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Eliminating Medicaid and CHIP Stability Provisions (MoE): What's at Stake for Children and Families

by Jocelyn Guyer and Martha Heberlein

The coverage of more than a third of Medicaid and CHIP beneficiaries is at risk if the stability protections are rescinded.

Introduction

Despite serious state budget problems, Medicaid and the Children's Health Insurance Program (CHIP) have been remarkably stable in offering coverage in recent years. As a result, they have been able to provide much-needed help to children and families struggling to gain solid footing after turbulent economic times; pregnant women enrolled in Medicaid to help ensure that they have a healthy birth; and seniors and people with disabilities in need of long-term care and other services. The stability in the programs can be directly attributed to the short-term fiscal relief provided to states in the American Recovery and Reinvestment Act (ARRA) and the federal requirements that states maintain their Medicaid and CHIP eligibility rules and enrollment procedures until broader health reform is implemented. Recently, a number of Governors have asked Congress to eliminate these stability protections (often referred to as "maintenance-of-effort requirements").

This issue brief describes the Medicaid and CHIP stability protections; identifies who is most at risk of losing coverage if the protections are weakened or eliminated; and discusses the policy implications.

Key Findings

- **The coverage of more than a third of Medicaid and CHIP beneficiaries is at risk if the stability protections are rescinded.** States could reduce coverage to mandatory federal minimum levels in Medicaid and scale back or even entirely eliminate their CHIP programs. Overall, an estimated 35 percent of all Medicaid and CHIP beneficiaries are covered at state option, including 14.1 million children, 8 million adults, 2.8 million low-income seniors, and 2.3 million people with disabilities (see Figure 1 on next page).

- **Even people who remain eligible for coverage will be vulnerable to cuts through "backdoor" strategies.** If the stability protections are rescinded, states can re-introduce red-tape barriers to coverage. While not as obvious as reducing eligibility levels, these "backdoor" strategies for depressing enrollment can be extremely effective at cutting coverage. In the last recession, close to half of all states used such strategies to make it more difficult for eligible uninsured children to enroll in coverage.

- **The nation's progress in covering children could unravel.** Through Medicaid and CHIP, the country has successfully driven the uninsured rate of children down to the lowest level on record. This progress could quickly unravel if states freeze enrollment in their CHIP programs or add new red-tape barriers to coverage. Children may also be indirectly at risk if their parents are cut from coverage, as there is strong evidence that children fare better when their family as a whole is insured. During the last recession, parents and other adults bore the brunt of the reductions in eligibility.

- **States have a range of alternative choices for tackling budget pressures.** Medicaid is not the major cause of state budget problems, but the growing number of people who are relying on the program until they can find a new job is adding to states' fiscal challenges. In this context, it is important to identify alternatives for addressing Medicaid budget pres-

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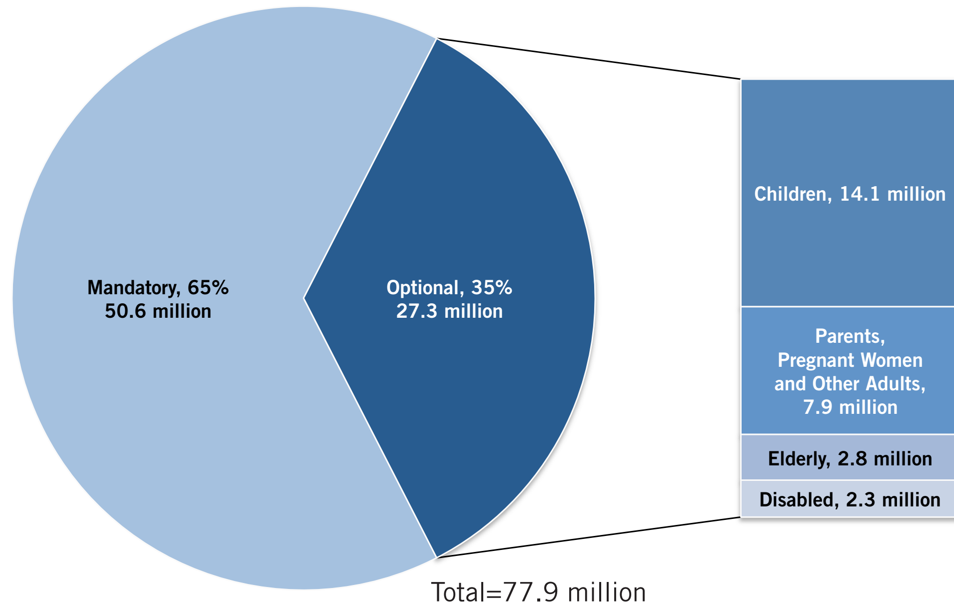
Figure 1
More than One-Third of Medicaid and CHIP Beneficiaries at Risk[1]



The Medicaid and CHIP stability protections were designed to prevent states from cutting people off coverage in response to their budget problems and in anticipation of health reform implementation in 2014.

sures that do not rely on simply slashing coverage for families, pregnant women, people with disabilities, and seniors in need of long-term care. These options can include looking outside of Medicaid (for example, by tapping rainy day funds or raising revenues); using the flexibility states retain within Medicaid to achieve savings without eliminating coverage; and turning to health care providers to help finance more of the share of state spending on Medicaid.

The Medicaid and CHIP Stability Protections

The Medicaid and CHIP stability protections were designed to prevent states from cutting people off coverage in response to their budget problems and in anticipation of health reform implementation in 2014. The stability protections that now apply to states were first put in place under the American Recovery and Reinvestment Act (ARRA) of 2009. In recognition of state budget problems and the importance of strong Medicaid programs during a recession, ARRA provided a time-limited infusion of additional federal Medicaid funding to states. It did so by temporarily increasing the share of Medicaid costs financed by the federal government (i.e., the "Federal Medical Assistance Percentage" or "FMAP"). As a condition of receiving the extra federal help from October 1, 2008 through December 31, 2010, states were required to maintain their Medicaid eligibility rules and enrollment procedures in effect as of July 2008. For example, they cannot eliminate eligibility for Medicaid beneficiaries covered at state option, lower the income threshold for Medicaid coverage, or adopt procedures that make it harder for eligible people to enroll in coverage (such as imposing a face-to-face interview requirement or requiring people to renew their coverage more frequently).[2] In August 2010, Congress extended the Medicaid fiscal relief and the accompanying stability protections through June 2011, although it scaled back the scope of the financial assistance to states.[3]

