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PERFORMING UNDER PRESSURE: ANNUAL FINDINGS OF A 50-STATE SURVEY OF ELIGIBILITY, ENROLLMENT, RENEWAL, AND COST-SHARING POLICIES IN MEDICAID AND CHIP, 2011-2012

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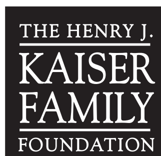
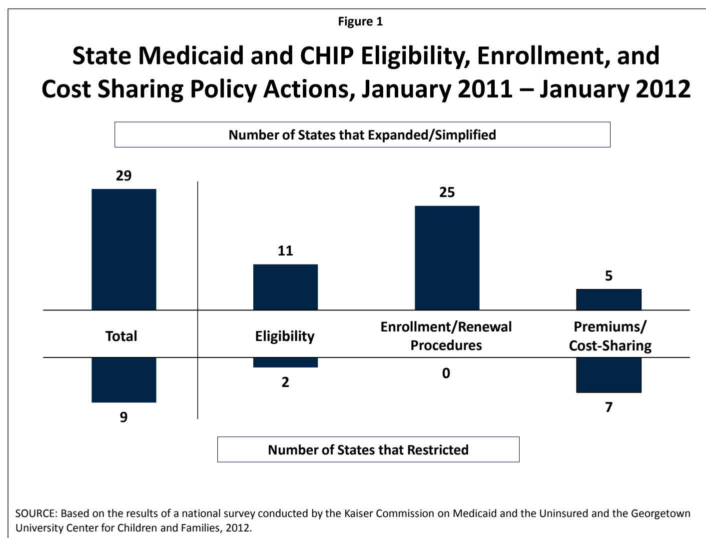


EXECUTIVE SUMMARY

In 2011, Medicaid and the Children's Health Insurance Program (CHIP) continued to be key sources of coverage for children, and, in some cases, for their parents, as the weak economic recovery was slow to add new jobs with access to employer-based insurance. At the same time, state budgets remained stressed due to dampened state revenue growth and the mid-year expiration of the temporary increase in the federal share of Medicaid provided through the American Recovery and Reinvestment Act of 2009 (ARRA).

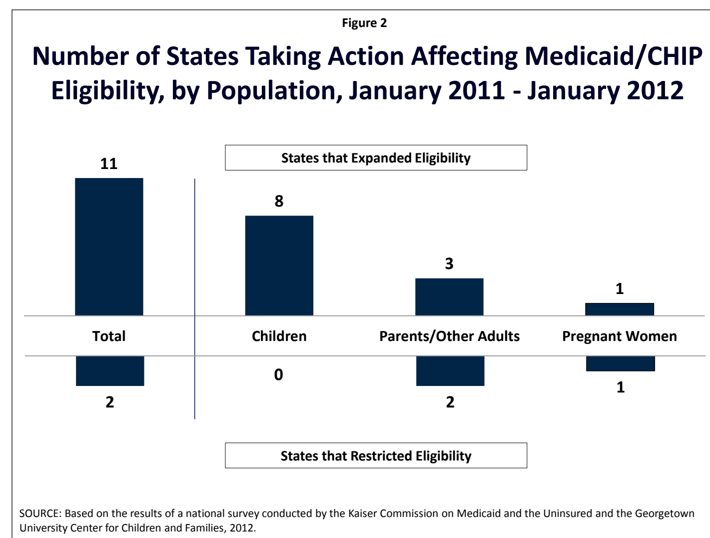
Amid state fiscal challenges, the requirement in the Affordable Care Act (ACA) that states maintain their eligibility levels and enrollment and renewal procedures was central in preserving coverage during 2011. In addition, some states made targeted eligibility expansions and many used technology to boost program efficiency and make it easier for families to enroll in coverage (Figure 1). Moreover, new enhanced federal funding spurred many states to launch major Medicaid systems improvements that will help states modernize their programs and prepare for the 2014 ACA coverage expansions.



In this eleventh annual report, the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families provide results from a 50-state survey of eligibility, enrollment, renewal, and cost-sharing policies in Medicaid and CHIP. The data identify changes implemented during 2011 and present policies in place for children, pregnant women, parents, and other non-disabled adults as of January 1, 2012.

Eligibility: States Maintained Coverage, and Some Moved Forward with Expansions

Reflecting the ACA requirement for states to maintain coverage, Medicaid and CHIP eligibility remained largely stable in 2011, while 11 states made targeted expansions (Figure 2). A number of the expansions utilized new options available through the ACA and the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) and some enabled the states to draw down federal matching funds for previously solely state-funded coverage. Two (2) states made eligibility cutbacks that were not subject to the ACA requirement. It is likely that without the requirement more states would have made reductions due to budget pressures.

