A Painful Recession:

States Cut Health Care Safety Net Programs

Families USA

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INTRODUCTION

The current recession has driven the unemployment rate to levels not seen since 1993, and it is likely to continue climbing for much of 2009. As Americans lose their jobs and their incomes shrink, too often, they also face the loss of their family's health insurance. Without health insurance, people must make tough choices about when and if to seek health care. Paying for food, transportation, housing, and other necessities may leave no room in the family budget for a child's trip to the doctor or mom's mammogram. A medical crisis can quickly turn into a financial crisis (or worsen existing financial problems).

> ***"Unless states receive fiscal relief, I believe the goal of stabilizing the economy cannot be achieved."***
>
> New York Governor David Paterson, House Ways and Means Committee Hearing on "Economic Recovery, Job Creation and Investment in America," October 29, 2008

More than ever, low-income families need the health care safety net that is provided by Medicaid and the State Children's Health Insurance Program (CHIP) to get them through these tough times. However, another unfortunate effect of the economic crisis is the decline in state revenues and the resulting growth in state budget deficits across the country. As of November 2008, at least 43 states have faced or are facing budget deficits for the current 2009 fiscal year and/or the coming 2010 fiscal year that, taken together, total $140 billion.[1] In response to this extreme fiscal pressure, states are forced to cut their Medicaid and CHIP budgets. This report documents this real impact of the recession. By looking at a 2008 snapshot of the first round of these cuts and the harm they have caused, our report offers a preview of the even greater harm that lies ahead if states do not receive help from the federal government.

Including financial help for states in a federal economic recovery package will help them preserve the Medicaid and CHIP health care safety net. This assistance is vital to prevent program cuts that will cause people to lose health coverage altogether or to lose access to critical health care services. Not only would this federal assistance help provide economic security to the families who depend on these programs, but a federal investment in Medicaid and CHIP would provide an immediate stimulus to state economies, increasing business activity, jobs, and wages.

There are two important components to how the federal government can provide this financial help. First, an increase in the share of the cost of the Medicaid program paid by the federal government (called the Federal Medical Assistance Percentage or FMAP) should be part of any economic recovery legislative package. This report quantifies, on a state-by-state basis, the potential magnitude of the financial stimulus that would be gained from the most recent Senate proposal to increase the federal investment in Medicaid.

Second, states must be reassured that the CHIP program will be adequately funded. Although Congress passed legislation—with broad bipartisan support—to reauthorize CHIP on two occasions in 2007, President Bush vetoed those bills. Congress, therefore, temporarily extended the program through March 2009, a deadline for congressional action that is fast approaching. The new Congress should act quickly to reassure states that extending and expanding CHIP as part of an economic recovery package will be accomplished in a timely manner, thereby providing both relief to families and a boost to the economy.

KEY FINDINGS

Medicaid and CHIP coverage for low-income families is at risk due to enacted and/or proposed cuts.

- Nineteen states have enacted or proposed Medicaid or CHIP cuts for fiscal year (FY) 2009 or FY 2010.[2]
  - Eighteen of the 19 states enacted program cuts in their FY 2009 budgets.
  - Six of the 19 states are already considering a second round of cuts in their FY 2009 or 2010 budgets.
- The cuts include 1) actions that will make it harder for new families to get coverage and for those currently enrolled to keep their coverage (cuts in eligibility and enrollment), and 2) actions that will prevent currently enrolled families from getting health care (cuts in provider reimbursement, cuts in benefits, and increases in cost-sharing) (see Table 1).

At least a million people will lose coverage.

- More than 1 million people are at risk of completely losing health coverage in Medicaid and CHIP because of cuts that have been enacted or that are currently under consideration in the following eight states: Arizona, California, Florida, Georgia, Nevada, Rhode Island, South Carolina, and Tennessee (see Table 2).
  - Of those, states estimate that more than one-quarter of a million people (274,800) will lose coverage because of cuts that have already been enacted, and more than three-quarters of a million people (762,980) are at risk of losing their coverage if proposed cuts become law.
  - Of those who have lost or are at risk of losing their coverage, more than 590,440 are adults, and more than 447,340 are children.
- Three states that were planning to expand coverage are putting those plans on hold because of the economy and uncertainty about CHIP reauthorization. Those states are Iowa, Kansas, and North Dakota.

