cap enrollment. Such practices could unravel decades of progress toward reducing the number of uninsured children and fundamentally undermine the nation's long-standing commitment to guaranteeing vulnerable children health care coverage. This analysis reviews the effects block granting Medicaid would have on America's health care safety net for children.

## BACKGROUND: MEDICAID AND CHILDREN

Created under Title XIX of the 1965 Social Security Act, Medicaid is a means-tested entitlement program financed jointly by the federal and state governments. Medicaid provides health coverage to nearly 60 million low-income people (see Table 1 for distribution of Medicaid beneficiaries), and it is the nation's primary safety net for nearly 30 million children. Medicaid's role has grown in importance given the state of the economy and the rising cost of private family coverage ($13,770 in 2010).[2] As the foundation for insurance coverage expansions under the Affordable Care Act passed in 2009, Medicaid will cover an estimated 16 million additional people starting in 2014.[1]

First Focus
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As a federal entitlement program, Medicaid coverage is guaranteed to all eligible people. States cannot impose enrollment caps, waiting lists, or turn eligible people away for any reason. Children have benefited from federal mandatory coverage expansions begun in the 1980s. Current federal rules require states to cover children younger than 6 in families with incomes at or below 133 percent of poverty ($29,327 for a family of four in 2010) and children ages 6 to 18 living in families with incomes at or below 100 percent of poverty.[1] Without Medicaid, most of these children would be uninsured. According to the National Health Interview Survey, the percentage of poor children without health insurance at the time of the 2009 survey declined to 12.1 percent from 22.8 percent in 1997. In contrast, the percentage of poor children with public insurance in 2007 increased to 78.7 percent from 62 percent a decade earlier.[3]

Medicaid finances health care that private insurers often exclude or limit, such as mental and behavioral health services. It is the safety net for catastrophic illnesses, such as childhood chronic illness and traumatic brain injuries. As the primary coverage source for America's most vulnerable residents, Medicaid is expensive, but children, in general, are the least expensive group to cover. While comprising half of Medicaid enrollees, children account for only 20 percent of program spending.[1]

With total program costs of $366 billion in 2009, Medicaid plays a major role in the U.S. health care system. Medicaid was the largest source of federal revenue for states and accounted for 8 percent of federal spending in 2010 (Medicare accounted for 15 percent and Social Security for 20 percent).[4] Medicaid accounts for about one in six total health care dollars spent and nearly one in three dollars spent on nursing home care.[1]

**Table 1: Enrollment distribution and average premiums by enrollee group**

| | Proportion of Medicaid enrollees FY 2007 | Proportion of total Medicaid spending FY 2009 | Average annual premium FY 2009 |
|---|---|---|---|
| Children | 49.5% | 20.5% | $2,135 |
| Adults | 25.2% | 12.4% | $2,541 |
| Elderly | 10.2% | 24.7% | $12,499 |
| Disabled | 15.1% | 42.4% | $14,481 |

*Source: Kaiser Family Foundation State Health Facts, www.statehealthfacts.org*

## THE REPUBLICAN BLOCK GRANT PROPOSAL

As part of their response to the national deficit, elected officials have put forth numerous proposals to balance the federal budget. The House passed in April a proposal by Congressman Paul Ryan, Chairman of the House Budget Committee, which included major changes to two of the nation's largest entitlement programs: Medicare and Medicaid.

Today, Medicaid's financing structure responds agilely to states' changing needs. As currently designed, the federal government pays its share of each state's Medicaid costs, whatever those costs turn out to be so long as they meet program criteria. The federal payments adjust automatically to fluctuating needs, particularly during economic downturns, when incomes fall, unemployment rises, and families lose access to employer-sponsored care.[5] The federal government matches state costs based on a reimbursement formula, called the Federal Medical Assistance Percentage (FMAP), which adjusts for state per capita income. Thus, the federal government pays a greater share of poorer states' Medicaid costs. On average, the federal government paid 57 percent[1] of total Medicaid costs in 2008.[1]

Ryan projects his proposal would save the federal government $1.4 trillion between 2012 and 2022, with $610 billion in savings coming from the repeal of the Affordable Care Act and $750 billion from transforming Medicaid from an entitlement into a block grant program.[6] Under Ryan's proposal, the federal government would pay states a fixed amount for Medicaid each year based on the state's low-income population.[2] The annual federal allotment would be indexed to increase with the size of the Medicaid population and growth in the gross domestic product per capita plus 1 percentage point.[6] In exchange for this slower growth in federal Medicaid payments, states would receive greater flexibility over the use of federal money. According to analysis by the Congressional Budget Office (CBO), meeting new federal spending targets would require states either to pay more from their own funds and/or lower program costs by reducing provider payment rates, curtailing eligibility, and narrowing benefits.[7]