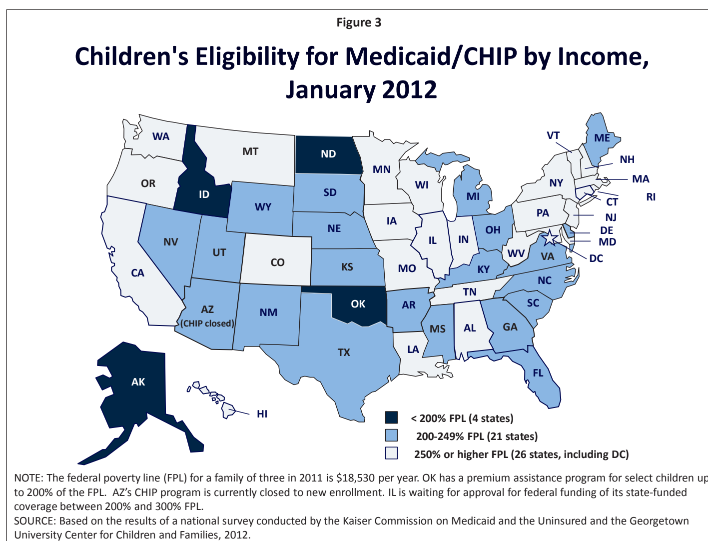


In keeping with the historic trend, most of the eligibility expansions (eight (8) of 11) focused on coverage for children. Specifically, West Virginia expanded CHIP eligibility for children from 250 to 300 percent of the federal poverty level (FPL). Moreover, Illinois, Texas, and Vermont took up the option provided by CHIPRA to cover lawfully-residing immigrant children without a five-year wait. Finally, five (5) states (AL, GA, KY, PA, and TX) took up the new ACA option to allow qualifying state employees to access affordable coverage for their children through CHIP.

Medicaid and CHIP remain key sources of coverage for low- and moderate-income children. As of January 1, 2012, half of the states (26, including DC) cover uninsured children in families with income at or above 250 percent of the FPL ($46,325 for a family of three in 2011) and 18 of these states cover uninsured children at or above 300 percent of the FPL ($55,590 for a family of three) (Figure 3). In addition, almost half of the states (24, including DC) cover lawfully-residing children in Medicaid or CHIP without a five-year waiting period, and nine (9) states make coverage available to children of state employees who are eligible for CHIP, in part, reflecting flexibility provided by the ACA to cover these children.

Figure 3

Children's Eligibility for Medicaid/CHIP by Income, January 2012

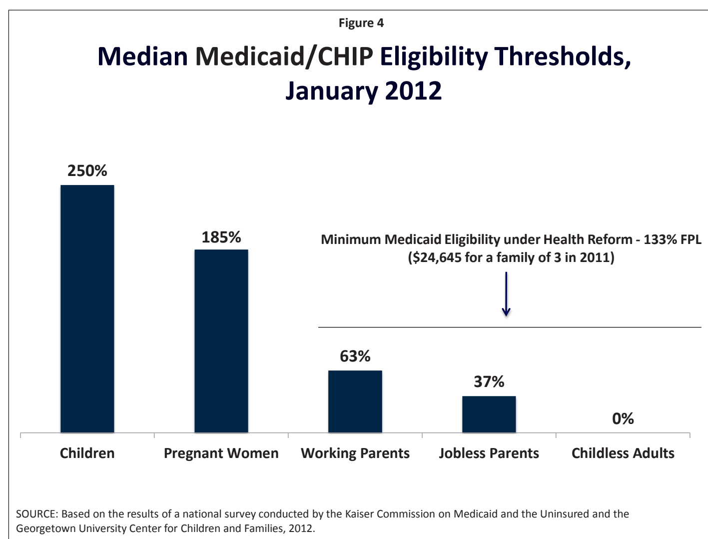


NOTE: The federal poverty line (FPL) for a family of three in 2011 is $18,530 per year. OK has a premium assistance program for select children up to 200% of the FPL. AZ's CHIP program is currently closed to new enrollment. IL is waiting for approval for federal funding of its state-funded coverage between 200% and 300% FPL.
SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2012.