With the Affordable Care Act (ACA), Congress modified and extended the stability protections. The stability protections in the ACA are designed to ensure that states do not slash coverage before broader health reform goes into effect, as well as to sustain and strengthen the country's successful effort to cover children through Medicaid and the Children's Health Insurance Program (CHIP). The ACA stability protections prevent states from adopting more restrictive eligibility rules and enrollment procedures than were in effect on March 23, 2010. These protections are in effect for adults until January 1, 2014 when Medicaid expands to 133 percent of the federal poverty level (FPL) nationwide and the state-based exchanges become operational.[4] (The federal government will finance 100 percent of the cost of the expansion for the first few years, and will continue to cover at

least 90 percent of the cost in the long run.)[5] With respect to children, the stability protections apply to both Medicaid and CHIP and continue through September 30, 2019. One exception to the stability protections is that states covering adults above 133 percent of the federal poverty level can reduce eligibility for these adults prior to January 1, 2014, if they have a documented budget deficit.[6]

To date, the stability protections have worked as intended by helping to prevent states from cutting coverage during the economic downturn. Medicaid and CHIP have been remarkably stable throughout the economic downturn. This has allowed the programs to offer affordable coverage to millions of children and families who lost jobs and access to employer-based coverage. In addition, Medicaid has been able to continue to provide long-term care services and supports to seniors and people with disabilities. In 2010, for example, all but two states "held steady" in their coverage rules for children, parents, and other adults and more than a dozen adopted targeted improvements in coverage.[7] (The two states that made cuts were Arizona and New Jersey, and they selected policy changes that did not violate the stability protections.) This stability and improvement in child and family coverage can be directly attributed to the temporary Medicaid fiscal relief and the Medicaid and CHIP stability protections.

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Who Is At Risk?

On January 7, 2011, 33 Republican Governors (29 sitting Governors and four leaving office) called on Congress to take "immediate action" to eliminate the Medicaid and CHIP stability protections. Since then, Governor Brewer of Arizona has asked the Administration to waive the stability protections in her state so that she can eliminate coverage for 280,000 Medicaid beneficiaries (see Box 1). In light of these efforts to overturn or weaken the stability protections, it is important to assess whose coverage would be at risk if such a change were adopted.

Box 1. Arizona: Seeking to End Coverage for 280,000 People

Arizona is currently the only state with an active freeze in its CHIP program, KidsCare. Since it was put in place in December of 2009, the number of children on the program has declined from 40,000 to 26,000.[8] Because this provision was in place prior to the enactment of the ACA, which extended the stability protections to CHIP, Arizona was able to retain the enrollment freeze; however, the stability protections did prevent the state from making the unprecedented move to eliminate its CHIP program entirely.

While the state has already limited coverage options for children, it now seeks to go much further. Arizona operates its Medicaid program under a waiver, which expires at the end of September 2011. As the Secretary recently made clear,[9] the stability protections do not require a state to renew an expiring waiver, putting Arizona in a unique situation. To save $541 million dollars in FY 2012 (with an accompanying loss of more than $1 billion in federal matching funds), the state is considering eliminating Medicaid coverage for people currently covered through its waiver. The Governor is looking to cut off at least 250,000 childless adults and coverage for 30,000 parents. Coverage for some children, adults with serious mental illness, and the "medically needy" could also be at risk.[10]

Overview

Overall, one-third of Medicaid and CHIP beneficiaries are at risk of losing their coverage if the stability protections are rescinded; even more are vulnerable to "backdoor" cuts. Under Medicaid, the federal government establishes minimum standards for who

Figure 2

Children and Adults at Risk is Stability Protections Rescinded

Children		Nearly all states cover children up to at least 200% FPL through Medicaid or CHIP; 25 states cover them up to at least 250% FPL. They could cut or eliminate their CHIP programs and reduce any Medicaid coverage of children under age six to 133% FPL and for children ages six to 19 to 100% FPL.
Adults	Pregnant Women:	40 states cover pregnant women at least to 185% FPL. They could scale back coverage to 133% FPL.
	Parents:	38 states have some optional coverage for parents. 23 of these states cover parents at least to 100% FPL. States could scale back coverage to the income threshold they used to determine eligibility for cash assistance in July of 1996 (now known as TANF). In the median state this threshold is 28% FPL.
	Other Non-Disabled Adults:	For other non-elderly adults without disabilities, 19 states provide at least some coverage. States could entirely eliminate this coverage.

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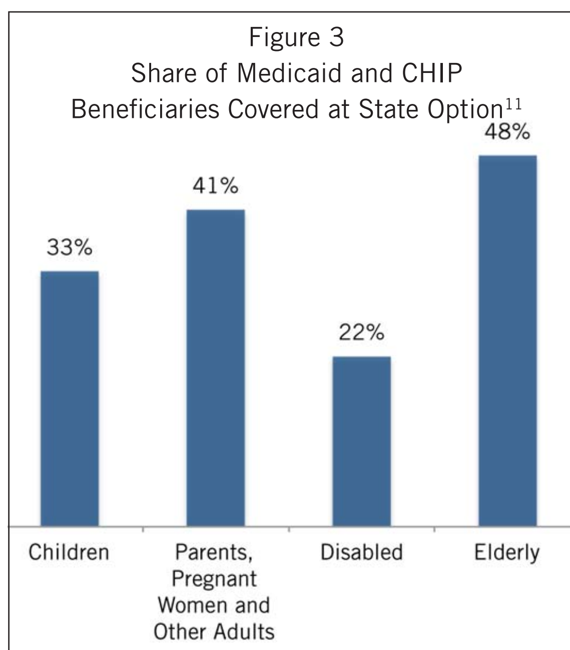
Children are the single largest group of beneficiaries at risk if the stability protections are rescinded.



must be covered ("mandatory" beneficiaries) as a condition of a state operating a Medicaid program. At their discretion, states can elect to cover additional people ("optional" beneficiaries) with the help of federal matching funds. If the stability provisions are rescinded, states could eliminate Medicaid for anyone who is covered at state option (see Figure 2). They also could cut back or even entirely eliminate their CHIP programs. Overall, an estimated 35 percent of Medicaid and CHIP beneficiaries are covered at state option (see Figure 1 on page 2).[12] Children are the single largest group of optional beneficiaries, with approximately 14.1 million covered either through optional Medicaid expansions or CHIP. In addition, 8 million parents, pregnant women, and adults are covered at state option, as are 2.8 million low-income seniors and 2.3 million people with disabilities. While far fewer seniors rely on Medicaid overall, they are more likely than children to be covered at state option (see Figure 3).

Along with cutting eligibility, states would be able to add new red-tape barriers to coverage, such as requiring families to renew coverage every three months or submit to a face-to-face interview. These "backdoor" strategies were commonly used by states in the last recession and can make the enrollment process so cumbersome that many of the people who remain eligible under federal law still are unable to enroll in coverage.

The potential implications of eliminating the stability protections for each of the key groups covered by Medicaid are described in more detail below, with a particular emphasis on the implications for children, pregnant women, and parents.[13]

Children

Children are the single largest group of beneficiaries at risk if the stability protections are rescinded.

