



Federal “Maintenance of Effort” Protections Help Kids Maintain Health Coverage Amid Tough State Budget Climates

by Sean Miskell and Joan Alker

Key Points

- Federal protections, notably the Affordable Care Act (ACA)’s ‘maintenance of effort’ provision, have helped bring uninsured rates for kids down to historic lows. Today, the only state in the country not subject to this protection is Arizona—without the MOE, the state virtually eliminated its Children’s Health Insurance Program (CHIP), underscoring the importance of the federal protection in keeping kids coverage off the state negotiating table.
- Even seemingly small changes to eligibility and enrollment procedures can have significant and lasting implications for families and coverage for children.
- Without federal protections on eligibility requirements, history shows that some states will almost certainly respond to tough fiscal environments by scaling back health coverage for children. Federal actions that cut or fundamentally restructure CHIP would compound the likelihood of state moves to cut children’s coverage.

Introduction

The Children’s Health Insurance Program (CHIP) serves more than 8.3 million children in the United States.¹ CHIP is jointly administered and financed by states and the federal government, but at the end of federal fiscal year 2015 (September 30), no new federal funding for CHIP will be available. Lawmakers from both parties have introduced plans to extend CHIP funding.² However, while some plans to do so would keep CHIP structure and design intact, others would make changes that could reduce children’s coverage.

The discussion draft released by House Energy and Commerce Health Subcommittee Chairman Joe Pitts (R-PA), full committee Chairman Fred Upton (R-MI), and Senate Finance Committee Chairman Orrin Hatch (R-UT) would extend CHIP funding. Yet it would also, among other changes, cut federal CHIP funding for states and end the ‘maintenance of effort’ (MOE) requirement currently in place through September 2019.

The MOE helps ensure that children and families maintain stability in their health coverage. Continuous coverage is important for children and families to ensure that they

The MOE helps ensure that children and families maintain stability in their health coverage.



Even modest or short-term tinkering with eligibility rules can reduce or create gaps in coverage for children and families.

receive the ongoing preventive and primary care that is essential to healthy development. It also protects families from financial peril should an uninsured child experience a broken bone or other medical emergency. States regularly face fiscal and political pressures that too often end up harming children. Without federal protections taking kids off the negotiating table, lawmakers may choose to balance their budgets by reducing, capping, or freezing CHIP eligibility levels. Even modest or short-term tinkering with eligibility rules can reduce or create gaps in coverage for children and families.

MOE Protections Ensure that Children Receive Stable, Continuous Coverage

The MOE, put in place through federal fiscal year 2019 by the Affordable Care Act (ACA), ensures stability of coverage for children in CHIP and Medicaid. The protection prohibits states from eliminating their CHIP program or

reducing Medicaid and CHIP income eligibility thresholds to make fewer children eligible. States must maintain the eligibility levels in place as of March 23, 2010. States that reduce eligibility will lose all of their federal Medicaid funding.³

The MOE also prevents states from setting enrollment caps or freezes on their CHIP programs or implementing less obvious, ‘back door’ ways to reduce enrollment in their CHIP programs, barring states from enacting more restrictive methodologies or procedures for CHIP enrollment or renewals. For example, states may not impose new onerous requirements that add extra steps for families to enroll, or additional red tape and paperwork requirements such as new or extended waiting periods.⁴ States may also not increase premiums in CHIP beyond what was in place as of March 23, 2010 beyond nominal inflation adjustments.⁵

Maintenance of Effort Requirement: What States Can and Cannot Do

States can:

- Adopt or continue enrollment simplification initiatives
- Maintain caps or freezes that existed prior to the MOE (March 23, 2010)
- Choose not to renew waiver programs once they expire

States cannot:

- Eliminate CHIP or scale back eligibility for children in CHIP or Medicaid below levels in place as of March 23, 2010;
- Raise premiums for CHIP or Medicaid children;
- Impose or increase waiting periods, or the time that children must remain without group coverage before becoming eligible to enroll in CHIP. Current federal rules do not allow states to impose waiting periods longer than 90 days.⁶

State Actions without the MOE: New Coverage Limits Imposed Amid State Budget Woes and Uncertain Federal Funding

Recent history shows that some states will reduce children's coverage absent of the federal MOE protection.