Coverage for parents, while remaining constant in 2011, continues to lag far behind that of their children (Figure 4). There were no changes to Medicaid coverage for parents in 2011, and, as of January 1, 2012, only 18 states cover parents with full Medicaid benefits at or above the poverty level ($18,530 for a family of three in 2011), while 17 states limit full Medicaid coverage to parents earning less than half of the poverty level ($9,265 for a family of three in 2011). A total of 19 states have expanded parent eligibility for more limited coverage through waivers or state-funded coverage, but enrollment was closed in three (3) of these programs at some point during 2011.

Figure 4

Median Medicaid/CHIP Eligibility Thresholds, January 2012



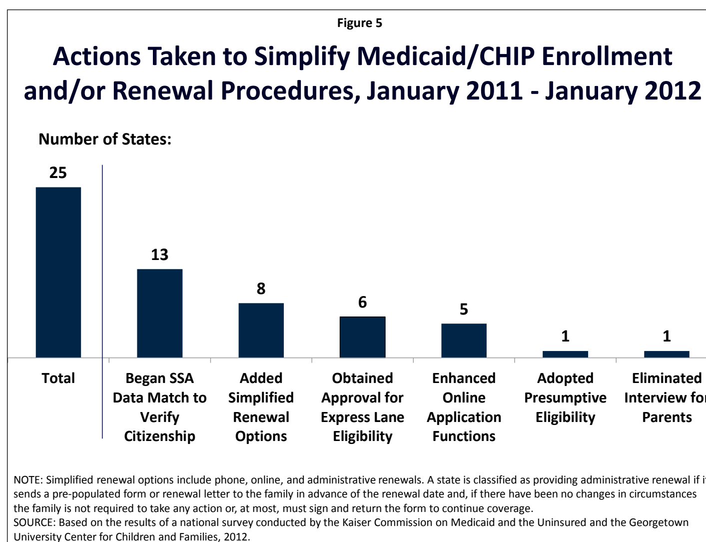
SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2012.

Three (3) states took steps to bolster Medicaid coverage for low-income adults in 2011, but these expansions were offset by reductions in two (2) states. New Jersey and Washington obtained Section 1115 waivers to draw down federal Medicaid matching funds to cover low-income adults who were previously covered by state-only funds. Minnesota also obtained federal matching funds for previously solely state-funded coverage of low-income adults through the new ACA early adult expansion option, in conjunction with a waiver. These actions helped the states preserve existing coverage by securing

federal financing and get an early start on the Medicaid expansion that will occur in 2014. However, two states made cutbacks in Medicaid waiver coverage that were exempt from the ACA requirement to maintain eligibility. Specifically, Arizona froze enrollment in its waiver coverage for adults without dependent children as part of its waiver renewal, and Nevada discontinued its limited coverage for some parents and pregnant women when its waiver expired in 2011. In addition, outside of Medicaid, Pennsylvania ended its state-funded program for low-income adults. Accordingly, coverage for low-income adults remains very limited as of January 1, 2012**.** Only eight (8) states (AZ, CT, DE, DC, HI, MN, NY, and VT) provide benefits to low-income adults that are equivalent to Medicaid. Eighteen (18) states provide more limited benefits to these adults, but five (5) of those programs were closed to new enrollment at some point during 2011.

Enrollment and Renewal: States are Using Technology to Achieve Efficiencies and Streamline Processes

Responding to budget pressures, half of the states (25) made strides in increasing the efficiency of their enrollment and renewal practices (Figure 5). These improvements have the dual benefit of reducing paperwork requirements for families and eligibility workers while streamlining program administration. Moreover, these actions assisted states in balancing the competing demands of increased caseloads and decreased staffing, while also helping them to prepare for the new eligibility changes that will take effect in 2014 under the ACA. The improvements also enabled seven (7) new states, for a total of 23 states, to earn between $1.3 and $28.3 million in CHIPRA performance bonuses, which reward states that are successful in enrolling eligible children in Medicaid.[1]



NOTE: Simplified renewal options include phone, online, and administrative renewals. A state is classified as providing administrative renewal if it sends a pre-populated form or renewal letter to the family in advance of the renewal date and, if there have been no changes in circumstances the family is not required to take any action or, at most, must sign and return the form to continue coverage.
SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2012.