Table 1.

Medicaid and CHIP Cuts, Fiscal Years 2009 and 2010

○ Cuts Proposed ◐ Cuts Encacted ● Cuts Enacted, Additional Cuts Proposed

	Enrollment & Eligibility Cuts[a]	Benefit Cuts[b]	Increased Cost-Sharing[c]	Provider Rate Cuts[d]	Other Cuts[e]
Arizona	◐				
California	●	●	●	●	
District of Columbia		◐		◐	
Florida	○	●		●	
Georgia	○	●	○	●	
Illinois				◐	
Kansas					○
Maine		◐	◐	◐	
Maryland				◐	
Massachusetts		◐		◐	
Minnesota		◐		●	
Nevada	○	●		●	
New Hampshire				◐	
New York		○		●	
Rhode Island	◐	●	◐		◐
South Carolina	◐	◐		◐	
Tennessee	○	◐			○
Utah		◐		◐	
Vermont			◐		
Total	8	13	5	14	3

Source: Families USA tracking based on conversations with state Medicaid and CHIP directors, as well as data from state health care experts, state budget documents, and news reports.

[a] Includes reducing eligibility levels, decreasing the length of the enrollment period, placing limits on enrollment, and requiring additional enrollment paperwork and fees.

[b] Includes eliminating benefits, as well as limiting or placing caps on services.

[c] Includes raising premiums and increasing co-insurance and copayments.

[d] Includes reducing reimbursement rates and delaying or eliminating enacted rate increases.

[e] Includes reducing program growth rates, reducing administrative costs, and implementing mandatory managed care. See "Other Types of Cuts" on page 16 for more details.

Table 2.

Number of People Cut from Medicaid and CHIP, Fiscal Years 2009 and 2010

State	Proposed Cuts		Enacted Cuts		Total
	Children	Adults	Children	Adults	
Arizona				4,500	4,500
California	160,000	430,000	260,000		850,000
Florida	n/a	40,000			40,000
Georgia	27,200	11,000			38,200
Nevada	140	4,640			4,780
Rhode Island				1,000	1,000
South Carolina				9,300	9,300
Tennessee		90,000			90,000
Total	**187,340**	**575,640**	**260,000**	**14,800**	**1,037,780**

n/a: not available

Source: Families USA tracking based on conversations with state Medicaid and CHIP directors, as well as data from state health care experts, state budget documents, and news reports.

Note: Numbers represent reported estimates of the number of people affected by eligibility reductions, enrollment freezes, and new policies that make it more difficult for people to apply for or retain Medicaid or CHIP. Timeframes and methodologies may vary.

Millions more will get less health care.

- As of November 2008, 13 states have enacted or are considering making reductions in the benefits that are covered by Medicaid or CHIP (see Table 2). Those states are California, the District of Columbia, Florida, Georgia, Maine, Massachusetts, Minnesota, Nevada, New York, Rhode Island, South Carolina, Tennessee, and Utah.
  - Benefit cuts vary from state to state. Among those cuts are the following:
    - Loss of access to dental care, vision care, and hearing services for adults in several states.
    - Seniors and people with disabilities in several states will be forced to stay in nursing homes instead of receiving services in the community or in their homes.
- The following five states have enacted or are considering increasing the out-of-pocket costs that low-income people must pay for health care in Medicaid or CHIP: California, Georgia, Maine, Rhode Island, and Vermont.

- So far, the most common type of Medicaid and CHIP cut that states have made is a reduction in how much providers who participate in the programs are paid for their services. Such provider rate cuts could mean that people enrolled in Medicaid and CHIP will have a harder time finding a health care provider to treat them.
  - The following 14 states have enacted or are considering reducing the rates that providers in Medicaid or CHIP are paid: California, the District of Columbia, Florida, Georgia, Illinois, Maine, Maryland, Massachusetts, Minnesota, Nevada, New Hampshire, New York, South Carolina, and Utah.

Increasing federal support for Medicaid and CHIP will provide direct aid to ailing state economies.

