

CHIP: Not a Model for a Medicaid Block Grant

by Jocelyn Guyer, Martha Heberlein, and Joan Alker

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Introduction

In a few of the proposals that have been released to reduce the deficit, policymakers have called for converting Medicaid to a block grant and deeply cutting funding levels (see Box 1 on page 2). In arguing for a Medicaid block grant, some lawmakers have cited the success of the Children's Health Insurance Program (CHIP), a popular block grant program, as justification for this idea.

In this analysis, we review in detail the role of Medicaid and CHIP in the health care system, outline the differences in their financing structures, and discuss the reasons it is not appropriate to use CHIP's experience as a guide to what will happen if federal Medicaid funding is capped or turned into a block grant.

Key Findings

CHIP helps many families, but plays a far more limited role in the health care system than its larger, companion program Medicaid. CHIP is a very successful program that has worked together with Medicaid to drive down the uninsured rate of children to ten percent, the lowest level on record.¹ In this partnership, the relatively modest CHIP program has had an "outsized" impact by spurring major improvements in eligibility and enrollment procedures for both Medicaid and CHIP. Even so, it remains a far smaller program than Medicaid and plays the simpler, more

circumscribed role of providing coverage to mostly healthy children in families with income somewhat above Medicaid thresholds. In comparison, Medicaid covers eight in ten of the children with public coverage in the United States and finances 34 times as much care as CHIP. It also provides long-term care and other services to many of the nation's seniors and people with disabilities; groups that often have complex and expensive needs.²

The major purpose of a Medicaid block grant is to reduce the federal deficit, but if CHIP were used as a model for Medicaid it would actually cost the federal government money. Unlike typical block grants, CHIP has been adequately funded for much of its history. Most recently, it was reauthorized in 2009 in the Children's Health Insurance Program Reauthorization Act and provided with strong federal funding through an increase in the tobacco tax.³ As a result, CHIP has acted much like a funding guarantee to states, allowing them to make decisions based on their policy goals rather than arbitrary federal caps. In fact, CHIP spending has grown more rapidly than Medicaid in recent years, as the program has expanded to cover more of the nation's uninsured children. If Medicaid were turned into a block grant and allowed to grow at the same rate as CHIP has been growing, it would actually cost the federal government an additional half a trillion dollars (\$514 billion) over the next ten years.⁴ This is clearly not a viable option in the current fiscal environment, and highlights that CHIP as it has been operating is not a workable model for Medicaid.

At times, the block grant structure of CHIP has resulted in unnecessary instability in state decision-making and waiting lists for uninsured children. Despite being adequately funded, the block grant structure of CHIP

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KidsWell is a state and national advocacy and organizing campaign initiated by The Atlantic Philanthropies to ensure successful implementation of health care reform on behalf of children.

Box 1. Proposals to Turn Medicaid into a Block Grant

The most widely-discussed proposal to turn Medicaid into a block grant was included in a budget proposal put forth by Congressman Ryan, Chairman of the House Budget Committee, and adopted by the U.S. House of Representatives on April 15, 2011. It would radically alter Medicaid by converting it to a block grant while deeply cutting federal funding for the current program by \$771 billion over the next ten years.⁵ Under the plan, the Congressional Budget Office (CBO) estimates that federal spending for Medicaid (as it exists without health reform) would be 35 percent lower in 2022 and 49 percent lower in 2030.⁶ This reduction in federal support is so large, that in order to maintain their existing Medicaid programs, the CBO anticipates that states will need to reduce payments to Medicaid providers, restrict the scope of benefits, limit eligibility or, outside of Medicaid, cut spending to other programs and/or increase taxes.

Medicaid and CHIP work in partnership to provide coverage to many of the nation's uninsured children.

has created a number of issues for children's coverage over the years. It has introduced uncertainty into the decision-making process in states, causing some to delay initiatives to cover more children because state policymakers were unsure if federal CHIP funding would be available. In 12 states, uninsured children have been turned away from coverage when the state ran short on its own funding for CHIP.⁷ If states faced this uncertainty in Medicaid or established similar waiting lists, it would affect a far greater share of the nation's children and have much deeper reverberations throughout the nation's health care system.

