



## Children's Defense Fund

# Keep Medicaid Strong: Reject Proposals to “Reform” through Block Grant or Per Capita Cap

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Thanks to Medicaid, the Children's Health Insurance Program (CHIP) and the health insurance marketplace, today more than 95 percent of children in America have health coverage. Medicaid is lean and efficient, serving millions of low-income children, pregnant women, children and adults with disabilities, and seniors. Children constitute 43 percent of all enrollees. Without Medicaid's strong protections, coverage guarantee, and comprehensive, age-appropriate health and mental health coverage, many children would go uninsured or underinsured, increasing short and long term costs for states and local communities while jeopardizing children's academic performance and their futures. Our nation's leaders must reject structural changes and cuts to Medicaid that would undermine its critical protections, hard-earned coverage and resulting health gains for children made over more than 50 years.

### **Medicaid's strong structure ensures millions of children, seniors, and people with disabilities access to quality health care.**

Currently, Medicaid guarantees health coverage to all eligible applicants without waiting lists or enrollment caps. Children are guaranteed all developmentally appropriate services, screenings and medically necessary treatments. A full range of care is available from preventive services through very specialized treatments for children with special health care needs. Under Medicaid, states are reimbursed at least dollar for dollar for expenses to deliver needed services.

### **What are the structural changes to Medicaid likely to be proposed?**

The proposals expected to be considered by the 115<sup>th</sup> Congress would block grant Medicaid, impose a per capita cap on spending, or include some combination of the two. While promoted under the guise of “reform,” both are designed specifically to save the federal government money while shifting costs to states, beneficiaries and health care providers.

The Medicaid block grant and per capita cap proposals would dramatically alter the current structure of Medicaid and its core protections for *all* enrollees, including low-income children and children with special health care needs – no group would be exempt. These changes would effectively eliminate states' ability to improve coverage by expanding eligibility, enhancing benefits and reducing cost

sharing. The block grant and per capita cap would be based on states' current expenditures, creating challenges for states with low and high Medicaid costs.

- Converting Medicaid to a **Block Grant** would give states a fixed dollar amount of federal funding in exchange for additional “flexibility” to decide what services and treatments they would provide and to whom. Current protections for the most vulnerable would likely be eliminated, along with other requirements to cover certain categories of needy people or certain coverage. However, because each state’s grant amount likely would be less than it currently receives and would grow more slowly than health care costs, states would have to put up ever-growing amounts of state funds to maintain their existing Medicaid programs, cut eligibility levels, benefits, and provider payments, or increase red tape and beneficiary cost sharing – or some combination of all of these. Any costs incurred by states in excess of their capped block grant would be borne by the state, providers or beneficiaries; there would be no extra dollars from the federal government, regardless of any unexpected developments such as population growth, a natural disaster or recession. Block grants lock in inequities between states and worsen them over time.
- States face enormous budget challenges when needs increase and dollars are capped. History makes clear that block grants, once established, generally diminish in size, and do not keep pace with inflation. Governors and state legislators who approve the original block grant deal might be long gone when the challenging decisions and large cuts need to be made.
- Converting Medicaid to a **Per Capita Cap** would also limit funding a state would receive to serve its Medicaid population. The federal government would give each state a set amount per person for different populations (likely children, adults, persons with disabilities, and seniors). These rates would differ by state, locking in current spending inequities. Per capita caps are more administratively complex than block grants and they also shift costs to the state and beneficiaries while saving the federal government money. Costs for care needed in excess of the per capita cap would have to be borne by the state, the beneficiary or providers still willing to serve Medicaid patients with their already very low reimbursement rates. These different caps also may create incentives for states to ration care to recipients with greater than average health care needs.

### **States cannot do more with less: Block Grants and Per Capita Caps shift costs to states, communities and beneficiaries.**

- Per capita caps and block grants do not create cost efficiencies; rather, they *shift* costs from the federal government to states, local communities, beneficiaries and providers. To meet the rigid constraints of a per capita cap or block grant, states would have to increase their own spending substantially, make deep cuts or both. Any “savings” would likely come from reducing eligibility, limiting benefits, increasing cost sharing, creating administrative barriers to make enrollment harder for eligible children, or cutting the already below-market provider payment rates. Such deep cuts would reverse the progress made in reducing the rate of uninsured children, pushing millions of children into the ranks of the uninsured and underinsured.