Arizona children lose CHIP; ACA 'stairstep' provision mitigates the loss.

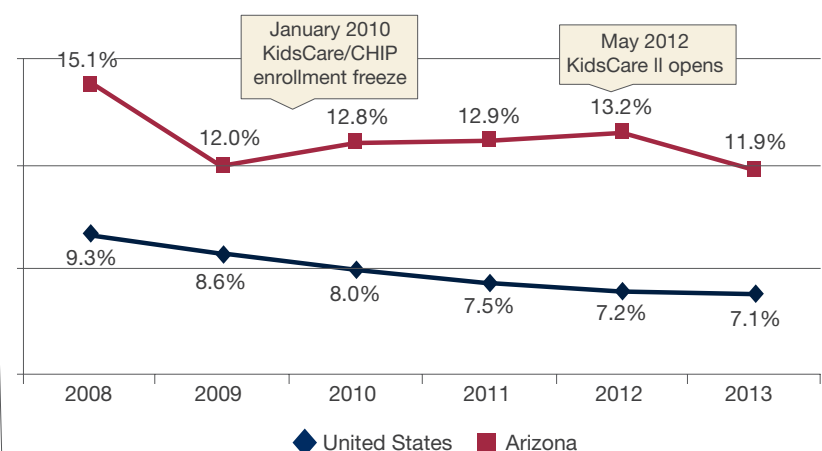
While virtually every state has kept eligibility steady per federal requirements, Arizona serves as an unfortunate example of what states may do in the absence of these protections. Arizona's CHIP program was, in effect, not subject to MOE requirements because the state already had a CHIP enrollment freeze before the ACA was enacted.

Without the federal requirement that Arizona maintain eligibility levels, state policy makers enacted multiple changes to CHIP amid rounds of state budget cuts that were reflected in the state's rate of uninsured children (see Figure 1). Between 2010 and 2014, Arizona made six policy changes in KidsCare, its CHIP program. In January 2010, Arizona froze enrollment in KidsCare, meaning no children could newly apply or renew coverage after disenrollment. The freeze led to a KidsCare waiting list that reached more than 100,000 by July 2011.⁷ In May 2012 Arizona re-opened CHIP under a time-limited program called KidsCare II. The state let the program end in 2014 and 14,000 children lost CHIP coverage.⁸ In addition to those that lost coverage, frequent changes to the program created confusion and instability for families seeking to insure their children.⁹ Today only 1,876 children remain enrolled in the state's separate CHIP program as compared to a peak of 112,100 in FY 2008.¹⁰

Coverage losses for Arizona children would be far worse without a provision of the ACA that required states to align eligibility for kids in the Medicaid program up to 138 percent of federal poverty level (FPL). Previously, children below six years old in this income range were covered by Medicaid, while states could choose to cover children aged 6-18 in this income range though CHIP, creating a 'stairstep' eligibility structure for children. However, because the ACA required that states raise Medicaid eligibility for children of all ages to 138 percent of FPL, these 'stairstep kids' in Arizona moved to Medicaid—a program that cannot be capped. In Arizona, 23,000 kids fell into this category and maintained their health insurance as a result. The Hatch-Upton-Pitts proposal would also eliminate this provision of the ACA that protected coverage for Arizona children.

Figure 1. Percent of Uninsured Children: Arizona vs. United States, 2008-2013

Without federal protections, Arizona's rate of uninsured children fluctuates





States have enacted freezes, caps, and “backdoor” cuts to suppress enrollment and save state funds.

Children lost coverage when states enacted freezes, caps, and ‘backdoor’ cuts to suppress enrollment and save state funds during recent recessions.

Prior to the existence of the children’s MOE protections, states often established barriers to reduce enrollment in CHIP. In response to an economic recession that began in 2001, many states took action to reduce enrollment in CHIP to save state dollars. Some states chose to implement subtle methods to depress enrollment, including reducing outreach efforts, charging co-pays, and scaling back administrative simplifications previously intended to facilitate sign-ups.¹¹ For example, in 2003 Washington began requiring families to reapply twice a year rather than annually and also stopped using the state earnings database to verify income, instead requiring families to submit paystubs. As a result, more than 30,000 children lost coverage over the next two years before the state reinstituted 12-month eligibility.¹² While requiring families to reapply more frequently is a strategy no longer allowed under the ACA, the example demonstrates that states may look for other ways to find savings through decreased enrollment that is not as explicit as cutting income eligibility.