Medicaid and CHIP's Role in the Health Care System

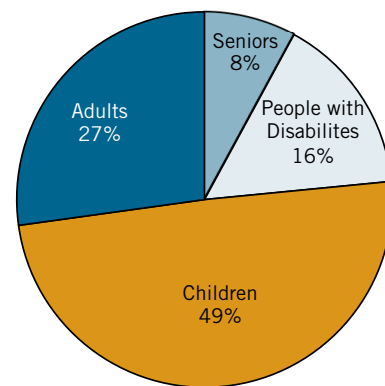
Medicaid and CHIP work in partnership to provide coverage to many of the nation's uninsured children. Together, these programs have driven the uninsured rate of children down to 10 percent, the lowest level on record. Medicaid, however, also plays a number of additional roles in the health care system, including providing health and long-term services and supports to many of the nation's seniors and people with disabilities.

Medicaid's Role

Medicaid has evolved significantly since it was first enacted in 1965. It originally was designed with strong ties to welfare and allowed states to provide coverage primarily to low-income children and families, seniors, and people with disabilities receiving cash assistance. Now it has been largely "delinked"

from cash welfare programs. It covers approximately 70 million people, nearly half of whom are children. This includes: 34 million children, 19 million adults, almost 11 million people with disabilities, and 5.5 million seniors (see Figure 1).⁸ One out of every six Medicare beneficiaries is also enrolled in Medicaid.⁹ One particularly distinctive role Medicaid plays is providing long-term care services in nursing homes or in the community for seniors and people with disabilities. This is an important function that requires Medicaid to provide care, at times in coordination with Medicare, for people with some of the most complex and often expensive health care needs in the country.

Figure 1: Children are About Half of Medicaid Enrollees



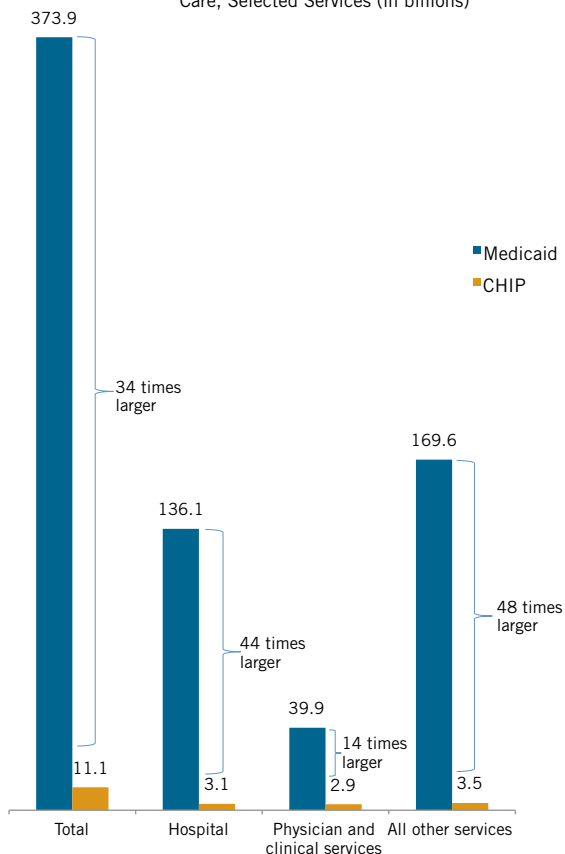
Source: CCF Analysis of Congressional Budget Office, "Spending and Enrollment Detail for CBO's March 2011 Baseline: Medicaid" (March 18, 2011).

Medicaid also fills in many of the gaps left by private insurance, including care for those struck by a serious or chronic illness who otherwise are uninsurable. For example, Medicaid has played a vital role in HIV/AIDS care since the beginning of the epidemic and continues to serve as the largest source of coverage for people with HIV in the United States.¹⁰ It also provides coverage for people with disabilities, such as those with multiple sclerosis or severe mental illness, as well as children with special health care needs like cerebral palsy. In order to meet the often-complicated health needs of its covered population, Medicaid provides benefits that are either unavailable or limited under private coverage, such as long-term services and supports and non-emergency transportation.

Medicaid plays a particularly vital role for low-income children and children with special health care needs. Overall, Medicaid covers two-thirds of children in poor families and almost 60 percent of children in low-income families.¹¹ It has helped fill the hole left in the

CHIP is designed to build on Medicaid by providing coverage to uninsured children with family income above Medicaid levels.