For more than a decade, states have made significant advances in covering low- and moderate-income children through Medicaid and CHIP. As a result of these efforts, the number of uninsured children reached the lowest level on record in 2008 and 2009.[14] Due to these continuing improvements, half the states, including DC, now cover children with family income at or above 250 percent of the federal poverty level (FPL) ($45,775 for a family of three in 2010). (See Table 1 for state-specific information.) If the stability protections are rescinded, states could decrease eligibility to the mandatory federal minimums – 133 percent of the FPL ($24,352 for a family of three in 2010) for those under age six and 100 percent of the FPL ($18,310 for a family of three in 2010) for older children. States also could shut down new enrollment in their CHIP programs (i.e., establish an enrollment freeze), scale back CHIP eligibility, or completely eliminate their CHIP programs.

Overall, there are an estimated 14.1 million children covered at state option through Medicaid or CHIP, making them the single largest group of beneficiaries at risk if the stability protections are rescinded. Of these children, approximately 7.5 million are enrolled in Medicaid and 6.6 million are enrolled in CHIP.[15] Most of them are in low or moderate-income working families with parents whose jobs do not offer affordable, employer-based insurance for dependents.

States, as well as the public, have shown a strong interest in providing affordable coverage to children over the years. This is evident in the fact that notwithstanding difficult budgets in 2010, 19 states took steps to expand eligibility and make gains in streamlining procedures.[16] Nevertheless, some states may directly eliminate coverage of children if the stability protections are rescinded, despite the fact that they are relatively inexpensive to cover. For example, Arizona would have entirely eliminated its CHIP program in the spring of 2010 if the stability protections had not been in place. Moreover, a number of the states asking Congress to rescind the stability protections,

such as Alabama, Florida, Georgia, Idaho, Kansas, Louisiana, Mississippi, Pennsylvania, and Texas, do not provide any optional coverage to parents or other non-disabled adults. This leaves them with few options except to target significant numbers of children or to roll back coverage for seniors and people with disabilities in need of long-term care.

While many states may be reluctant to directly cancel coverage for children, a number of states are likely to consider imposing enrollment freezes in their CHIP programs. During the last recession, six states instituted such freezes. As a result, tens of thousands of eligible uninsured children were placed on waiting lists for coverage. For example, Florida instituted a freeze effective July 1, 2003, and as of mid-November of that year, more than 44,000 uninsured children who had been determined eligible for CHIP were on the waiting list.[17] The research on the effect of freezes shows that they have a chilling effect on enrollment for years, even after they are lifted.[18]

Adults who are covered at state option tend to be very low-income and have relatively serious health conditions. In the past recession, they were especially vulnerable to cuts.

States could also adopt new red-tape barriers that would discourage the enrollment or renewal of children in coverage. The strategy of erecting administrative barriers to coverage was used by many states during the last recession, and it had particularly serious consequences for children, as discussed in more detail below.[19] Children may also be indirectly at risk if their parents are cut from coverage, as there is strong evidence that children fare better when their family as a whole is insured.[20]

Pregnant Women

Forty-five states cover at least some pregnant women at state option, which leaves them at risk if the stability protections are rescinded.

Medicaid eligibility has been expanded in the last twenty years to improve access to prenatal care for low-income women. The expansions were adopted with the goal of tackling the United States' high infant mortality rate. Now, Medicaid is one of the largest payers of pregnancy-related services, financing 44 percent of all births in the United States.[21] (Estimates of the number of pregnant women covered at state option are not available. Pregnant women are included in the estimate in Figure 1 that 8 million non-disabled adults are covered at state option.)

Currently, forty states, including DC, cover pregnant women in families with income at or above 185 percent of the FPL ($33,874 for a family of three in 2010) through Medicaid or CHIP (See Table 2 for state-specific information). If the stability protections are removed, states could reduce eligibility to 133 percent of the FPL, the mandatory minimum allowed under federal law.[22] In the past, it was not common for state policymakers to directly eliminate coverage for pregnant women, but it did sometimes occur. During the last recession, for example, Texas reduced eligibility for pregnant women from 185 percent to 158 percent of the FPL. This change was in effect for over a year and resulted in a loss of coverage for about 8,100 pregnant women each month.[23]

Parents and Other Adults

Adults who are covered at state option tend to be very low-income and have relatively serious health conditions. In the past recession, they were especially vulnerable to cuts.

While states have made significant progress in expanding and improving coverage for children and pregnant women, coverage for parents and other adults lags far behind. As of January 1, 2011, 33 states still do not offer Medicaid coverage to parents up to 100 percent of the FPL ($18,310 for a family of three in 2010); in fact, the median eligibility level is only 37 percent of the FPL ($6,775 for a family of three in 2010) for a parent who is unemployed and 64 percent of the FPL ($11,718 for a family of three in 2010) for a working parent. Other non-disabled adults remain ineligible for Medicaid in the vast majority of states, regardless of their income level.

Nevertheless, 38 states have elected to provide some optional coverage to parents and 19 states have elected to do so for other adults without children, although many through very modest income eligibility expansions (See Table 3 for state-specific information). Overall, there are approximately eight million non-disabled adults, parents, and pregnant women covered in Medicaid at state option.[24] In many instances, this coverage is not as robust as the coverage provided to children. For example, it may cover fewer services or impose more onerous cost-sharing obligations. Still, it offers critical services to low-income people who otherwise would be entirely uninsured. Many of these adults face significant health problems – half of them have a diagnosed chronic condition, such as hypertension, and about one in five is living with a mental health condition, such as depression.[25] If left untreated, such conditions can have serious long-term health consequences and can adversely

affect a person's ability to work and care for family members.

If the stability protections are rescinded, states could reduce eligibility for adults to the minimum level allowed under federal law. For parents, this minimum level is tied to the eligibility level used by a state in 1996 in its cash assistance program (now known as TANF). In every state, this level is far below the poverty line; in some states, it is below 20 percent of the poverty line ($3,662 for a family of three in 2010). For adults without children, there currently is no federal minimum coverage level, which means states could simply eliminate all of their existing coverage of such adults.

Evidence from the last recession indicates that parents and other adults are highly vulnerable to cutbacks when states are facing budget problems.[26] In 2003, several states cut eligibility for parents, either through decreases in the income eligibility threshold or through a cap in enrollment. For example, Missouri rolled back eligibility from 100 percent to 77 percent of the FPL. This reduction, coupled with other changes, resulted in an estimated loss of coverage for between 32,000 and 42,700 parents. Other states, such as New Jersey and Washington, froze enrollment in their adult coverage programs.[27]

If the stability protections are rescinded, states can reinstitute red-tape barriers to enrollment as a "backdoor" strategy for discouraging eligible people from signing up for coverage.