- An increase in federal funding for Medicaid through a temporary increase in the federal matching rate for Medicaid will have a measurable effect on business activity, jobs, and wages in *every state in the country* (see Table 3).
  - Based on the latest congressional proposal to increase the FMAP (S. 3689, sponsored by Senators Harry Reid and Robert Byrd), the following 10 states would receive the greatest increase in business activity: New York, California, Texas, Pennsylvania, Florida, Illinois, Ohio, Massachusetts, North Carolina, and New Jersey.
  - The 10 states that would receive the greatest number of additional jobs because of the temporary FMAP increase are New York, California, Texas, Florida, Pennsylvania, Ohio, Illinois, North Carolina, Massachusetts, and Michigan.
  - The 10 states that would receive the greatest increase in wages because of the temporary FMAP increase are New York, California, Texas, Florida, Pennsylvania, Ohio, Illinois, Massachusetts, North Carolina, and Arizona.
- CHIP brings in a significantly higher rate of federal matching funds than Medicaid. Therefore, state dollars that are spent on CHIP have an *even bigger* positive economic impact on state economies.

Table 3.

Effect on State Economies of Proposed Temporary Increase in Federal Medicaid Matching Payments (FMAP), October 2008 - December 2009*

State	Additional Federal Support for Medicaid *	Economic Benefits of Additional Federal Support		
		Business Activity	Jobs	Wages
Alabama	$418,720,000	$696,900,000	7,400	$253,700,000
Alaska	$145,921,000	$227,200,000	2,200	$83,000,000
Arizona	$925,907,000	$1,569,700,000	14,400	$590,500,000
Arkansas	$427,009,000	$667,400,000	7,300	$244,400,000
California	$4,192,805,000	$8,250,900,000	71,900	$2,932,700,000
Colorado	$339,414,000	$649,400,000	6,000	$230,000,000
Connecticut	$486,929,000	$805,100,000	7,000	$289,600,000
Delaware	$128,103,000	$191,700,000	1,400	$61,500,000
Florida	$1,861,834,000	$3,347,900,000	34,000	$1,250,400,000
Georgia	$708,943,000	$1,379,100,000	12,600	$484,300,000
Hawaii	$141,462,000	$237,500,000	2,300	$88,400,000
Idaho	$135,557,000	$218,200,000	2,500	$81,500,000
Illinois	$1,302,185,000	$2,572,800,000	22,800	$883,900,000
Indiana	$629,680,000	$1,083,400,000	10,800	$383,100,000
Iowa	$302,582,000	$485,000,000	5,400	$175,000,000
Kansas	$244,114,000	$403,900,000	4,100	$137,200,000
Kentucky	$520,356,000	$846,500,000	8,300	$292,400,000
Louisiana	$733,969,000	$1,200,800,000	13,500	$435,600,000
Maine	$228,930,000	$380,300,000	4,300	$143,900,000
Maryland	$631,480,000	$1,108,800,000	9,500	$381,500,000
Massachusetts	$1,274,276,000	$2,197,800,000	18,800	$779,500,000
Michigan	$935,375,000	$1,550,000,000	15,400	$578,000,000
Minnesota	$779,645,000	$1,368,900,000	12,800	$503,000,000
Mississippi	$423,051,000	$659,900,000	7,500	$237,900,000
Missouri	$807,845,000	$1,409,200,000	13,200	$461,700,000
Montana	$83,173,000	$132,700,000	1,600	$49,500,000
Nebraska	$180,367,000	$289,100,000	3,100	$103,900,000
Nevada	$174,947,000	$283,400,000	2,600	$103,600,000
New Hampshire	$124,884,000	$204,300,000	1,800	$69,800,000
New Jersey	$845,023,000	$1,574,000,000	12,700	$523,900,000
New Mexico	$370,022,000	$574,700,000	6,200	$212,000,000
New York	$5,246,764,000	$8,627,900,000	72,000	$2,988,000,000
North Carolina	$1,124,127,000	$1,945,600,000	20,200	$711,600,000
North Dakota	$66,930,000	$102,100,000	1,100	$35,800,000
Ohio	$1,417,069,000	$2,512,800,000	24,900	$897,100,000
Oklahoma	$453,426,000	$819,700,000	9,300	$297,400,000
Oregon	$372,659,000	$619,800,000	6,100	$222,100,000
Pennsylvania	$1,830,512,000	$3,402,300,000	30,400	$1,167,300,000
Rhode Island	$193,369,000	$306,700,000	2,800	$105,000,000
South Carolina	$404,109,000	$712,100,000	7,800	$254,800,000
South Dakota	$66,445,000	$100,400,000	1,100	$37,200,000
Tennessee	$815,422,000	$1,450,400,000	12,900	$507,000,000
Texas	$2,695,315,000	$5,409,700,000	51,400	$1,907,500,000
Utah	$175,094,000	$334,900,000	3,600	$120,600,000
Vermont	$117,916,000	$171,900,000	1,800	$63,600,000
Virginia	$599,485,000	$1,028,300,000	9,300	$353,100,000
Washington	$657,354,000	$1,179,700,000	10,900	$420,700,000
West Virginia	$270,282,000	$394,100,000	4,000	$137,700,000
Wisconsin	$568,463,000	$942,600,000	9,500	$347,500,000
Wyoming	$51,544,000	$71,400,000	800	$27,100,000

