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Fact Sheet

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MEDICAID FINANCING: DANGERS OF BLOCK GRANTS AND PER CAPITA CAPS

LESSONS FROM TANF AND CCDBG

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. Medicaid provides health insurance for more than one in five Americans, including 80 percent of children living in poverty; 44 percent of children with special health care needs; 43 percent of nonelderly adults with disabilities; and more than 60 percent of nursing home residents.[1] Medicaid covers about one-third of the non-elderly Black and Hispanic populations and 17 percent of the white population.[2] People of color are more likely to be insured by Medicaid because of systemic racism and economic oppression that has denied them access to quality jobs, including those that provide health insurance.[3]

Medicaid is overwhelmingly popular among voters. More than 80 percent of people want to increase or maintain Medicaid spending.[4] But despite the program's popularity, Republicans are again threatening to make dangerous changes to Medicaid, some of which would impact its funding structure. Under current law, Medicaid is funded through a shared state-federal funding arrangement. The federal government pays states a percentage of Medicaid costs, called the Federal Medical Assistance Percentage (FMAP). The federal government's contribution varies based on per capita income and other criteria. Republicans want to limit how much federal money flows to states to help pay for Medicaid coverage for every eligible person through per capita caps or block grants.

Capping state funding would place severe fiscal pressures on states, threaten patient access to care, and increase racial disparities. Other federal 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) block grant—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 had difficulty providing adequate child care assistance to eligible families due to the lack of public investment.[5] Per capita caps would also undermine the core guarantee of comprehensive medical insurance.

Using these financing models for Medicaid would be catastrophic for the people Medicaid serves.

WHAT ARE BLOCK GRANTS AND PER CAPITA CAPS?

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 and generally guarantees coverage to everyone who meets the eligibility criteria[6]. 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. We know from other programs that a block grant funding structure simply isn't adequate to provide services to everyone who is eligible.

Under a per capita cap option, states would receive a set amount of federal Medicaid dollars *per enrollee* for the population included in the waiver. In this scenario states would receive limited federal dollars for Medicaid, putting several aspects of the program at risk. No other large program uses per capita caps. Implementing an untested financing structure in a program the size of Medicaid puts people's health care in danger.

TANF, currently the largest block grant program at $16.5 billion a year, is designed to help families with low incomes 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 almost three decades since provide 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 for parents transitioning from cash assistance. Because Congress expected women with low incomes 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 families receiving TANF and other working families with low incomes by using limited TANF and CCDBG dollars.[7] CCDBG has never served more than a small share of eligible children. In 2020, CCDF subsidies reached only 14 percent, or 1,430,000 children, of all potentially eligible children based on state income eligibility.[8]

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, states are at significant risk of not receiving 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 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 nearly 30 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 half since its creation. States that have experienced growth in the number of children living in families with incomes under the poverty level are forced to spread fewer dollars across a larger number of children. Seventeen states receive less than half as much per child living in poverty as they did when TANF was created and four receive less than 40 percent of what they did.[9] States have responded by both cutting benefits and serving fewer families in need.

While funding for CCDBG grew in the early years after lawmakers created it (as part of the same law that created TANF), it later remained flat and then experienced minimal increases in baseline funding until 2018. That year, CCDBG received a $2.4 billion increase[10] in federal appropriations to support state implementation of enhanced quality, safety, health, and accessibility requirements included in the 2014 CCDBG Act reauthorization. This was the largest increase in funding in the program's history. Although the 2018 CCDBG increase, and some increases until fiscal year (FY) 2025, began to make progress in the right direction, the number of eligible children receiving CCDBG assistance has never matched levels of 2006, the year with the largest number of children served through CCDF. Compared to that year, which served 1,770,100 children, 1,434,900 children received CCDF-funded assistance in FY2022—a 19 percent decrease, with 335,200 fewer children served.

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. Medicaid is the largest source of federal funding for states.[11] 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.[12]

2. MEDICAID WILL NO LONGER RESPOND AUTOMATICALLY TO ECONOMIC DOWNTURNS OR HEALTH CRISES

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 or crises like the COVID-19 pandemic, 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.