Under the Affordable Care Act (ACA), Medicaid will expand to cover individuals up to 133 percent of the FPL, helping fill the gap in coverage for parents and providing millions of currently uninsured adults with a new coverage option. However, until the expansion is implemented, if states roll back their already extremely limited coverage, many low-income adults with serious health care conditions will be rendered uninsured.

Seniors and People with Disabilities

While the number of seniors and people with disabilities who rely on Medicaid is far below the number of children and non-disabled adults, it plays a particularly critical role in their lives as they often rely on Medicaid for life-sustaining access to long-term care services.

States are required to provide Medicaid coverage to most people with disabilities and the elderly receiving assistance through Supplemental Security Income (SSI).[28] In 2010, the SSI eligibility level was $8,088 (or approximately 75 percent of the FPL)[29], however, states have the option to cover this population up to 100 percent of the FPL ($10,830 for an individual in 2010). As of 2009, more than half the states (27 states) had eligibility levels for the elderly and people with disabilities set above the SSI income level.[30]

States can also provide optional coverage to nursing home residents up to 300 percent of the SSI level (or $24,264 for an individual in 2010), as well as the medically needy (those who have medical expenses that "spend down" to a state's medically needy eligibility level). As of 2009, 34 states offer the medically needy option and 38 states provide coverage to nursing home residents up to 300 percent of the SSI level.[31] In addition, states have the option of developing home- and community-based services as an alternative to institutional care through a waiver. As of 2006, there were 269 waivers in 49 states, including DC.[32]

Medicaid currently provides coverage for more than 10 million people with disabilities, serving those with conditions such as multiple sclerosis, severe mental illness, and traumatic brain injury. Medicaid also covers almost six million of the nation's seniors, many of whom have chronic conditions, such as dementia, Parkinson's disease, cancer, and heart disease. More than five million of these vulnerable citizens are covered at state option (2.8 million seniors and 2.3 million people with disabilities).[33] They rely on Medicaid for the support services and equipment they need, both within long-term care facilities, as well as in the community.

If the stability protections are revoked, states could roll back coverage for those in long-term care facilities, those receiving home- and community-based services, those who "spend down" to be eligible for coverage, as well as any of the elderly and those with disabilities who have incomes above 75 percent of the FPL. During the last recession, Oregon and Oklahoma ended their medically needy programs, Florida reduced its Medicaid income eligibility levels for the elderly and disabled, and other states made changes to how they determined eligibility that dampered enrollment (for example, the amount of assets a spouse can retain). [34]

All Beneficiaries Through "Backdoor" Cuts

If the stability protections are rescinded, states can reinstitute red-tape barriers to enrollment as a "back-

door" strategy for discouraging eligible people from signing up for coverage. In the last recession, close to half of states adopted such a strategy to make it harder for eligible, uninsured children to enroll in coverage.

The decisions states make about their eligibility and renewal procedures can have a dramatic effect on the extent to which eligible people secure coverage. Over the past decade, states have made significant progress, particularly with respect to children, in adopting streamlined application and renewal procedures. These simplifications have contributed significantly to the country's remarkable success in covering children. If, however, the stability protections are lifted and a state were seeking to discourage enrollment in Medicaid and CHIP, it would have a range of strategies at its disposal to do so. For example, instead of allowing families to apply for coverage via mail or on-line, a state could decide to require families to visit an agency office; to produce multiple pay stubs to establish their recent income; and to renew coverage every three months. While the effects of such actions may not be as immediately obvious as scaling back eligibility, they can sharply depress enrollment. In contrast to eligibility cutbacks, such changes affect everyone who might rely on Medicaid, including the very lowest-income people in need of coverage.

While many states face daunting fiscal challenges, they have a range of options for responding that does not entail cutting off coverage for children and families, pregnant women, people with disabilities, and seniors in need of long-term care.

During the last recession, the stability protections that accompanied fiscal relief did not preclude states from imposing new barriers to enrollment and renewal procedures. Between April 2003 and June 2004, almost half of the states (23 states) made it more difficult for eligible children and families to secure and maintain coverage (see Box 2).[35]

On top of additional red-tape barriers to enrollment and renewal, states may also look to significantly increase or add substantial premiums or other cost sharing requirements. While some families enrolled in Medicaid and CHIP are able to pay premiums, others, especially those at lower-income levels or with extensive health care needs, may find that such fees make it difficult for them to access needed care. For example, during the last recession, Oregon increased premiums for low-income parents and adults. The state also established a new lock-out period for non-payment of premiums and eliminated exemptions for extenuating circumstances such as lack of income or homelessness. Following these changes enrollment dropped by 50,000 people.[36]

Box 2. Examples of "Backdoor" Cuts Used by States in the Last Recession

If the stability protections are rescinded, states could impose new red-tape barriers to enrollment that cause eligible people to miss out on coverage. In the last recession, close to half of the states (23 states) made it more difficult for eligible children and families to secure and maintain coverage, including:

Washington eliminated 12-month continuous eligibility for children and, instead, required parents to renew their children's coverage twice year. In the two years that followed, more than 30,000 children lost coverage. In January 2005, the program returned to 12-month continuous eligibility, which then allowed 30,000 children to gain coverage by the end of that same year.[37]

Texas also dropped 12-month continuous eligibility and began requiring families to renew coverage twice a year. In combination with other changes it made to discourage enrollment and increase premiums, the number of children with coverage dropped by 215,000 (42 percent) before the 12-month renewal period was reinstated in September 2007.[38]

Wisconsin added new paperwork-intensive income and insurance verification requirements to its Medicaid expansion program. In the first four months following implementation, enrollment declined by nearly 13,000 or 11 percent.[39]

Policy Alternatives

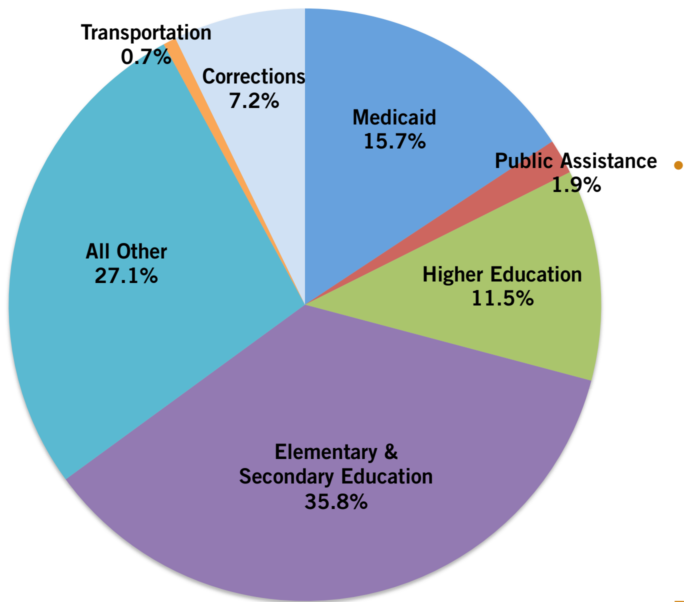
While many states face daunting fiscal challenges, they have a range of options for responding that does not entail cutting off coverage for children and families, pregnant women, people with disabilities, and seniors in need of long-term care.