## THE PROBLEMS WITH BLOCK GRANTING MEDICAID

Converting Medicaid into a block grant has been proposed several times over the last 30 years: in 1981 by President Ronald Reagan, in 1995 by House Speaker Newt Gingrich, and in 2003 by President George W. Bush. Congress passed Gingrich's legislation, but President Bill Clinton agreed only to block grant welfare, which became the Temporary Assistance for Needy Families (TANF) program.[8] In each of these attempts, the policy failed to find sufficient support both among lawmakers and the public. Currently, Americans do not support proposals to cut funding for Medicaid, according to two public opinion polls conducted this spring.[9,10] A Kaiser Health Tracking Poll released in late May, for example, found that 60 percent of respondents supported the current Medicaid structure, 35 percent supported block grants, and 53 percent favored no Medicaid reductions.[9]

While block grants can be structured in a number of

1 The 2009 American Recovery and Reinvestment Act (ARRA) raised the average federal Medicaid share to 64 percent in fiscal years 2010 and 2011, representing billions of additional federal funding for state Medicaid programs. In exchange for the increased funding, states had to maintain their current eligibility and benefit guidelines.

2 Determined with Federal Poverty Level (FPL) guidelines.

ways, they generally provide fixed federal funding allotments to states based on current expenditures trended forward using a pre-determined growth rate. No federal block grant program includes a federal requirement guaranteeing coverage to all eligible people.[4] This analysis describes how a block grant would differ and how these changes would impact low-income children and families.

### *A Block Grant Undermines the Coverage Guarantee for Children*

Medicaid is an entitlement program, guaranteeing every child and adult meeting the eligibility criteria health insurance coverage. While states currently have some flexibility in setting the scope of coverage, federal law states they may not impose waiting lists, cap enrollment, or prioritize applicants. Under the Ryan proposal, however, states would receive additional flexibility in designing their Medicaid programs. Experience from two other block grant programs suggests that losing the federal entitlement will lead to children losing insurance coverage.

The State Children's Health Insurance Program (SCHIP) was created in 1997 as a capped block grant program to cover children in families with incomes above the Medicaid cutoffs. Today, SCHIP covers an additional 6 million children. During the recession in the early 2000s, several states froze enrollment to their SCHIP programs and many others imposed spending and enrollment caps, though never reached them.[4] It is reasonable to assume that states would repeat the SCHIP cost-cutting measures in Medicaid, if given that flexibility. New Jersey Governor Chris Christie, for example, told the New York Times recently that he would Medicaid tighten eligibility and reduce provider payment rates to deal with the pending decrease in federal stimulus funding.[11]

The TANF block grant replaced entitlement cash welfare in 1996. Over the past 15 years, federal funding for the program has stagnated, while the total number of families living in poverty increased by 41 percent.[4] Additionally, TANF instituted time limits on receiving cash assistance. Between 2007 and 2009, the unemployment rate doubled to 10 percent, but the TANF caseload increased by just 13 percent. An analysis by the Center on Budget and Policy Priorities concluded that TANF's block grant structure creates several disincentives for states to increase the number of people receiving cash assistance.[12] Many Americans on TANF remain unemployed and are losing unemployment benefits. Yet to cut costs, states are taking advantage of their block grant flexibility and reducing the length of time families qualify for cash assistance — leaving families extremely financially vulnerable. In Washington, for example, more than 5,000 families lost welfare assistance after reaching the 60-month mark and the state opted not to give them extensions.[13] If states wanted to adopt similar time limits for Medicaid coverage under additional flexibility in the Ryan Proposal, it could lead to children not receiving care when they need it most and throughout all stages of development.

### *A Block Grant Undermines Federal Support, Leaving States and Low-Income Families Vulnerable*

Currently, the federal government has an ongoing commitment to helping states cover Medicaid costs. In return, states must cover certain groups of people and provide specific benefits. Medicaid is a counter-cyclical program, meaning the need for government help increases during economic downturns, when unemployment rises and tax revenues fall. Under a

block grant scenario, federal funding would not adjust automatically to support states' rising costs due to economic downturns, demographic changes, epidemics, or emergency disasters.[14]

Experience from the recent severe economic downturn provides convincing evidence that states cannot predict fluctuating Medicaid costs and that the federal matching portion is vital to maintaining the health care safety net for children. An additional 4.6 million children gained coverage in Medicaid and SCHIP in 2007 and 2008.[2] In fact, due to expanded access to public programs thanks to increased federal dollars, the uninsured rate for children actually declined between 2007 and 2009, with 600,000 fewer uninsured children.[15]