Seven states (Alabama, Colorado, Florida, Maryland, Montana, North Carolina, and Utah) froze CHIP enrollment between 2001 and 2003.¹³ State officials cited difficulties meeting the state share of CHIP costs, 30 percent on average, leaving eligible low-income children uninsured.¹⁴ For example, when Florida implemented a freeze on July 1, 2003, it only took four and a half months for the waiting list of uninsured children who would have been eligible for CHIP in the state to grow to 44,000.¹⁵

Though these recession-induced enrollment restrictions were in place for relatively brief periods, the impact on children’s coverage was

significant. By the fall of 2004, enrollment had declined by 29 percent in North Carolina, by 27 percent in Colorado, by 17 percent in Utah, by 12 percent in Alabama, and by six percent in Florida and Maryland.¹⁶

These efforts to reduce enrollment caused hardship for the families whose children were unable to get CHIP coverage. For example, in North Carolina, families reported “juggling payments, borrowing money from friends or family, buying basic and lower quality food, and going without food” in their efforts to ensure that their children continue to have health coverage.¹⁷ Years later, some families were still paying for medical bills incurred during the freeze. Others delayed care, sometimes requiring more extensive treatment such as surgery or tooth extraction.¹⁸ In addition to increasing the number of children who were unable to obtain CHIP coverage, the freeze was disruptive and confusing for families in North Carolina. When the state lifted the freeze almost one-fourth (22 percent) did not reapply for coverage.¹⁹ Even after North Carolina ended its enrollment freeze, it came close to re-instituting waiting lists twice by the end of 2003.²⁰

More recent rollbacks suggest states need confidence about availability of federal funds to keep children covered.

State decisions on children’s coverage leading up to the 2009 reauthorization of CHIP suggest concerns about hitting federal allotments also influenced eligibility or enrollment rollbacks. For example, Georgia instituted an enrollment freeze for its CHIP program in 2007 when faced with a federal funding shortfall.²¹ California ended up freezing enrollment in 2009. State officials estimated that the as many as 350,000 children would have to be put on waiting lists because of the freeze.²² Wyoming also imposed a cap on CHIP sign-ups in 2009.²³



Cutting Back or Eliminating CHIP Leaves Some Families Without Options and Can Increase Costs for States

Were the MOE to be lifted, it would be especially tempting in light of the ACA for states to reduce CHIP eligibility—because of the perception that families could enroll in marketplace coverage with tax subsidies and be no worse off. However, the Medicaid and CHIP Payment and Access Commission (MACPAC) estimates that subsidized exchange coverage is likely to be available to less than half of the 5.3 million children enrolled in separate state CHIP programs.²⁴ Those families that lose CHIP coverage may indeed be able to obtain subsidized coverage through the ACA's marketplaces, while others might not be eligible for this financial assistance as a result of the way in which the ACA has been interpreted to define eligibility for subsidies—known as the 'family glitch.' A parent's offer of employer-sponsored insurance is deemed affordable based solely on the offer of individual, not family, coverage—thus many families are not eligible for tax credits even if their employer coverage remains financially out of reach. For these families, if states cap their CHIP programs, those affected by the family glitch have no path to affordable coverage. Growing research shows that even families that are able to secure financial support to purchase marketplace coverage for their children will face higher costs for coverage that is less comprehensive than the CHIP coverage they receive today. Marketplace plans in many states have service gaps or limits that can hinder children's healthy growth and development.²⁵

But federal protections like the MOE help ensure that children continue to have a stable source of coverage. The Hatch-Upton-Pitts proposal would also exacerbate the budget problems that have caused states to cap their CHIP programs by not fully funding CHIP. The proposal cancels a 23 percent increase in federal CHIP matching funds slated to begin in FY 2016. Because this match increase is current law, many states have included it in their budgets. Previous experience shows that states seek to reduce CHIP enrollment when federal funding is threatened, in addition to their own state budget concerns.