Medicaid is not the major cause of state budget problems, but the growing number of people who are relying on the program to cover their children (and, in some instances themselves) until they can find a new job is adding to states' already daunting fiscal challenges (see Box 3 on the next page for a discussion of the share of state spending attributable to Medicaid). States are facing continued budget shortfalls due to depressed revenues that still remain below 2008 levels, the end of time-limited federal fiscal relief on July 1, 2011, and continued growth in demand for services in a broad array of areas. In this context, it is important to identify strategies to address budget pressures that are alternatives to simply cutting off coverage for children and families, pregnant women, people with disabilities, and seniors in need of long-term care. While the right alternatives for any given state will depend on the severity of its budget situation, its political environment, and the policies that it already has adopted, there is a wide range of strategies potentially available.

Box 3. Medicaid in State Budgets

While significant, Medicaid's role in state budgets is far more modest than is often reported, constituting only 15.7 percent of state general fund spending in 2009. In fact, as shown below, states spent nearly twice as much of their own money on elementary and secondary education (35.8 percent) as on Medicaid. When federal Medicaid matching funds are included, however, the share of spending shifts, with total spending (state and federal) in Medicaid accounting for 21.1 percent of total state spending, which is just slightly less than total spending on elementary and secondary education (21.7 percent).[40]

Figure 4
Medicaid as a Share of State
General Fund Expenditures, 2009[41]



- Considering options outside of Medicaid to address budget shortfalls. States can consider a balanced approach that combines spending reductions with strategies for increasing revenues or tapping reserve funds. For example, eight states have sizable "rainy day" funds that could be used to significantly ease their budget challenge.[42] During 2008 and 2009, 33 states raised revenues either through implementation of new fees or taxes or by expanding their current tax base (e.g., expanding the sales tax to include digital downloads). These changes brought in approximately $30 billion in increased revenues.[43]

- Using the broad flexibility already available to states to better manage Medicaid. The stability protections prevent states from cutting people off coverage, but states continue to have significant flexibility to design and better manage their Medicaid programs. The Department of Health and Human Services (HHS) recently sent a letter to governors that outlined several areas where states can adopt innovations aimed at generating short-term savings.[44] These include more efficiently managing the care of high-cost enrollees and more aggressively tackling the rising cost of prescription drugs in Medicaid. In acknowledgement of the severity of state budget problems, HHS indicates in the letter that it will support and approve on a fast-track basis promising Medicaid cost-saving initiatives. New federal resources and tools are also available to assist states in their efforts, such as federal funding to help states establish health homes for people with chronic conditions, as well as to develop new models of providing care to people enrolled in both Medicare and Medicaid.

- Turning to health care providers for contributions. States also can look to health care providers to help finance the state share of Medicaid costs, as they have an enormous financial stake in the stability of Medicaid and CHIP. Currently, 29 states require hospitals to pay fees to help support the Medicaid program, 37 require nursing homes to do so, and 12 require managed care companies to contribute.[45] In 2011, a number of states, including Arizona, Colorado, Oklahoma, Tennessee, and North Carolina, already are considering this option.[46]

Policy Implications

If the stability protections are rescinded, the implications will be significant for the families that rely on Medicaid and CHIP, for the country's successful efforts to cover children, and for the nation's economy.

If the stability protections are rescinded, the implications will be significant for the families that rely on Medicaid and CHIP, for the country's successful efforts to cover children, and for the nation's economy.

- Loss of coverage. If the stability protections are rescinded, states can cancel coverage for children and families struggling to gain solid footing after turbulent economic times; for low and moderate-income pregnant women enrolled in Medicaid to help ensure that they have a healthy birth; and for seniors and people with disabilities in need of long-term care services. The extent to which each state might cut coverage if the stability protections are weakened is unknown, but states' actions during the last recession suggest that some states will indeed use the flexibility to

directly eliminate coverage for hundreds of thousands of low-income parents and other adults in need of coverage. Most states may not directly cancel coverage for children and pregnant women already enrolled in Medicaid or CHIP, but many may stop taking new enrollees in CHIP or use "backdoor" strategies to depress enrollment. The loss of coverage not only harms people, it can also drive up uncompensated care costs and result in pressure on private health insurance premiums.[47]

- Unraveling the country's success in insuring children. Through Medicaid and CHIP, the country has driven the uninsured rate of children down to the lowest level on record. If the stability protections are rescinded, these major gains could unravel. In the short-run, some states are likely to freeze enrollment in their CHIP programs and many are likely to re-impose red-tape barriers to coverage as a means of depressing enrollment. In the long run, states that weaken or dismantle their CHIP programs now may find it difficult to reconstruct them in the future as they move forward with health reform in 2014 and beyond. Children may also be indirectly at risk if their parents are cut from coverage, as there is strong evidence that children fare better when their family as a whole is insured. During the last recession, parents and other adults bore the brunt of the reductions in eligibility.
- Weakening of the economic recovery. With the pace of job creation still sluggish, it also is important to consider the effect on the economy if states are allowed to cut people off Medicaid and CHIP coverage. Cuts to Medicaid and CHIP can translate into significant cuts in state business activity and jobs, particularly in the health sector. Additionally, the economic effect of cutting Medicaid is greater than cutting most other parts of a state budget because a reduction in state funding for Medicaid or CHIP also results in a state losing considerable federal funding, leaving it with far fewer resources to provide ongoing care.

States continue to have broad flexibility in the design and execution of their Medicaid and CHIP programs, despite the fact that the stability protections place limits on where reductions can occur.

Conclusion

States continue to have broad flexibility in the design and execution of their Medicaid and CHIP programs, despite the fact that the stability protections place limits on where reductions can occur. If the stability protections included in the Affordable Care Act are rescinded, it could have a dramatic impact on many of the low- and moderate-income children, families, seniors, and people with disabilities that rely on Medicaid and CHIP. It also could unleash cuts in health care spending that weaken the pace of economic recovery and job growth. Given that 50 million people already are without coverage and the economic recovery remains tenuous, the focus should be on strengthening these public programs and continuing to find more efficient, cost-effective ways to manage them. It is not the time to be adding to the ranks of the uninsured, especially when better alternatives exist.