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.

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 can fluctuate as enrollment and costs increase, expenditures also increased. This increase happened because the long-standing successful funding formula allows for fluctuations in enrollment and health costs 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.

During the Great Recession, Congress provided additional Medicaid dollars to states through a higher federal match (also known as the Federal Medicaid Assistance Percentage or FMAP). The FMAP boost provided over $100 billion to states to offset increased Medicaid costs, and state spending on Medicaid *declined* during fiscal years 2009 and 2010 due to the increased FMAP.[13]

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 Georgia, Indiana, and Rhode Island, TANF caseloads actually decreased during the recession.[14] TANF responded modestly during the early months of COVID-19 pandemic, with half the states experiencing caseload increases of at least 5 percent from February 2020 to June 2020. By late 2020, TANF caseloads had resumed their steady downward trajectory.[15] States that had the biggest increases in their TANF caseloads were those that suspended work requirements due to the pandemic and did not count pandemic unemployment benefits as income.[16]

Medicaid was a key component of the nation's response to the COVID-19 pandemic. In expansion states, Medicaid provided health insurance for people who lost their jobs. Increased federal dollars to states for Medicaid helped shore up the health care sector and state budgets during a time of great uncertainty and challenges. Medicaid was able to be responsive to a national health emergency because of its current financing structure, and its response would have been much weaker if the program was a block grant or per capita cap at the time.

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. They would be forced to raise revenues or drastically cut eligibility, benefits, and provider payments. 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. It's unclear if a new block grant for Medicaid would retain the coverage requirements currently in place.

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–and increase health

disparities for people of color. One study found that a bump in Medicaid reimbursements increased the likelihood of a Medicaid patient being able to access a primary care appointment.[17]

The inflexibility of the block grant funding structure has prevented CCDBG payments from keeping pace with inflation and rising child care costs. This impacts the ability for states to continue to pay for child care without compromising the number of children able to be reached with limited resources. Sometimes, this leads to states having to lower the amount they can pay for a child's care to a provider, or the reimbursement rate. This reduction in payment rates has left providers weighing the costs and benefits of accepting families using CCDBG subsidies. Many factors, including the costs of maintaining CCDBG provider requirements and the deficit between subsidies and actual provider costs, has translated to fewer providers accepting CCDBG payments[18] and fewer families accessing child care. Compared to 2006, there were 475,394 fewer child care providers accepting CCDBG subsidies in 2022— a 68 percent decline.[19]

A decrease in assistance is exactly what happened with TANF. The value of cash assistance awarded to families has substantially decreased since TANF replaced AFDC. Ten states had the same nominal maximum benefit in 2023 as in 1996, meaning that the value of these benefits fell by 46 percent taking inflation into account–and four had grants that were lower in 2023 than in 1996. Only 11 states had provided inflation-adjusted grant increases. Every state's TANF benefit level for a family of three with no other income was at or below 60 percent of the federal poverty line as of July 2023.[20] Another consequence of not adjusting TANF for inflation is that states must cover the full cost of any increases in benefits, including during an economic downturn.

CCDBG also demonstrates that block grants lead to reduced benefits and payments. While the reauthorization of CCDBG in 2014 established additional rules for the program, states retain flexibility to set many key policies.[21] Restrictive eligibility policies are one way of controlling costs in a capped program. As of 2023, state-determined income eligibility for CCDBG was lower as a percent of poverty in nine states, and 11 states required higher parent co-payments as a percentage of household income when compared to 2001.[22] A 2024 CCDF final rule requires states to cap co-payment amounts to families at 7 percent of a family's income. While this will reduce out-of-pocket costs for many families, states can still decide whether to allow child care providers to charge parents more than the co-payment if the co-payment plus the subsidy reimbursement do not cover the cost of care—and a number of states do allow this. However, the agency encourages state lead agencies to set the reimbursement rates high enough so that providers do not need to do this even in states that allow it.[23] Payment rates to child care providers have been most affected by stagnant funding. In 2001, 22 states set payment rates at the federally recommended level. By 2019, this was down to just four states.[24] The funding increases that were provided starting in 2018 have allowed more states to raise their rates, with 17 states meeting the federally recommended standard in 2023.[25] Low payment rates disproportionately impact Black and Hispanic providers who are overrepresented in the field compared to their general workforce participation.[26]

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 with low incomes, such as 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.