The Hatch-Upton-Pitts proposal also reduces the federal enhanced CHIP match for families over 250 percent of the poverty level to the Medicaid match level and eliminates CHIP coverage for families above 300 percent of poverty. These measures would result in less federal CHIP funding for a majority of states. For the 33 states that currently use federal CHIP funding to provide children with coverage through Medicaid, moving from the federal CHIP matching rate to lower federal Medicaid matching rate would increase state expenditures for those children by 43 percent.²⁶ Combined with the elimination of federal protections like the MOE, these funding reductions would undermine state CHIP programs and almost certainly reduce coverage for children.



Federal protections like the MOE protect children's coverage from getting caught in the back and forth of state budget-making, preventing lawmakers from tinkering with or rolling back CHIP enrollment.

Conclusion: Federal Protections Are Essential to Protect Children's Health Coverage

Some recent proposals to change CHIP call for more flexibility for states, including ending the federal MOE protection. Even though CHIP is a popular program, past experience shows that states will employ ways to reduce CHIP enrollment to save state funds during economic downturns when families need it the most and/or as a result of reductions or limits on federal funding. Despite the success of CHIP and Medicaid in reducing the number of uninsured children to historic lows, it is clear that additional state flexibility of this kind will result in some children losing coverage.

Stable health coverage is critical for children and families to ensure access to health services children need and to ensure financial security for these families, especially during difficult economic times. Further, in light of recent research that establishes the long term economic and educational benefits of covering children, programmatic changes to CHIP that result in even a temporary loss of coverage for children can have lasting effects.²⁷ The MOE keeps children's coverage from getting caught in the back and forth of state budget making, helping to ensure that historic state and national success covering children continues.

Endnotes

¹ Data is recent as of FY 2013, according to Medicaid and CHIP Payment and Access Commission, "MACStats: Medicaid and CHIP Program Statistics," (March 2014), available at <http://www.macpac.gov/macstats>.

² In February 2015, various lawmakers introduced plans to extend CHIP. Republicans on the House Energy and Commerce Health Subcommittee released a discussion draft of a bill, Democrats on the House Energy and Finance and Ways and Means Committees released the CHIP Extension and Improvement Act of 2015, Senate Democrats released their Protecting & Retaining Our Children's Health Insurance Program Act of 2015, and President Obama's FY 2016 budget also called for an extension of CHIP.

³ CHIP MOE provisions are spelled out in Section 2105(d) (3) of the Social Security Act, as added by section 2101(b) of the Affordable Care Act. See also Centers for Medicare & Medicaid Services, "The Affordable Care Act Maintenance of Effort (MOE)—Questions & Answers," (February 25, 2011), available at <http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD11001.pdf>.

⁴ For additional information see Georgetown Center for Children and Families and Center on Budget and Policy Priorities, "Holding the Line on Medicaid and CHIP: Key Questions and Answers About Health Care Reform's Maintenance of Effort Requirements," (March 26, 2010),

available at http://ccf.georgetown.edu/wp-content/uploads/2012/03/Health%20reform_final%20qa%20on%20moe.pdf.

⁵ Kaiser Commission on Medicaid and the Uninsured, "Understanding the Medicaid and CHIP Maintenance of Eligibility Requirements," (May 2012), available at <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8204-02.pdf>.

⁶ T. Brooks, "Making Kids Wait for Coverage Makes No Sense in a Reformed Health System," Georgetown Center for Children and Families (February 2015), available at <http://ccf.georgetown.edu/wp-content/uploads/2015/03/Making-Kids-Wait-for-Coverage-Makes-No-Sense-in-a-Reformed-Health-System-2015.pdf>.

⁷ E. Burak, "Children's Health Coverage in Arizona: A Cautionary Tale for the Future of the Children's Health Insurance Program (CHIP)," Georgetown University Center for Children and Families (January 2015).

⁸ *Ibid.*

⁹ M. Heberlein, J. Guyer, and C. Hope, "The Arizona KidsCare CHIP Enrollment Freeze: How Has it Impacted Enrollment and Families?" Kaiser Commission on Medicaid and the Uninsured and Georgetown University Center for Children and Families (September 2011), available at <http://ccf.georgetown.edu/ccf-resources/1403/?issue=chip%2F>.