Figure 2: The Role of Medicaid and CHIP in Financing Health Care, Selected Services (in billions)



Source: Medicaid and CHIP Payment and Access Commission, "Report to the Congress on Medicaid and CHIP" (March 2011).

wake of deteriorating employer-sponsored coverage, which has declined steadily over the last decade. This is especially true in the recent economic downturn, as Medicaid has provided much-needed help to families struggling to gain solid footing during turbulent economic times. Between 2008 and 2009, at the height of the recession, enrollment among families rose by 9.3 percent. As a result, Medicaid has protected three million children and families by assuring access to affordable, comprehensive coverage.¹² Among children with special health care needs, Medicaid is a particularly critical source of coverage, covering nearly 30 percent of them.¹³ In many instances, families with children who have disabilities rely on Medicaid to supplement or "wrap around" their private insurance. Medicaid can play this vital role because of its unique Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, which requires states to provide a wide-range of critical child-specific services that often are missing from private insurance.

Medicaid plays a large role in financing health care in the United States. In fiscal year 2010, a total of \$406 billion was spent on Medicaid, with the federal

government contributing \$274 billion and states an additional \$132 billion. In 2009, Medicaid accounted for 15 percent of health care spending (\$373.9 billion). It paid for 18 percent of hospital care (\$136.1 billion); 8 percent of physician and clinical visits (\$39.9 billion); and 8.1 percent of all other health services (\$169.6 billion), including 33 percent of nursing home care (see Figure 2).¹⁴ Medicaid's role is particularly important for safety-net providers, including community health centers, but it also finances care provided by a wide range of other providers.

CHIP's Role

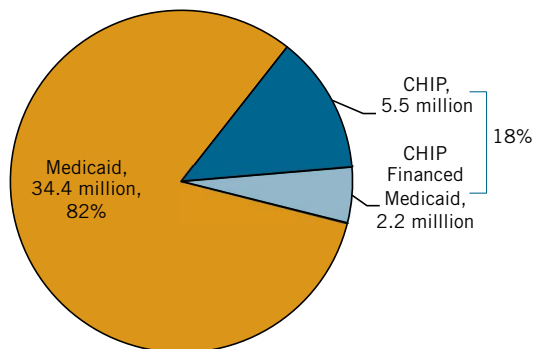
Established in 1997, CHIP is designed to build on Medicaid by providing coverage to uninsured children with family income above Medicaid levels.

States have the option to use their CHIP funds to expand Medicaid, to establish a separate state CHIP program, or to adopt a combination approach. As of January 2011, 17 states were operating a separate state program, 13 had expanded Medicaid, and 21 had adopted a combination approach. Together, Medicaid and CHIP now cover children up to at least 200 percent of the federal poverty level (FPL) in all but four states and in 25 states (including DC), they offer affordable coverage options to uninsured children in families with income up to 250 percent of the FPL or above.¹⁵

CHIP enrollment is relatively modest compared to Medicaid. In 2010, more than 34 million children were enrolled in Medicaid and an additional 7.7 million were enrolled in CHIP (see Figure 3 on page 4). Similarly, CHIP plays a much smaller role in the nation's health care system. In fiscal year 2010, a total of \$11.4 billion was spent on CHIP with the federal government contributing \$8 billion and states \$3.4 billion. In 2009, CHIP spending accounted for less than one percent of total health care spending in the United States. In comparison, Medicaid is responsible for covering 15 percent of health care costs in the United States, or 34 times as much as CHIP (see figure 2).¹⁶

CHIP has played a role in improving coverage for children that goes well beyond its relatively modest size. Despite its more limited enrollment, CHIP has had a transformative effect on the health coverage of the nation's children. Its creation in 1997 spurred states to implement new strategies to enroll eligible uninsured

Figure 3: The Role of Medicaid and CHIP in Covering Children



Total Child Enrollment in Public Programs = 42.1 million

Source: Medicaid and CHIP Payment and Access Commission, "Report to the Congress on Medicaid and CHIP" (March 2011).