While the Centers for Medicare and Medicaid (CMS) guidance is limited to certain Medicaid populations, increasing state fiscal pressures for one group will inevitably cause harm to all Medicaid groups. When a state faces a funding shortfall for the waiver population, it will likely look to other Medicaid spending to reduce expenses and cover the shortfall. Other areas states could consider reducing or eliminating include non-essential benefits (e.g., prescription coverage) and provider payments across all Medicaid populations. They could also explore cutting eligibility for populations that they currently cover above the federal requirement. For example, many states cover pregnant women at income levels above the federal requirement. The same is true of children in many states. Within the block grant population, states could take steps to limit enrolment by adding red tape and bureaucracy.

CCDBG and TANF have no guarantee to serve all eligible children. The share of children who live in poverty and receive cash assistance has declined dramatically since TANF replaced AFDC. Today, a little less than one in five children living in poverty receives cash assistance, compared to 68 out of 100 in 1996 when TANF replaced AFDC.[27] [28]

5. THE SAFETY NET WILL BE INCONSISTENT ACROSS STATES, INCREASING RACIAL DISPARITIES

Medicaid programs are not identical across states now, but should Medicaid block grants become a reality, the difference in access to health care among states could become even greater. Current law requires Medicaid to cover certain minimum benefits as well as certain populations. As funding erodes and states continue to make choices about limiting eligibility or coverage, the differences in Medicaid coverage among states will be amplified.

One result of leaving decisions to states will be an increase in racial disparities. After the Supreme Court deemed Medicaid expansion to be a state choice, most states that delayed expansion, or have still not expanded, are in the South, which has high concentrations of people of color. As a result, nonelderly Black and Hispanic people are disproportionately likely to fall in the coverage gap.[29]

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 the creation of TANF. This has locked into place sharp disparities in how much states receive on a per-child basis for those children who live under the poverty level, based on historical choices that were often driven by a racist lack of concern about the well-being of Black children and fear that cash assistance would

allow Black mothers to reduce their paid domestic labor for white households.[30] These gaps have gotten even larger due to differences in population growth among states. In 1996, some states received as much as eight times more per child in a family with income under the poverty level than others; today, this gap has increased to 13 times more.[31] In 2023, Alabama, Arkansas, Nevada, and Texas received a block grant worth less than $215 per child in poverty for the year.[32] This means that even if today's policymakers in these states wanted to increase cash assistance benefits, they would have less ability to do so than states with larger per capita grants.

The combination of disparate state funding and high state flexibility has created vast inconsistencies in cash assistance programs across the country. For example, the share of children who live under the poverty level receiving cash assistance ranges from almost 50 percent in California to under 2 percent in Arkansas, Georgia, Kansas, Mississippi, and Texas.[33] States choose how much each family can get in monthly TANF cash assistance benefits and this also varies dramatically on a state-by-state basis. The amount a family of three receives in TANF monthly cash assistance benefits varied from $1,243 in New Hampshire to $204 in Arkansas in 2023.[34] Black children are disproportionately likely to live in states where TANF reaches few families and thus are less likely to have access to cash assistance when their families are in need.[35]

Similarly, state flexibility has created huge variation in states' child care subsidy programs and policies related to health, safety, quality, and access. Twenty-four states and the District of Columbia (D.C.) have reduced their average monthly number of children served by more than a quarter since 2006, including six states and D.C. that are now serving 50 percent (or more) fewer children. In a study of access to CCDBG, CLASP found great variation by state in the share of potentially eligible children served, ranging from 3 percent in Montana to 16 percent in Pennsylvania, based on federal eligibility limits. Based on the income limits states set, access ranged from 7 percent in D.C to 27 percent in Alabama. Access also varied across racial and ethnic groups, with eligible Asian, Hispanic, and multi-racial.[36]