Endnotes

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The Center for Children and Families (CCF) is an independent, nonpartisan policy and research center whose mission is to expand and improve health coverage for America's children and families. CCF is based at Georgetown University's Health Policy Institute.

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1. Georgetown Center for Children and Families estimates based on Congressional Budget Office "CBO's August 2010 Baseline" (August 25, 2010); Kaiser Commission on Medicaid and the Uninsured, "Medicaid: An Overview of Spending on "Mandatory" vs. "Optional" Populations and Services" (June 2005); and M. Rosenbach, et al., "National Evaluation of the State Children's Health Insurance Program: A Decade of Expanding Coverage and Improving Access Final Report," Mathematica Policy Research, Inc. (September 2007). See methodology for details.
2. Letter from Cindy Mann, Director of Center for Medicaid and State Operations, Centers for Medicare and Medicaid Services, to State Medicaid Directors (SMD# 09-003) (June 17, 2009).
3. Originally available to states from December 2008 through December 2010, the temporary increase in the Medicaid matching rate was extended at a reduced level through June 30, 2011 by Public Law 111-226, signed by President Obama on August 10, 2010. Under the original ARRA provisions, states receive an extra 6.2 percentage points in the federal matching

rate for their Medicaid programs, plus an additional increase based on the state's unemployment rate. Under the extension, the size of the enhancement declines to 3.2 percentage points in January 2011 and 1.2 percentage points in April, again with an additional increase based on the state's unemployment rate. The same maintenance-of-effort requirements that applied to states under ARRA were continued by the extension. Center for Medicaid, CHIP, and Survey & Certification, Centers for Medicare and Medicaid Services, "CMCS Informational Bulletin: FMAP Extension Guidance" (August 18, 2010).

4. The Medicaid stability protections remain in place for adults until the new exchanges are fully operational, which must be accomplished by January 1, 2014.

5. While states will receive full federal financing for the "newly eligible," this matching rate is tied to those not eligible for coverage as of December 1, 2009. If states reduce eligibility, they will receive their current matching rate for those populations covered as of December 1, 2009, when the broader Medicaid expansion goes into effect in January 2014. There are exceptions for "leading states" (those covering parents and childless adults at least up to 100 percent of the FPL on the date of enactment). These states will receive a phased-in increase in their matching rate for childless adults. For details, see M. Heberlein, J. Guyer, & R. Rudowitz, "Financing New Medicaid Coverage Under Health Reform: The Role of the Federal Government and States," Kaiser Commission on Medicaid and the Uninsured (May 2010).

6. For more details, see Georgetown University Center for Children and Families & Center on Budget and Policy Priorities, "Holding the Line on Medicaid and CHIP: Key Questions and Answers About Health Reform's Maintenance-of-Effort Requirements" (March 26, 2010).

7. M. Heberlein, et al., "Holding Steady, Looking Ahead: Annual Findings of a 50-State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost Sharing Practices in Medicaid and CHIP, 2010-2011," Kaiser Commission on Medicaid and the Uninsured (January 11, 2011).

8. M. Reinhart, "Study: Arizona Nearly Alone in 2010 Health-Care Cuts," The Arizona Republic (January 12, 2011).

9. Letter to Governor Janice Brewer from Kathleen Sebelius, Secretary of Health and Human Services (February 15, 2011).

10. M. Reinhart, "State to Request Medicaid Waiver," The Arizona Republic (January 21, 2011).

11. op. cit. (1).

12. op. cit. (1).

13. For more details on implications for seniors and people with disabilities, see J. Solomon, "Repealing Health Reform's Maintenance-of-Effort Provision Could Cause Millions of Children, Parents, Seniors, and People with Disabilities to Lose Coverage," Center on Budget and Policy Priorities (February 10, 2011).

14. C. DeNavas-Walt, B. Proctor, & J. Smith, "Income, Poverty, and Health Insurance Coverage in the United States: 2009," U.S. Census Bureau (September 16, 2010).

15. The number of children enrolled as "optional" in Medicaid includes those children covered through a CHIP-financed Medicaid expansion; the number of "optional" CHIP children represents those covered in separate CHIP programs. op. cit. (1).

16. op. cit. (7).

17. D. Cohen Ross & L. Cox, "Out in the Cold: Enrollment Freezes in Six State Children's Health Insurance Programs Withhold Coverage from Eligible Children," Kaiser Commission on Medicaid and the Uninsured (December 2003).

18. P. Silberman, et al., "The North Carolina Health Choice Enrollment Freeze of 2001," Kaiser Commission on Medicaid and the Uninsured (January 2003).

19. Note that fiscal relief was also enacted during the last recession; however, the maintenance-of-effort requirement applied only to eligibility and did not go into effect until September 2, 2003. For details on the fiscal relief, see V. Wachino, M. O'Malley, & R. Rudowitz, "Financing Health Coverage: The Fiscal Relief Experience," Kaiser Commission on Medicaid and the Uninsured (November 2005).

20. S. Rosenbaum & R. Perez, "Parental Health Insurance Coverage as Child Health Policy: Evidence from the Literature," First Focus (June

25, 2007).

21. Georgetown Center for Children and Families calculations based on C. Marks, "2010 Maternal and Child Health Update: States Make Progress Towards Improving Systems of Care," National Governors Association (January 19, 2011).

22. The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) allowed states to draw down federal funding to cover lawfully-residing immigrant children and pregnant women without imposing a 5-year waiting period. As of January 2011, 21 states have adopted this option to cover children and 17 have adopted the option to cover pregnant women. A number of states had previously been providing this coverage with state-only dollars. While it is unclear whether states would eliminate this coverage now that they are securing federal funding, immigrant populations that are ineligible for a federal match (and not subject to the stability protections) may be at greater risk. In the last recession, a number of states eliminated coverage for immigrant populations and both Massachusetts and Washington have debated reductions to their state-funded coverage during the current economic downturn.

23. L. Ku & S. Nimalendran, "Losing Out: States Are Cutting 1.2 to 1.6 Million Low-Income People from Medicaid, SCHIP and Other State Health Insurance Programs," Center on Budget and Policy Priorities (December 22, 2003).

24. Note that the share of non-disabled adult beneficiaries covered at state option also includes childless adults, parents, and pregnant women covered under 1115 and family planning waivers. op. cit. (1).

25. K. Schwartz & A. Damico, "Expanding Medicaid Under Health Reform: A Look at Adults at or below 133% of Poverty," Kaiser Family Foundation (April 2010).

26. During the current economic downturn, New Jersey has stopped enrolling parents covered in a CHIP waiver, which was not subject to the stability protections.

27. op. cit. (23).