Accompanying the guarantee to federal Medicaid funding is a requirement that states serve everyone who meets a state's Medicaid eligibility criteria.

children in coverage. In the process, many states made related improvements to their Medicaid programs for children. As states expanded eligibility and conducted outreach efforts, many families learned about Medicaid coverage for their children. This "welcome mat" effect has been one of the most powerful legacies of CHIP, helping to drive the sharp drop in the uninsured rate among low-income children.¹⁷ The creation of CHIP also stirred interest among federal and state policymakers in new initiatives to improve the quality of care provided to children in public programs, as well as private insurance.

Financing Structure of Medicaid and CHIP

The financing structures of Medicaid and CHIP reflect the historical origins of each program, the beneficiaries they cover, and their respective roles in the larger health care system.

Medicaid's Financing Structure

To finance Medicaid in a manner that meets the complex needs and wide-ranging purpose of the program, the federal government matches state spending on a guaranteed basis. Specifically, the federal matching rate ranges from 50 percent to 75 percent, and is determined for each state by a formula that considers its per capita income relative to the national average. The formula provides a higher matching rate to states with a relatively low per capita income and a lower matching rate to more affluent states. The federal government guarantees it will match any allowable Medicaid expense, meaning it does not arbitrarily cap the amount of federal matching money available. On the other hand, Congress can control federal Medicaid spending by restricting the range of Medicaid expenses for which it will provide matching funds or requiring states to adopt efficiencies. For example, in the past, Congress has reduced the rate of growth in federal Medicaid spending by limiting the payments to disproportionate share hospitals that it will match and securing better rebates for prescription drugs from the pharmaceutical industry.¹⁸

Accompanying the guarantee to federal Medicaid funding is a requirement that states serve everyone who meets a state's Medicaid eligibility criteria. For example, a state cannot shut down enrollment of seniors in need of nursing home care or children in need of health coverage toward the end of its fiscal year because it is running short of funding. Similarly, during economic downturns states cannot deny coverage to

Key Elements of the Financing Structure of Medicaid and CHIP

	Medicaid	CHIP
Basic Structure	State spending matched on an open-ended basis.	State spending matched up to a capped allotment. Additional funds may be available if not needed by other states or through a special contingency fund established in CHIPRA.
Matching Rate Level	50 percent to 75 percent; average, is 57 percent. ¹⁹	65 percent to 82 percent; average is 70 percent.
Federal Funding (FY 2011)	\$275 billion in federal funds	\$8.5 billion in federal funds
Distribution of Funds among the States	Federal funding is distributed based on the extent to which states need and make use of funds.	Federal funding is distributed by a formula based on a state's historical use of CHIP funds.
Mechanism for Controlling Federal Spending	Congress can change policies about how Medicaid funding can be used.	Congress can change allotment levels or policies affecting how CHIP funds can be used.
Guarantee to Coverage	States must serve all eligible beneficiaries.	States can shut down enrollment if they run out of federal funding. ²⁰

Unlike many block grants, CHIP has been adequately funded for much of its history, allowing it to grow even more rapidly than Medicaid.

Box 2. Funding Shortfalls Have Led to Enrollment Freezes in CHIP

Over the thirteen-year history of CHIP, 12 states have put an enrollment cap or freeze in place causing eligible uninsured children to remain without coverage until they were lifted. Most lasted for less than one year, but the research on the effect of freezes shows that they have a chilling effect on enrollment for years even after they end.²¹ The states include Arizona, California, Georgia, and North Carolina, as well as eight (Alabama, Colorado, Florida, Idaho, Maryland, Montana, Tennessee, and Utah) that adopted freezes during the 2003 – 2004 recession.²² One such state, 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.²³ More recently, California and Tennessee instituted short-term enrollment freezes in 2009.

Currently, only Arizona has an enrollment freeze in place. Established in December of 2009, the freeze already has caused the number of children covered through Arizona’s CHIP program to drop from approximately 47,000 children in December 2009 to just over 19,000 as of May 2011.²⁴ Right now, other states are precluded from imposing new freezes by protections included in the Affordable Care Act (known as the stability protections or maintenance-of-effort requirement) that prevent states from scaling back their Medicaid or CHIP eligibility below March 23, 2010 levels. For children, these protections continue through 2019.²⁵

unemployed families because Medicaid enrollment is higher than expected and state coffers have dwindled. States have a range of tools at their disposal to control their Medicaid expenditures, including extensive flexibility over how they deliver care and, within federal guidelines, their provider reimbursement rates, benefit structure, and cost-sharing policies. They, however, cannot turn away eligible people from coverage as a strategy to address funding shortfalls.