* Dollar estimates are from a Center on Budget and Policy Priorities analysis of S. 3689, introduced by Senators Reid and Byrd.

Source: Families USA calculations using the Bureau of Economic Analysis Regional Input-Output Modeling System (RIMS II).

DISCUSSION

Medicaid and CHIP Are Crucial during a Recession

Together, Medicaid and CHIP provide health coverage to tens of millions of low-income Americans, including close to 30 million children.[3] These programs give vulnerable Americans access to critical health care services, providing a safety net for people who have no other way to get health care. Such coverage is even more important during an economic downturn, when people lose employer-based health coverage because they lose their jobs or because it becomes too expensive.

As Table 1 shows, however, the Medicaid and CHIP programs in many states are in jeopardy because of the current economic downturn. This is not surprising, given the countercyclical nature of Medicaid and CHIP. Because eligibility for these programs is largely based on income, enrollment is highest during periods of economic decline. When the unemployment rate goes up by one percentage point, an additional 1 million people enroll in Medicaid and CHIP. This, in turn, increases costs for these programs by $3.4 billion, of which states are responsible for $1.4 billion.[4]

In fact, as early as 2007, when the economy was in significantly better shape, states saw a dramatic increase in the number of people–primarily children–who were enrolled in Medicaid. The U.S. Census Bureau reported that enrollment in Medicaid and CHIP increased by more than 1.2 million from 2006 to 2007.[5] In 2008, as the unemployment level has risen each month since April, the demand for these programs is likely to have grown significantly.[6] Indeed, states as disparate as California and Kentucky are reporting "unprecedented" numbers of applications for Medicaid and CHIP.[7]

Unfortunately, these increased costs come precisely when states are least able to afford them. During a downturn, income tax receipts fall as unemployment rises, reduced consumer activity translates into a drop in sales tax revenue, and the declining housing market greatly diminishes revenue from property taxes. A one percentage point increase in the unemployment rate causes state general fund revenues to drop by 3 to 4 percent.[8] The National Governors Association and the National Conference of State Legislatures estimate that, for the budgets for fiscal years 2009 and 2010, states face a cumulative deficit of more than $140 billion.[9]

Because almost every state is constitutionally required to balance its budget,[10] governors and state legislators are forced to look for places to reduce spending as revenue declines. Often, such calculations involve examining the feasibility of cutting Medicaid and CHIP, as these programs account for a significant share of any state's budget. However, while Medicaid and CHIP are obvious sources of spending in state budgets, they are difficult

programs to cut. Program cuts result in loss of access to health care for vulnerable people, which can have adverse health consequences in the short term, and which can actually lead to increased health care costs in the long term.[11] But perhaps what is even more germane, from a budgeting standpoint, is that, when states cut Medicaid or CHIP, they also lose significant federal funding. For every dollar a state cuts from its Medicaid or CHIP program, it saves only between 17 and 50 cents in state fund, but it loses between 50 and 83 cents in federal funding and the economic stimulus that results from those federal funds. Thus, cutting Medicaid or CHIP is a counterproductive way to reduce state spending.