28. In 11 states, eligibility rules for the elderly and people with disabilities are slightly different than the SSI program. In these states, known as 209(b) states, the standards can be more restrictive than the federal standards as long as they are no more restrictive then the rules in place in 1972. Kaiser Commission on Medicaid and the Uninsured analysis of data collected by Medicare Rights Center, "Medicaid Financial Eligibility: Primary Pathways for the Elderly and People with Disabilities, 2009" (February 2010).

29. Social Security Administration, "Update 2010" (January 2010).

30. Two states, Connecticut and Ohio, are 209(b) states and have eligibility levels below SSI levels.

31. op. cit. (28).

32. T. Ng, C. Harrington, & M. O'Malley Watts, "Medicaid Home and Community-Based Service Programs: Data Update," from the Kaiser Commission on Medicaid and the Uninsured (November 24, 2009).

33. op. cit. (1).

34. op. cit. (23).

35. D. Cohen Ross & L. Cox, "Beneath the Surface: Barriers Threaten to Slow Progress on Expanding Health Coverage of Children and Families," Kaiser Commission on Medicaid and the Uninsured (October 2004).

36. S. Artiga & M. O'Malley, "Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experiences," Kaiser Commission on Medicaid and the Uninsured (May 2005).

37. Washington State Department of Social and Health Services, 2005, updated 2006.

38. A prior version of this report cited a lower figure of 149,000 (29 percent), reflecting the decline in enrollment from September 2003 to June 2004. A. Dunkelberg, "Texas Health Care 2008: What Has Happened and What Work Remains," Center for Public Policy Priorities (September 2008).

39. op. cit. (35).

40. National Association of State Budget Officers, "2009 State Expenditure Report" (December 2010).

41. ibid.

42. M. Leachman, E. Williams, & N. Johnson, "Governors are Proposing Further Deep Cuts in

Services, Likely Harming Their Economies: Less Harmful Alternatives Include Revenue Increases and Rainy-Day Funds," Center on Budget and Policy Priorities (Updated February 7, 2011).

43. N. Johnson, C. Collins, & A. Singham, "State Tax Changes in Response to the Recession," Center on Budget and Policy Priorities (March 8, 2010).

44. Letter from Kathleen Sebelius, Secretary of Health and Human Services (February 3, 2011).

45. V. Smith, et al., "Hoping for Economic Recovery, Preparing for Health Reform: A Look at Medicaid Spending, Coverage, and Policy Trends," Kaiser Commission on Medicaid and the Uninsured (September 2010).

46. For details see, L. Bonner, "Hospitals Offer Medicaid Deal," News Observer (February 8, 2011); M. Booth, "Hospitals, State Officials Agree to Provider Fee to Help Shore Up Medicaid in Colorado," Denver Post (February 4, 2011); A. Sher, "Hospitals Agree to Bail Out TennCare," Chattanooga Times Free Press (February 4, 2011); Editorial, "Lawmakers Should Keep Open Mind About Hospital Assessment Idea," Oklahoman (February 2, 2011); and K. Alltucker, "Arizona Hospital Group Wants to Assess $300 Million Bed Tax," Arizona Republic (January 28, 2011).

47. J. Hadley, et al., "Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs," Health Affairs, 27(5): w399-w415 (September 2008).

Methodology for Estimating the Number of Optional Beneficiaries in CHIP and Medicaid

To estimate the number of "optional" beneficiaries in CHIP and Medicaid, CCF began with data prepared by the Urban Institute for the Kaiser Commission on Medicaid and the Uninsured on the share of the Medicaid population that was "optional" in each of the major Medicaid eligibility groups in 2001. The analysis, "Medicaid: An Overview of Spending on "Mandatory" vs. "Optional" Populations and Services," was based on data reported by states to the Centers for Medicare and Medicaid Services through the Medicaid Statistical Information Services (MSIS). To address enrollment growth since 2001, we trended these data forward to reflect the Congressional Budget Office's (CBO) August 2010 baseline estimates of fiscal year 2010 Medicaid enrollment in each of the major eligibility groups.

For data on the number of children enrolled in CHIP, all of whom are considered "optional," we used CBO's August 2010 CHIP baseline. Since the Urban Institute's estimates of the "optional" share of children in Medicaid include those with CHIP-financed Medicaid, we adjusted the data to prevent a child with CHIP-financed Medicaid from being counted as both an optional Medicaid child and a CHIP child. Specifically, we discounted the CBO CHIP enrollment figure to reflect the share of CHIP children enrolled in CHIP-financed Medicaid coverage. For this purpose, we used administrative data provided by states to CMS to determine the share of CHIP children in CHIP-financed Medicaid in 2001 as reported in "National Evaluation of the State Children's Health Insurance Program: A Decade of Expanding Coverage and Improving Access Final Report."

It is important to highlight that the figures in the paper are estimates. It is likely that the share of "optional" beneficiaries has changed since the Urban Institute published its analysis in 2005. If anything, however, the figures in this paper reflect a low estimate of the number of optional beneficiaries. Since 2001, states are more likely to have adopted new optional expansions than to have contracted coverage. As a result, it is quite possible that the share of beneficiaries who are covered at state option has increased, especially as much of the expansion activity over the past decade has occurred for children through the CHIP program.

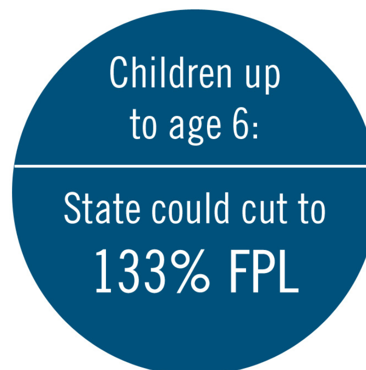
Note that the estimates in this report are based on the number of people ever-enrolled in Medicaid and CHIP over the course of a year and include people who are enrolled in Medicaid only for "partial benefits" (e.g., women who receive only family planning services and seniors and people with disabilities who receive assistance only with Medicare premium and cost-sharing charges).