CHIP’s Financing Structure

Established in 1997, CHIP is a block grant in which the federal government makes a capped amount of new funding available for each fiscal year. In fiscal year 2011, for example, the total amount of new federal funding made available to states and territories was \$8.5 billion. Most of the funds are divided among states (and territories) based on a statutory formula that has evolved over the years and is now calculated primarily on a state’s historical use of CHIP funds. As under Medicaid, the federal government matches states’ expenditures, although at a higher rate than under Medicaid. Since states are not provided with an entitlement to federal CHIP matching funds, they, in turn, are not required to guarantee coverage to eligible uninsured children. (However, it appears that instituting an enrollment cap, unless already in place, may be considered a violation of the stability protections included in the Affordable Care Act.)²⁶ This “flexibility” has resulted in 12 states establishing waiting lists or enrollment freezes at some point during the history of the program, causing eligible children to be turned away from coverage (see Box 2).²⁷

Throughout CHIP’s history, there often has been a “mismatch” between the size of the block grant

and the amount needed by states. When CHIP was enacted in 1997, total appropriations were approximately \$40 billion over ten years. In the early years of CHIP when states were working to establish their programs, the allotments were more than adequate and many states temporarily had a surplus of available CHIP funds. As CHIP programs matured, spending grew relatively rapidly and states began to run short on federal CHIP funds. Congress stepped in on a number of occasions to help fill the funding shortfall. In fiscal years 2006 and 2007, for example, it appropriated more than \$900 million in additional federal funds to cover the gap.²⁸ The financing uncertainty at times discouraged states from moving forward to cover more uninsured children. Most notably, in the years and months prior to reauthorization of CHIP in February of 2009, a number of states were hesitant to act because they thought federal CHIP funding might run short. For example, Kansas passed legislation in 2008 to expand the state’s CHIP program to 250 percent of the federal poverty level, but included the stipulation that the expansion would not go into effect until CHIP was reauthorized and sufficient federal funding was available.²⁹

Unlike many block grants, CHIP has been adequately funded for much of its history, allowing it to grow even more rapidly than Medicaid (see Box 3). In its early years, CHIP expenditures grew rapidly as states were establishing and ramping up their programs. Even in recent years, however, CHIP has typically grown more rapidly than Medicaid as states have made progress in covering more uninsured children. Between 2005 and 2010, for example, CHIP grew at an average annual rate of nine percent while Medicaid grew at an average annual rate of under six percent. In effect,

Box 3. Other Block Grants are Funded at Much Lower Levels

In some key respects, CHIP is an aberration among block grant programs. Its funding levels are relatively generous, leaving states the flexibility to make decisions about which children to cover based on their policy objectives rather than arbitrary federal funding limits. Other block grants, such as Temporary Assistance for Needy Families (TANF) and the Title V Maternal Child Health (MCH) block grants, may provide a more useful guide as to what might happen to Medicaid if it were turned into a block grant. Both are presently facing budget shortfalls.

TANF: TANF, a block grant program providing cash assistance to families in need, is on average receiving 15 percent less in federal funding this year than in 2009 and 2010. To further the problem, the TANF Contingency Fund, which was created to help supplement basic funding when states experienced a substantial increase in need, ran out as of December 2009. To further help states respond to more enrollees, TANF created the Emergency Fund in 2009; that, too, has since expired. Thus, with no additional funds to draw upon and the TANF program in dire fiscal straits, states are cutting their programs. Florida, Mississippi, and Kentucky have completely ended their subsidized jobs programs, eliminating jobs for 10,000 adults. Illinois, facing a large budget deficit, and without the promise of renewed federal funding for its jobs program, is preparing to end subsidies for its enrollees, with the expected loss of 17,000 jobs. As other states continue the process of balancing their budgets, they too, will likely face the same funding shortfalls.³⁰

Title V: The Title V MCH block grant, a program serving the needs of 40 million infants, children, and pregnant women each year, is facing similar troubles. In spite of the importance of maternal child health programs, MCH has seen a gradual decrease in federal funding over the years, resulting in it being funded in fiscal year 2011 at its lowest level since 1993.³¹

The country's experience with CHIP is a poor guide as to what would happen if Medicaid were turned into a capped program for deficit reduction purposes.