The Scope of the Enacted and Proposed Cuts

Despite the fact that cutting their Medicaid and CHIP programs means losing federal funding, at least 19 states are proposing or have already enacted cuts to these programs for FY 2009 and/or FY 2010 (Table 1). These early cuts are evidence of the deep impact that the recession is already having on states.

These cuts include actions that will erect barriers to obtaining care for current enrollees, as well as actions that will make it harder for uninsured people to get Medicaid or CHIP coverage. This list of cuts was comprehensive at the time this report was written. However, states are proposing more cuts with each passing week, as governors and state legislators grapple with budget deficits, rising unemployment, and the need to balance next year's budgets. Indeed, the cuts discussed here are likely only the tip of the iceberg in terms of the Medicaid and CHIP cuts that will take place in the period immediately ahead.

- **Cuts in Eligibility and Enrollment**

  One of the most dramatic ways states can reduce Medicaid and CHIP spending is to control the number of people who can be covered in these programs. States can directly reduce the income limit for eligibility, or they can enact policies that make it harder for families to enroll or keep coverage (such as increasing documentation requirements or requiring more frequent renewals). In CHIP, states can close enrollment completely (an enrollment "freeze") or limit the number of children who can enroll in the program and close enrollment when that number is reached (an enrollment "cap").[12] Five states have already enacted eligibility and/or enrollment cuts; two of them are currently considering additional cuts, and three more states are weighing eligibility and/or enrollment cuts.

  - **Arizona** instituted a requirement that adults reapply for Medicaid every six months rather than annually, starting in FY 2009. This provision is expected to result in the loss of coverage for more than 4,500 adults.[13]

- **California** instituted a new requirement that children reapply for Medi-Cal (its Medicaid program) every six months rather than annually. The state's Department of Health Care Services estimates that more than 260,000 children will lose coverage by the end of 2011 due to the new paperwork requirement.[14] The state also delayed implementation of a new streamlined enrollment process for FY 2009 that would have made it easier for children to enroll in Medi-Cal or Healthy Families (its CHIP program).

  Governor Schwarzenegger is now proposing further eligibility and enrollment reductions for FY 2009 and FY 2010. Income eligibility for parents would be reduced from approximately 100 percent of the federal poverty level to 72 percent of poverty (from $17,600 to $12,600 for a family of three in 2008). In addition, he has proposed reinstituting an old provision that would make parents who work more than 100 hours per month ineligible for Medi-Cal. He is also proposing to drastically reduce Medicaid and CHIP coverage for immigrants.[15] The state's Department of Health Care Services estimates that about 430,000 parents will lose coverage by 2011 due to the lowered income eligibility limit.[16]

  Finally, the state CHIP agency (MRMIB) is proposing to freeze enrollment in Healthy Families to fill a $17.2 million gap in the program's budget. This would leave more than 160,000 children on a waiting list for health care.[17]

- **Florida** funded care for 40,000 people who are "medically needy" (people whose medical bills take up the vast majority of their income) or who qualify for a special Medicaid waiver program for the elderly and people with disabilities with one-time funding from the state's tobacco settlement fund in its FY 2009 budget. However, the same budget also included language that eliminates coverage for these individuals in FY 2010.[18] In addition, Governor Crist has requested that all government agencies supply him with their plans to cut 10 percent from their budgets. In its list, the Agency for Health Care Administration included eliminating Medicaid coverage for 19- and 20-year-olds, eliminating coverage for pregnant women and children who qualify as medically needy, and reducing the regular Medicaid eligibility level for pregnant women from 185 percent of poverty to 150 percent of poverty (from $32,560 to $26,400 for a family of three in 2008).[19]

- **Georgia** originally avoided making significant cuts to Medicaid or PeachCare (its CHIP program) in its FY 2009 budget. But in September, Governor Perdue required every agency to adopt immediate budget cutting measures. Medicaid and PeachCare were subject to an immediate 5 percent reduction, which amounted to approximately