- Such cost shifts would result in loss of or limits on health coverage for children and other vulnerable populations, but not reduce their health needs or the cost of care. Instead, costs would have to be borne by states and local communities. An uninsured child costs the local community \$2,100 more than a child covered by Medicaid.
- Medicaid is already far more efficient and cost effective than private insurance for children. It costs substantially less to cover a child through Medicaid than through private coverage, and Medicaid administrative costs are about half those of private insurance coverage. Over the past decade, Medicaid costs per enrollee generally have grown more slowly than premiums for employer-sponsored coverage or overall national health expenditures.

### **Historically, Block Grants have resulted in federal funding cuts to core assistance and services.**

- History shows that funds generally decline once funding for programs is block granted. Funding for the Temporary Assistance for Needy Families Block Grant, for example, has not been increased since it was established in 1998. Its value, accounting for inflation, has decreased by 32 percent. The Social Services program was block granted in 1982 and is currently funded at 73 percent less than its original level.
- Looking forward, House of Representative Budget Committee Chairman Tom Price, President-elect Trump's nominee to lead the Department of Health and Human Services (HHS), which is responsible for administering the Medicaid program, proposed a budget for 2016 that would have block granted and cut federal spending on Medicaid and CHIP by \$913 billion over the next decade. If enacted, federal Medicaid and CHIP spending in 2025 would be \$161 billion — or nearly 34 percent — less than what states would receive under current law.

### **State flexibility under Block Grants and Per Capita Caps will effectively result in states reducing eligibility or the types of services and treatment provided, rather than making improvements.**

- States already have significant flexibility to design their Medicaid programs within broad federal guidelines. As a result, each state sets its own rules about who gets coverage, benefits offered, how much they must pay and more. This flexibility allows states to streamline health care delivery and improve health to meet local needs.
- By severely curtailing Medicaid funds for an already lean program, state flexibility would be limited to cutting off coverage for children, pregnant women, people with disabilities, or low-income seniors, imposing enrollment freezes (disproportionately harming newborns), putting those in need on waiting lists, eliminating medical or mental health benefits including treatment for opioid abuse, further slashing payment rates to providers, raising taxes, or most likely some combination of the above.

## Changes to Medicaid's structure would also significantly impact other systems serving children, particularly the most vulnerable.

While Medicaid is lodged in state and local health care systems, its benefits reach children in a range of child-serving systems, assisting those systems to better meet children's needs.

- **Early Childhood Systems.** Quality health coverage and care are essential for healthy brain development in children's early years, the years of greatest brain development. Child care teachers can help children learn and develop, but cannot provide them basic health and mental health coverage. Early coverage also helps identify problems in the early years, before they become more complicated and expensive to treat.
- **Education Systems.** Since child health impacts educational attainment, any structural changes to Medicaid would compromise returns on other major investments in children from Early Head Start to college. Medicaid helps ensure our nation's most disadvantaged children are not only healthy and in school learning, but reimburses schools for services delivered to children enrolled in Medicaid. This is particularly important for children with disabilities, who are eligible for special services, as well as for students who get critical health services at school, such as vision and hearing screenings and immunizations. Research shows services provided by school-based health centers can significantly improve key educational outcomes among students.
- **Child Welfare Systems.** Medicaid for both children and parents can help address needs that can otherwise result in children entering the child welfare system. Medicaid helps children in foster care including those in residential treatment programs, children who move from foster care to guardianship and those with special needs adopted from foster care. It also provides case management and other services and treatment that children in foster care need that can prolong their stays in foster care if not provided.
- **Juvenile Justice Systems.** While Medicaid cannot be used for care when youth are detained, it is an essential support as they transition out of the detention system and return to their family and community. Youth who have been involved in the juvenile justice system often have significant health and/or mental health needs, in part because they may not have received regular or continuous medical care.

For more than fifty years, the guarantee of Medicaid has been a lifeline for tens of millions of children and others of all ages, including millions of vulnerable children. Medicaid is an essential part of our health care system and it works. The structure of Medicaid and its protections must be maintained to ensure all eligible children have access to the health coverage they need to survive, thrive and drive the economy of tomorrow.