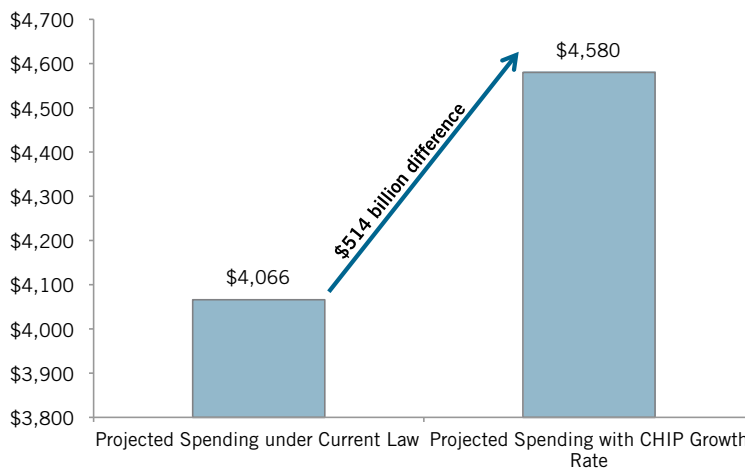
the generous allotment levels in CHIP mean it has acted much like a funding guarantee to states. States largely have been free to make decisions based on their policy goals rather than arbitrary federal caps. To put this trend into some perspective, if Medicaid were allowed to grow over the next decade at the same rate as CHIP has been growing, it would actually cost the federal government an additional \$514 billion (see Figure 4).³² Since the primary goal of a Medicaid block grant is to reduce federal Medicaid spending, it is impossible to imagine Congress relying on CHIP as it has operated in recent years as a model for Medicaid.

Policy Implications

While some policymakers have pointed to CHIP as a model for a Medicaid block grant, the country's experience with CHIP is a poor guide as to what would happen if Medicaid were turned into a capped program for deficit reduction purposes. Most fundamentally, Medicaid and CHIP work together to cover children, but also serve very different roles in the health coverage system. Not only does Medicaid cover eight in ten children with public coverage, but it also is a major player in financing care for many groups besides children, including low-income seniors and people with disabilities who often have extremely complicated health care needs. Overall, Medicaid finances far more care in the United States than CHIP, which means that the problems created by turning Medicaid into a block grant would reverberate far more deeply through the health care system.

Moreover, for the majority of its history, CHIP has been adequately funded, effectively leaving states free to make CHIP policy decisions without having to face arbitrary caps on federal funding. If Medicaid were turned into a block grant, it would be done to save federal money and states would presumably never be able to increase spending at the rate that has occurred in CHIP. Instead, they would

Figure 4: If Congress Adopted CHIP Model for Medicaid, It Would Create a Bigger Deficit (numbers in billions)



Source: Georgetown University Center for Children and Families calculations based on March 2011 CBO Medicaid Baseline and op. cit. (4).

face deep cuts that would create powerful incentives for states to shut down enrollment, scale back on the scope of coverage, or shift costs onto providers and families.

Even with its relatively generous funding levels, CHIP's history still illustrates some of the issues likely to arise if Medicaid is capped or turned into a block grant.

The lack of a historical guarantee to coverage in CHIP has resulted in a dozen states shutting down enrollment since the program's inception. More generally, the uncertainty surrounding the allotment structure, especially in the years prior to reauthorization, has led some states to balk at moving forward to cover more of the nation's uninsured children. Allowing such flexibility in Medicaid would have even more far-reaching consequences since it covers many more of the nation's children, and also plays a vital role in health and long-term care services for millions of parents, seniors, and people with disabilities.

In sum, CHIP has had an extremely positive impact on children's coverage but it would be a major error to imagine that similar results would occur if Medicaid funding were turned into a block grant and deeply cut.

To the contrary, the country would likely experience on a far more massive scale some of the problems that have plagued CHIP during lean times, including waiting lists for care and other forms of rationing.

End Notes

Jocelyn Guyer, Martha Heberlein, and Joan Alker of the Georgetown University Center for Children and Families prepared this issue brief.