**Table 2: Medicaid Spending in FY 2009**

| | Total Spending | Portion of Total National Medicaid Spending | Portion of State Medicaid Budget Paid by Federal Government* |
|---|---|---|---|
| United States | 366.47 billion | 100% | 66.4% |
| *Most Expensive States* | | | |
| New York | 41.37 billion | 13.5% | 59.3% |
| California | 41.68 billion | 11.4% | 61% |
| Texas | 23.7 billion | 6.5% | 68.3% |
| *Least Expensive States* | | | |
| Wyoming | 526 million | 0.1% | 56.8% |
| North Dakota | 572 million | 0.2% | 69.9% |

*Reflects increased matching rates under the ARRA; the federal portion was lowest in New Hampshire (56.5 percent) and highest in Mississippi (83.5 percent).

*Source: Kaiser Family Foundation State Health Facts, www.statehealthfacts.org*

### *A Block Grant Undermines the Benefits Guarantee for Children*

Medicaid provides nearly 30 million children coverage for comprehensive medical services, including early screenings, vaccinations, preventive check-ups, hospital care, chronic disease management, and vision and dental care. Since the enactment of the Medicaid Early Periodic Screening, Diagnosis, and Treatment (EPSDT) rules in 1967, Medicaid has been required to offer pediatric coverage across the entire spectrum of health care from prevention to advanced treatment for complex, chronic conditions. This breadth of coverage extends beyond what most employer-based health plans offer and is particularly important for low-income children covered by Medicaid, who tend to have greater and more complex health care needs than children with private insurance.[16]

Currently, states must offer the full range of EPSDT benefits. Under a block grant scenario, there would be no federally required minimum benefits package. With expanded program control, states could set their benefits based on what the budget calls for — not what children need. Based on evidence from state choices in designing SCHIP benefit packages, it is likely that states would limit coverage and treatment under a block grant scenario. An analysis of SCHIP program design in 2000, for example, found that among the 34 states with separately administered SCHIP programs, 32 designed their benefits more like commercial plans and used coverage exclusions impermissible by Medicaid.[17]

### *A Block Grant Undermines Preventative Care for Children*

Health insurance coverage is required for children to access necessary and appropriate health care. Uninsured children are less likely to have regular sources of care and more likely to suffer from preventable illness than children with insurance.[18] Access to primary care that offers continuous, coordinated, and comprehensive care helps reduce preventable hospitalizations and inappropriate use of hospital emergency departments.[18] Under a capped funding scenario, inexpensive preventive care that helps children grow into healthy, productive adults may be squeezed out. Seniors and people with disabilities comprise just one-quarter of Medicaid beneficiaries nationally but account for two-thirds of all Medicaid expenditures. Just 5 percent of beneficiaries account for more than half of total program costs.[1] In contrast, the half of enrollees who are children account for less than one-quarter of total program spending. The aged and disabled beneficiaries use more (and more expensive) services so the cost to cover them is substantially higher than for children and their parents. In 2009 there was nearly a seven-fold difference in the average annual premiums for children ($2,135) and people with disabilities ($14,481).[4]

When funding becomes limited in health care, the tendency is to focus on critical, life-saving services. The Emergency Medical Treatment and Active Labor Treatment Act (EMTALA) is one example of this — even when no government money is available, the law requires that hospitals have an obligation to provide life-saving care to all people. This trend also is seen in the historical distribution of national health care spending, which has shifted away from emphasizing primary and preventative care and toward acute care the final months of life.[19] Over time, a greater percentage of Medicare dollars is dedicated to heroic, life-saving measures that are significantly more expensive than chronic care management, for example. Applied to a block grant approach, this means that as funding becomes more scarce, a greater portion of Medicaid spending will go toward life-saving care, which would crowd-out resources available for the preventative care that is critical for young children.

### *A Block Grant Adds to Provider Strain*

Children in Medicaid have greater trouble accessing specialist care than children with insurance.[20] Pediatricians cite low provider payment rates and burdensome paperwork as reasons for not accepting Medicaid patients.[21] Historically in times of financial duress, states have frozen or reduced Medicaid payment rates to providers, worsening access problems. In response, Medicaid beneficiaries and health care providers have sued state officials, claiming the low payment rates make it difficult to find doctors who will see them. A California lawsuit over Medicaid payment rates, for example, currently is pending in the

United States Supreme Court.[22]

Children's poor access to dental care provides a foreshadowing of the access problems children could experience for medical care if the pay differential between the private sector and Medicaid widens further. Tooth decay is the most common chronic childhood disease and almost always preventable. If left untreated, however, tooth decay causes pain, malnutrition, and in extreme cases, death.[23] According to national surveys, only one in three children ages 2 to 18 enrolled in Medicaid received dental care in the year prior to the survey. One in eight had never seen a dentist.[24] If the few dentists who see the bulk of children with Medicaid are squeezed out by even lower payment rates, access to necessary dental care would worsen.