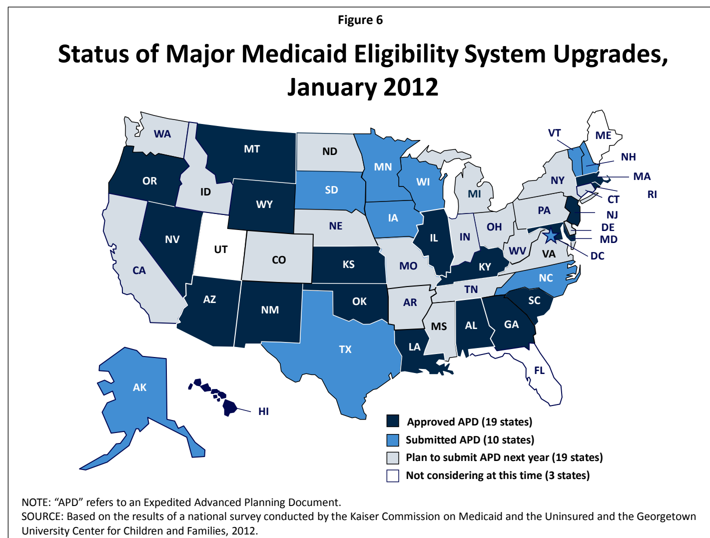
States increasingly used technology to modernize eligibility and enrollment processes, often adopting policy options provided by CHIPRA. During 2011, 13 states adopted the CHIPRA option to use an electronic data match with the Social Security Administration to more efficiently and accurately verify citizenship for children, bringing the total number of states using this option in Medicaid and/or CHIP to 44. Another CHIPRA option – Express Lane Eligibility (ELE) for children – was implemented or expanded in five (5) states in 2011, resulting in a total of 9 states taking up this option in Medicaid and/or CHIP as of January 2012. Also, under separate waiver authority, Massachusetts received approval to utilize ELE to renew coverage for parents. In addition, five (5) states enhanced their online application capabilities, for example, by enabling applications to be electronically submitted.

Many improvements focused on streamlining the renewal process to increase retention of eligible children and families. By concentrating on retention, states can reduce the inefficient administrative effort required to close and reopen cases, as well as eliminate gaps in coverage created when eligible individuals “churn” on and off of Medicaid and CHIP over short periods of time. Specifically, five (5) states implemented administrative renewals by sending out a form pre-populated with the family’s information and not requiring families to take any action beyond returning a signed copy of the form if circumstances have not changed. Also, eight (8) states added online or telephone renewal options.

Enhanced federal funding for technology investments spurred state action to upgrade their eligibility systems. Technology allows states to modernize their eligibility systems to achieve gains in efficiency and vastly streamline or automate enrollment processes. However, the high cost of these investments has long prevented many states from upgrading to new technology. Recognizing these opportunities and challenges, in April 2011, the Centers for Medicare and Medicaid Services (CMS) made enhanced federal funding available to states to upgrade or replace eligibility systems to help prepare for the ACA. Through 2015, states are able to secure a 90 percent federal match, as opposed to the typical 50 percent administrative matching rate, for the design and implementation of eligibility and enrollment systems. The enhanced federal funding has already made a difference in states' willingness to invest in technology. As of January 1, 2012, 19 states have received approval for their system upgrades, while an additional 10 have submitted plans to CMS (Figure 6).

Figure 6

Status of Major Medicaid Eligibility System Upgrades, January 2012



NOTE: "APD" refers to an Expedited Advanced Planning Document.
SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2012.

Cost-Sharing: Few States Changed Premium and Copayment Requirements for Families

Even with the flexibility to do so, the majority of states did not impose additional cost-sharing requirements on beneficiaries. Outside of routine annual rate adjustments, only one state increased premiums or enrollment fees during 2011, reflecting the fact that premiums can be a barrier to enrollment and are, therefore, subject to the ACA requirement that states maintain enrollment processes. While copayments are not subject to this same requirement, only six (6) states increased copayments while four (4) states reduced copayments.

Conclusion

Despite ongoing state fiscal pressures, the requirement that states hold steady on their eligibility levels and enrollment and renewal procedures maintained coverage for children and their families during 2011 and preserved the foundation that Medicaid and CHIP coverage will provide under the ACA. While strained state budgets have taken a toll on administrative resources, states have sharpened their use of technology and streamlined their procedures to create more efficient programs, while also simplifying the steps for families to enroll in and renew coverage. Moreover, the CHIPRA tools to streamline program administration, some new options provided in the ACA, and the significant new federal financial incentive for eligibility system upgrades have all served as key catalysts for continued state improvement and modernization of Medicaid and CHIP programs. These actions have not only helped states deal with current pressures, but also lay the groundwork for the coverage expansions and new enrollment requirements that will take effect in 2014.