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1. C. De Navas-Walt, B. Proctor, & J. Smith, "Income, Poverty, and Health Insurance Coverage in the United States: 2009," U.S. Census Bureau (September 2010).
2. Medicaid and CHIP Payment and Access Commission, "Report to the Congress on Medicaid and CHIP" (March 2011).
3. Specifically, CHIPRA increased the tax on tobacco products to finance new federal CHIP allotments through fiscal year 2013, along with a series of

other changes aimed at increasing and improving coverage of uninsured children. In the Affordable Care Act, Congress extended CHIP funding for an additional two years, providing the program with funding through fiscal year 2015. Throughout this period, federal CHIP allotments are set at levels in excess of what states are expected to be able to use. See Congressional Budget Office, March 2011 baseline.

4. Georgetown Center for Children and Families calculation based on Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates from HCFA/CMS (Form 64); Centers for Medicare and Medicaid Services, "Net Reported Medicaid and CHIP Expenditures, FY1998-FY 2008," Special Data Request for the Kaiser Commission on Medicaid and the Uninsured (January 2010); and op. cit. (2).
5. P. Ryan, "The Path to Prosperity," House Committee on the Budget (April 2011).
6. Congressional Budget Office, "Long-term Analysis of a Budget Proposal by Chairman Ryan" (April 2011).
7. Georgetown Center for Children and Families review of the annual 50-state survey on eligibility and enrollment procedures published by the Kaiser Commission on Medicaid and the Uninsured.
8. Congressional Budget Office, "Spending and Enrollment Detail for CBO's March 2011 Baseline: Medicaid" (March 18, 2011).
9. op. cit. (2).
10. Kaiser Family Foundation, "Medicaid and HIV/AIDS" (February 2009).
11. Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2010 Current Population Survey, Annual Social and Economic Supplements.
12. J. Holahan, et al., "Medicaid Spending Growth Over the Last Decade and the Great Recession, 2000-2009," Kaiser Commission on Medicaid and the Uninsured (February 2011).
13. Georgetown Center for Children and Families calculation based on data from the 2005-2006 National Survey of Children with Special Health Care Needs.
14. op. cit. (2).
15. M. Heberlein, et al., "Holding Steady, Looking Ahead: Annual Findings 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).
16. op. cit. (2).
17. L. Dubay, et al., "Medicaid at the Ten-Year Anniversary of SCHIP: Looking Back and Moving Forward," Health Affairs, 26(2): 370-381 (March/April 2007).

In sum, CHIP has had an extremely positive impact on children's coverage but it would be a major error to imagine that similar results would occur if Medicaid funding were turned into a block grant and deeply cut.

18. "The Deficit Reduction Act of 2005," Pub. L. 109-171(2006) and "The Affordable Care Act," Pub. L. 111-148 & 111-152 (2010).
19. Note this does not take into account the matching rate increase in the American Recovery and Reinvestment Act which expires June 30, 2011.
20. Prior to the Affordable Care Act (ACA), states also could shut down enrollment if they ran out of state funds. However, it appears that instituting an enrollment cap, unless already in place as in Arizona, may be considered a violation of the stability protections (or maintenance-of-effort provisions). CMS, however, has not yet directly addressed this issue.
21. P. Silberman, et al., "The North Carolina Health Choice Enrollment Freeze of 2001," Kaiser Commission on Medicaid and the Uninsured (January 2003).
22. Note that Tennessee has two CHIP-funded programs, both of which have been closed and reopened at various times, including during the last recession. Between 2001 and 2007, Utah's CHIP program was only accepting new applicants during specific open enrollment periods. *op. cit.* (7).
23. 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).
24. Arizona Health Care Cost Containment System, "KidsCare Enrollment" (May 2011).
25. *op. cit.* (20).
26. *Ibid.*
27. *op. cit.* (7).
28. *op. cit.* (2).
29. S.B. 541, 2007-2008 Legislative Session (Kansas, 2008).
30. L. Schott & L. Pavetti, "Federal TANF Funding Shrinking While Need Remains High," Center on Budget and Policy Priorities (December 15, 2010)
31. P. Sloyer, "Written Testimony of Association of Maternal and Child Health Programs (AMCHP)," Testimony before the U.S. Senate Committee on Appropriations, Subcommittee on Labor, Health and Human Services and Education (April 23, 2010).
32. *op. cit.* (4).