PER CAPITA CAPS ARE NOT A VIABLE ALTERNATIVE

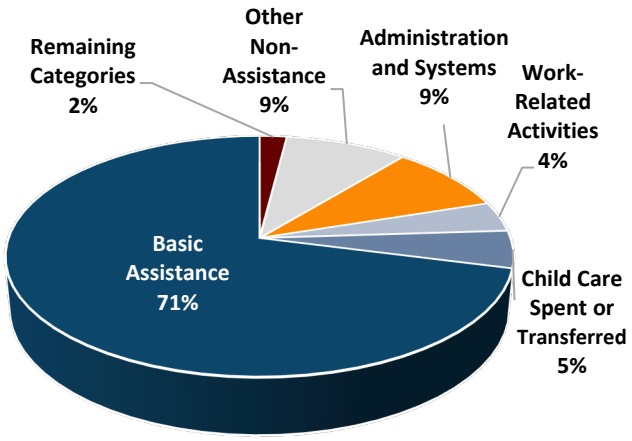
Previous Congressional debates and the recent CMS guidance have proposed Medicaid per capita caps as an alternative to a full aggregate cap. Both approaches are dangerous and raise all the concerns listed above.

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	Likely
States will be under pressure to cut benefits and reimbursements	X	X
States may cut eligibility, pitting vulnerable populations against each other	X	Likely
Communities of color will be disproportionately harmed	X	X
States' safety-net programs will vary widely	X	X

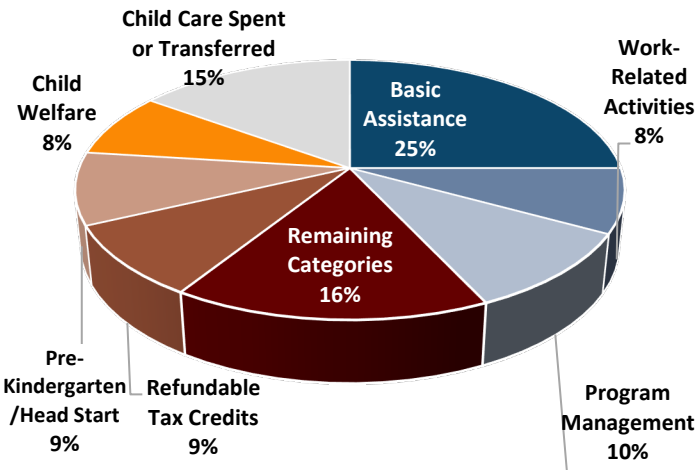
BLOCK GRANTS AND PER CAPITA CUTS DO NOT PROVIDE TRUE FLEXIBILITY

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 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.

FY 1997 TANF & MOE



FY 2023 TANF & MOE



Governor Josh Stein of North Carolina wrote to his Congressional delegation and said, "Proposals such as per capita caps or block grants would potentially reduce federal Medicaid funds in North Carolina by nearly $30 billion over the next decade, forcing North Carolina to cut benefits, limit eligibility, or reduce provider payments."[37]

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, including ones that have limited or no benefit to people with low incomes, such as college scholarships for middle-income students. TANF funds are also commonly used to pay for programs with real benefits to families with low incomes like child care subsidies and child welfare programs. While these are crucial supports for 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 that they can use to purchase necessities. In FY1997, 71 percent of TANF/MOE spending was dedicated to cash assistance for families. In FY 2023, under a quarter of TANF/MOE spending went to cash assistance for families.[38]

It is sometimes suggested that "flexibility" offered by capped funding would allow states to expand funding to address social determinants of health, such as housing or other anti-poverty efforts. The experiences of TANF and CCDBG serves as a cautionary tale and refutes this message. Given limited funding, states are highly unlikely to support such activities, and if they did, they would need to make cuts in other areas such as eligibility, benefits, or payments.

CONCLUSION

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. Cuts to Medicaid would disproportionately affect communities of color, especially Black people, for whom Medicaid significantly reduces the coverage gap left by private insurance. 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 nearly 60 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 changes to Medicaid should build on this current successful foundation rather than threatening states' financial stability and patients' health and well-being.

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