Ryan's proposal laments the unfair "two-tier hierarchy" of medical care created by Medicaid's low reimbursement rates.[6] Evidence demonstrates, however, that capping federal payments and shifting the financial burden to states would not solve this problem but only pressure states to slash payment rates further.[11]

### *A Block Grant Overlooks Structural Causes of Health Care Inflation*

Over the next decade, federal Medicaid spending is projected to grow at an average annual rate of 7 percent per year, accounting for the new enrollees added under health reform.[1] Medicaid has controlled health care costs better than the private sector, while often providing more comprehensive benefits. Accounting for health differences, the average cost per Medicaid beneficiary is significantly lower than private insurance. Medicaid spending growth on a per capita basis over the last decade (4.6 percent) was slower than the rate of growth in private insurance premiums (7.7 percent).[4]

While some argue that block grants control costs by incentivizing states to better manage costs, a block grant actually would make cost containment more difficult. States would be locked into stagnant funding arrangements that do not support the longer-term investments needed to overhaul the system and address underlying drivers of health care inflation. For example, many states have expanded the use of managed care to control costs. While managed is intended to save money over the long run, there are additional start-up costs, which currently are shared by the state and federal governments. Under a block grant, states would have to finance such innovations on their own.

### *A Block Grant Creates Uncertainty for Children's Insurance Payments*

Allocating funds equitably across states would be challenging under a block grant scenario. Under the Ryan proposal, the initial allotment seems to be set according to state's current Medicaid expenditure levels. States that have done a poor job promoting efficiency and value in Medicaid and have high per-person costs, would in essence, be rewarded for that inefficiency by locking in that high spending level moving forward. Furthermore, states with narrower Medicaid eligibility and benefits, lower provider reimbursement rates, and/or lower overall health care costs when the block grant started, would receive fewer funds and would seemingly be locked in at that level. Any future coverage expansions or program improvements in those states likely would have to be financed entirely with state funds.[14]

SCHIP provides an example of the challenges of

establishing a capped funding formula that accounts for all states' different and evolving needs. Under SCHIP, federal funding was set 10 years in advance. The pre-set formula resulted in surpluses and shortages of SCHIP funding across the states. Initially, the allotments were too high, resulting in money returning to the federal treasury, but then as programs matured and enrollment increased, the allotments were too low for many states to afford the increased demand.[4]