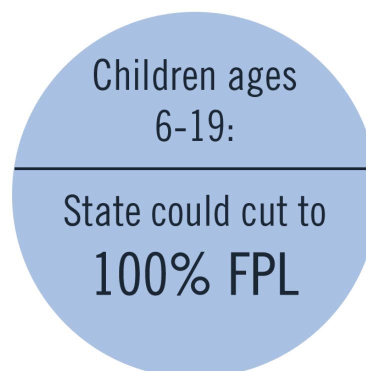
Table 1
Upper Income Eligibility Limit for Children's Coverage

January 2011

State	**Upper Income Limit (Percent of the 2010 FPL)**
Alabama	300%
Alaska	175%
Arizona	200% ***(closed)***
Arkansas	200%
California	250%
Colorado	250%
Connecticut	300%
Delaware	200%
District of Columbia	300%
Florida	200%
Georgia	235%
Hawaii	300%
Idaho	185%
Illinois	200%
Indiana	250%
Iowa	300%
Kansas	241%
Kentucky	200%
Louisiana	250%
Maine	200%
Maryland	300%
Massachusetts	300%
Michigan	200%
Minnesota	275%
Mississippi	200%
Missouri	300%
Montana	250%
Nebraska	200%
Nevada	200%
New Hampshire	300%
New Jersey	350%
New Mexico	235%
New York	400%
North Carolina	200%
North Dakota	160%
Ohio	200%
Oklahoma	185%
Oregon	300%
Pennsylvania	300%
Rhode Island	250%
South Carolina	200%
South Dakota	200%
Tennessee	250%
Texas	200%
Utah	200%
Vermont	300%
Virginia	200%
Washington	300%
West Virginia	250%
Wisconsin	300%
Wyoming	200%

If the stability protections are rescinded...





Source: Based on a national survey conducted by the Georgetown University Center for Children and Families and the Kaiser Commission on Medicaid and the Uninsured, 2011.

Note: Table represents highest income eligibility level for children, either through Medicaid or CHIP. State-funded coverage is not displayed.

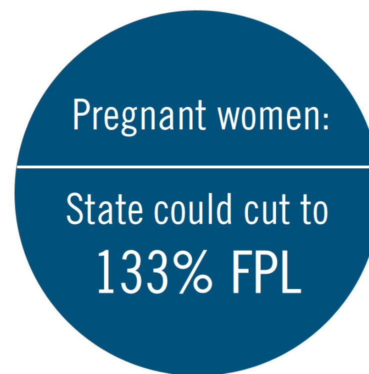
Table 2

Upper Income Eligibility Limit for Pregnant Women's Coverage

January 2011

State	Upper Income Limit (Percent of the 2010 FPL)
Alabama	No Optional Coverage
Alaska	175%
Arizona	150%
Arkansas	200%
California	300%
Colorado	250%
Connecticut	250%
Delaware	200%
District of Columbia	300%
Florida	185%
Georgia	200%
Hawaii	185%
Idaho	No Optional Coverage
Illinois	200%
Indiana	200%
Iowa	300%
Kansas	150%
Kentucky	185%
Louisiana	200%
Maine	200%
Maryland	250%
Massachusetts	200%
Michigan	185%
Minnesota	275%
Mississippi	185%
Missouri	185%
Montana	150%
Nebraska	185%
Nevada	185%
New Hampshire	185%
New Jersey	200%
New Mexico	235%
New York	200%
North Carolina	185%
North Dakota	No Optional Coverage
Ohio	200%
Oklahoma	185%
Oregon	185%
Pennsylvania	185%
Rhode Island	250%
South Carolina	185%
South Dakota	No Optional Coverage
Tennessee	250%
Texas	200%
Utah	No Optional Coverage
Vermont	200%
Virginia	200%
Washington	185%
West Virginia	150%
Wisconsin	300%
Wyoming	No Optional Coverage

If the stability protections are rescinded...



Source: Based on a national survey conducted by the Georgetown University Center for Children and Families and the Kaiser Commission on Medicaid and the Uninsured, 2011.

Note: Table represents highest income eligibility level for pregnant women, either through Medicaid or CHIP. State-funded coverage is not displayed.

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Table 3
Parent and Other Adults: Range of Coverage at Income
January 2011

State	Parents of Dependent Children (Percent of the 2010 FPL)	Other Adults (Non-Disabled) (Percent of the 2010 FPL)
	Range of Coverage at Risk	Range of Coverage at Risk
Alabama	No Optional Coverage	No Optional Coverage
Alaska	54-77%	No Optional Coverage
Arizona	23-100%	0-100%
Arkansas	No Optional Coverage	No Optional Coverage
California	40-200%*	0-200%*
Colorado	28-100%	No Optional Coverage
Connecticut	57-185%	0-56%
Delaware	22-100%	0-100%
District of Columbia	28-200%	0-200%
Florida	No Optional Coverage	No Optional Coverage
Georgia	No Optional Coverage	No Optional Coverage
Hawaii	41-200%*	0-200%*
Idaho	No Optional Coverage	No Optional Coverage
Illinois	25-185%	No Optional Coverage
Indiana	19-200%*	0-200%* (closed)
Iowa	28-200%*	0-200%*
Kansas	No Optional Coverage	No Optional Coverage
Kentucky	34-36%	No Optional Coverage
Louisiana	No Optional Coverage	No Optional Coverage
Maine	36-200%	0-100%* (closed)
Maryland	24-116%	0-116%*
Massachusetts	37-300%*	0-300%*
Michigan	32-37%	0-35%* (closed)
Minnesota	35-275%*	No Optional Coverage
Mississippi	No Optional Coverage	No Optional Coverage
Missouri	No Optional Coverage	No Optional Coverage
Montana	28-32%	No Optional Coverage
Nebraska	24-47%	No Optional Coverage
Nevada	23-25%	No Optional Coverage
New Hampshire	36-39%	No Optional Coverage
New Jersey	28-200% (closed)	No Optional Coverage
New Mexico	25-200%* (closed)	0-200%* (closed)
New York	46-150%	0-100%
North Carolina	No Optional Coverage	No Optional Coverage
North Dakota	28-34%	No Optional Coverage
Ohio	22-90%	No Optional Coverage
Oklahoma	20-200%*	0-200%*
Oregon	30-201%*	0-201%*
Pennsylvania	No Optional Coverage	No Optional Coverage
Rhode Island	36-175%	No Optional Coverage
South Carolina	13-50%	No Optional Coverage
South Dakota	33-52%	No Optional Coverage
Tennessee	38-70%	No Optional Coverage
Texas	No Optional Coverage	No Optional Coverage
Utah	37-150%* (closed)	0-150%* (closed)
Vermont	43-300%	0-300%*
Virginia	23-25%	No Optional Coverage
Washington	36-37%	No Optional Coverage
West Virginia	No Optional Coverage	No Optional Coverage
Wisconsin	34-200%	0-200%* (closed)
Wyoming	24-39%	No Optional Coverage

Source: Based on a national survey conducted by the Georgetown University Center for Children and Families and the Kaiser Commission on Medicaid and the Uninsured, 2011; and CCF calculations based House Ways and Means Committee, "1996 Green Book: Background Material and Data on Programs Within the Jurisdiction of the Committee on Ways and Means" (November 4, 1996).

Note: Limits for adults are calculated based on a family of three for parents and based on an individual for other adults, without taking into account income disregards. Table does not include state-funded coverage. States whose expanded coverage is more limited (e.g., more limited benefits, higher cost-sharing requirements, enrollment caps) are noted with an asterisk (*). States that provide premium assistance only programs are not shown.