¹⁰ Current data reflects enrollment as of January 1, 2015 as reported by the Arizona Health Care Cost Containment system, available at <http://www.azahcccs.gov/reporting/Downloads/KidsCareEnrollment/2015/Jan/KidsCareDemographics.pdf>. Historical enrollment data available from the Kaiser Family Foundation, "Total Number of Children Ever Enrolled in CHIP Annually," available at <http://kff.org/other/state-indicator/annual-chip-enrollment/>.

¹¹ I. Hill, H. Stockdale, and B. Courtot, "Squeezing SCHIP: States Use Flexibility to Respond to the Ongoing Budget Crisis," New Federalism: Issues and Options for States The Urban Institute Program to Assess Changing Social Policies. A-65: 1-12 (2004).

¹² 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 24, 2011), available at <http://www.cbpp.org/cms/?fa=view&id=3397>. Note: At the same time, the state maintained Medicaid income eligibility because the 2009 American Recovery and Reinvestment Act paired more federal financial assistance to state Medicaid programs via an increase in the Federal Medical Assistance Percentages to the requirement that states maintain Medicaid eligibility levels.

¹³ Montana, North Carolina, and Utah enacted enrollment caps in 2001 as the recession began, while Alabama, Colorado, Florida, and Maryland capped enrollment between July and November 2003 at the recession's height. For more information see I. Hill *et al.*, "Coping With SCHIP Enrollment Caps: Lessons From Seven States' Experiences," Health Affairs, volume 26, number 1, January 2007, pages 258-268.

¹⁴ D. Cohen Ross and L. Cox, "Enrollment Freezes in Six State Children's Health Insurance Programs Withhold Coverage for Eligible Children," Kaiser Commission on Medicaid and the Uninsured (December 2003). See also M. Broaddus, "CHIP's Success Not an Argument for Block-Granting Medicaid," Center on Budget and Policy Priorities (June 29, 2011), available at <http://www.cbpp.org/cms/?fa=view&id=3528>.

¹⁵ *Ibid.*

¹⁶ *Op. cit.* (11).

¹⁷ As reported in focus groups conducted by the Kaiser Commission on Medicaid and the Uninsured. See P. Silberman *et al.*, "The North Carolina Health Choice Enrollment Freeze of 2011," Kaiser Commission on Medicaid and the Uninsured (January 2003).

¹⁸ *Ibid.*

¹⁹ *Ibid.*

²⁰ E. Madigan, "Five States Freeze CHIP Enrollment," Stateline (November 4, 2003), available at <http://>

www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2003/11/04/five-states-freeze-chip-enrollment.

²¹ Gwinnett Daily Post, "State to Freeze PeachCare Enrollment," (February 9, 2007).

²² K. Sack, "Defying Slump, 13 States Insure More Children," The New York Times (July 18, 2009), available at <http://www.nytimes.com/2009/07/19/us/19chip.html>.

²³ *Ibid.*

²⁴ Medicaid and CHIP Payment and Access Commission, "Report to the Congress on Medicaid and CHIP," (June 2014).

²⁵ *Ibid.*

²⁶ See for example S. Cohodes *et al.*, "The Effect of Child Health Access on Schooling: Evidence from Public Insurance Expansions," National Bureau of Economic Research (Working Paper 20178, May 2014) available at <http://www.nber.org/papers/w20178>; and S. Brown *et al.*, "Medicaid as an Investment in Children: What is the Long-term Impact on Tax Receipts?" National Bureau of Economic Research (Working Paper 20835, January 2015) available at <http://www.nber.org/papers/w20835>.

Authors: Sean Miskell and Joan Alker

The authors would like to thank Elisabeth Wright Burak and Alisa Chester of CCF, as well as Edwin Park, Matt Broaddus, and Jesse Cross-Call at the Center on Budget and Policy Priorities for their feedback and reviews. Design and layout assistance provided by Nancy Magill.

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.

Center for Children and Families
Health Policy Institute
Georgetown University
Box 571444
3300 Whitehaven Street, NW, Suite 5000
Washington, DC 20057-1485
Phone (202) 687-0880
Email childhealth@georgetown.edu



ccf.georgetown.edu/blog/



facebook.com/georgetownccf



twitter.com/georgetownccf