## CONCLUSION

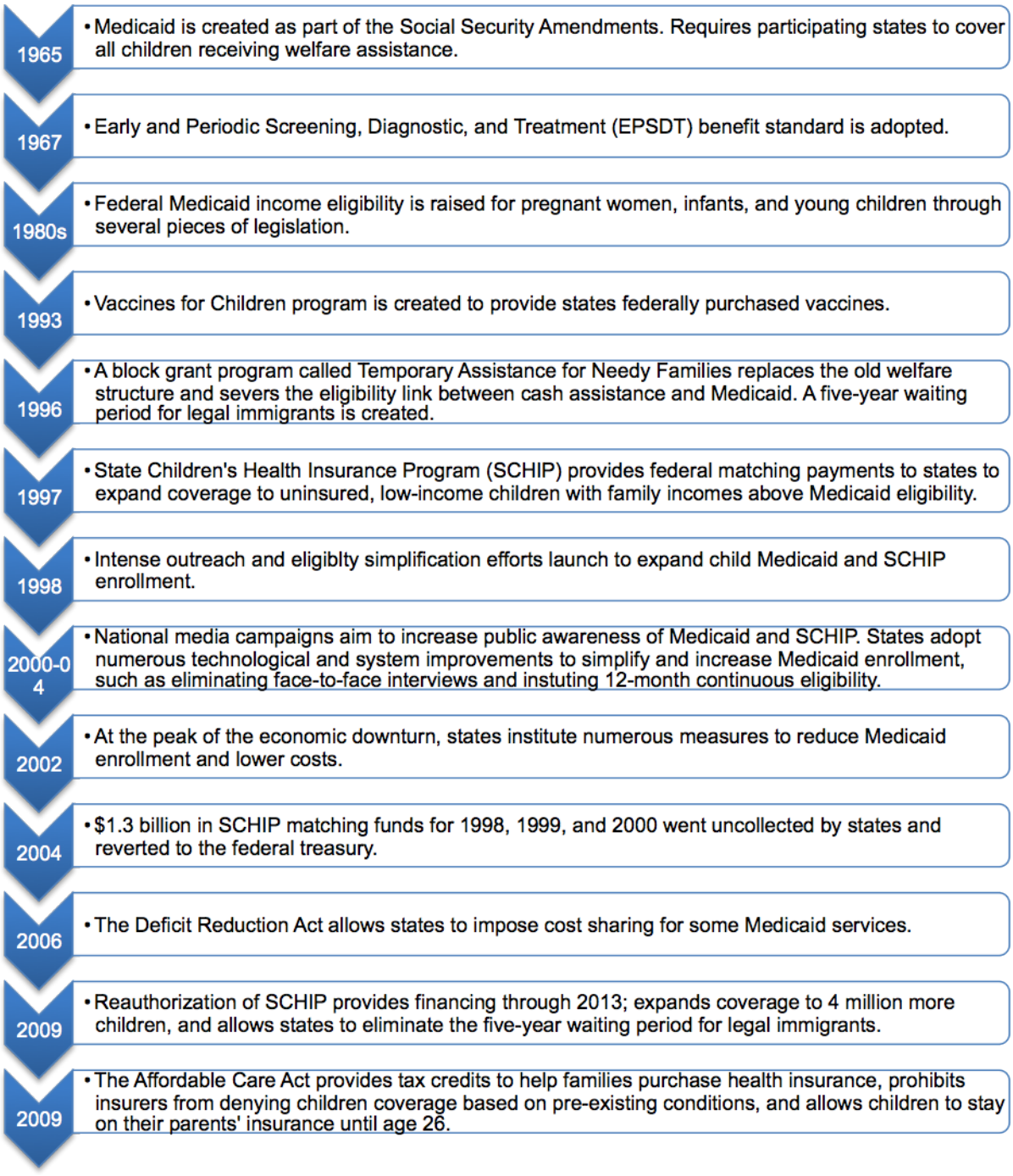
Health insurance provides the doorway for access to health care services children need for a healthy start and to become productive contributors to society. Since 1965, Medicaid has provided a crucial safety net for millions of low-income children, leveling the playing field so they, too, would have a chance at a bright future. Transforming Medicaid from an entitlement program and into a block grant with capped federal funding would undermine this 45-year-old commitment to nearly 30 million children. With lessons from the most recent economic downturn fresh in our minds, it is evident that states alone cannot shoulder the burden of sharp increases in Medicaid enrollment and costs.

The percentage of insured children in the United States has reached an all-time high due to successful efforts at increasing enrollment in Medicaid and SCHIP. The Ryan proposal would erode this progress toward universal health care coverage for children by leaving states, health care providers, and low-income families on the hook for rising costs. Block-granting Medicaid is a shortsighted approach to solving America's fiscal problems. It does not address fundamental drivers of rising health care costs and merely shifts tough financial choices from the federal government to states and low-income families. More critically, a block grant undermines the long-term investment in America's greatest asset for future economic growth: our children.

### Table 3: Comparison of Current Medicaid Financing and a Block Grant

| | Current Medicaid Rules | Block Grants |
|---|---|---|
| **Federal Funding** | Provided "as needed" regardless of total program costs. Matches actual total costs states incur and reimburses at a pre-set rate. | Capped by a pre-set formula that does not adjust for variations in actual costs influenced by things like economic recessions, demographic changes, health care inflation, medical breakthroughs, unpredictable epidemics and emergency disasters. |
| | States and federal government share the risk of growing enrollment and rising health care cost. | States bear most risk of growing enrollment and rising health care costs. |
| | Federal spending is uncertain based on state's actual annual costs. | Federal spending is predictable. |
| **Eligibility and Coverage** | All eligible children are guaranteed coverage. States cannot impose waiting lists or deny coverage to qualifying applicants. | Block grants do not guarantee coverage for eligible children so states may impose waiting lists and freeze enrollment. |
| **Benefit Levels** | Early Periodic Screening, Diagnosis, and Treatment (EPSDT) rules assure that eligible children receive all necessary prevention and treatment services. | Eligible individuals have no federal right to minimum benefit levels or patient protections. |
| **Statewide Funding Equity** | The federal government matches states' total Medicaid spending based on the predetermined growth rate, regardless of other states' spending. | Increasing funding for one state requires taking away from another. States with narrower programs and lower costs today would likely have to use only state dollars to expand their programs. |

### Figure 1: Milestones in Public Health Insurance Coverage for Children



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