$114 million for each of FY 2009 and FY 2010.[20] The FY 2009 reductions did not include eligibility and enrollment cuts, but the state's Department of Community Health could be forced to make drastic enrollment reductions in FY 2010. In FY 2010, the state will either have to extend a "Quality and Assessment" fee that it now charges only some managed care organizations that participate in Medicaid to all managed care organizations that participate in Medicaid, or stop charging that fee altogether. This fee will largely fill the anticipated Medicaid and PeachCare budget shortfalls. If the state does not extend that fee, the state agency has outlined a host of dramatic cuts that will eliminate coverage for thousands of people. Those cuts include eliminating Medicaid coverage for 600 foster children between the ages of 19 and 20, eliminating coverage for 11,000 people whose medical bills take up the vast majority of their income (the medically needy), and eliminating coverage for more than 3,000 children in the "Katie Beckett" category of Medicaid. This category allows children with severe disabilities to qualify for Medicaid and receive care at home rather than being in an institution away from their families. The proposal would also roll back eligibility for PeachCare from 235 percent of poverty to 200 percent of poverty (from $41,360 to $35,200 for a family of three in 2008), and it would reduce the number of children who could enroll in the program. There are currently more than 23,600 children enrolled in PeachCare who fall into this income group.[21]

- **Nevada**'s Governor Gibbons has requested that all state agencies provide him with a plan for reducing expenditures for FY 2010. In response, the Department of Health and Human Services Division of Health Care Financing and Policy has proposed eliminating a Medicaid waiver program that currently provides coverage to approximately 100 pregnant women, reducing Medicaid eligibility for elderly and disabled individuals in need of institutional care (leaving almost 300 individuals without coverage), eliminating Medicaid coverage for 4,340 adults and 146 children in working families by June 2011, and capping Nevada Check Up (its CHIP program) at 25,000 children. Enrollment in the program as of October 2, 2008, was 24,100. With unemployment continuing to grow, enrollment in Nevada Check Up will likely hit the cap soon.[22]
- **Rhode Island** reduced its Medicaid income eligibility limit for parents from 185 percent of poverty to 175 percent of poverty (from $32,560 to $30,800 for a family of three in 2008) for FY 2009. As a result, approximately 1,000 parents lost coverage in RIteCare (its Medicaid program).[23]

- **South Carolina** reduced the duration of "Transitional Medical Assistance" (which provides Medicaid coverage to families who have moved from welfare to work) from 24 months to 12 months for 5,600 people who earn less than the federal poverty level ($17,600 for a family of three in 2008). It also eliminated coverage for at least 3,700 aged, blind, or disabled individuals by reducing the monthly income limit by $30.[24]
- **Tennessee**'s Governor Bredesen has proposed imposing new, onerous reapplication requirements on about 180,000 people in TennCare (its Medicaid program). He expects that these new requirements will cause as many as 90,000 TennCare enrollees to be dropped from the program, which would cut state spending by as much as $200 million for the current fiscal year.[25]

Cuts in Benefits

Another way that states can reduce their Medicaid and CHIP costs is by limiting coverage for health care services for people who are enrolled in the programs. States can cut so-called "optional" Medicaid benefits, such as dental and vision services, prescription drugs, or therapies (physical therapy, speech therapy, etc.). They can also cut similar services from their CHIP benefit package.[26] In addition, they can place limits on the number of visits or dollar amounts they allow for services in Medicaid and CHIP.

Because states spend a significant amount of money on prescription drugs in Medicaid, one common way to reduce spending is to contain costs for prescription drugs. Many states have adopted "preferred drug lists" that prioritize access to certain prescription drugs over others. Creating such a list allows states to limit access to more expensive drugs, but it can also make it more difficult for individuals who need those drugs to get them.

Reducing benefits can have severe consequences for people who need these services. Most enrollees will have no other way of obtaining these services and will simply go without them, with potentially life-threatening consequences.

Thirteen states have enacted or are currently considering reductions to their Medicaid or CHIP benefits:

- **California** enacted a cap on Healthy Families (its CHIP program) dental benefits for FY 2009.[27] Governor Schwarzenegger recently announced a proposal to eliminate coverage of dental care, podiatry services, vision care, chiropractic services, incontinence creams and washes, acupuncture, audiology services, speech therapy, and psychology services for adult Medi-Cal (its Medicaid program) beneficiaries for the remainder of FY 2009 and for FY 2010.[28]

- **District of Columbia** limited the health care services that individuals who are covered under certain home- and community-based Medicaid waiver programs can receive in their home or in a community setting in FY 2009.[29]
- **Florida** moved 27,000 Medicaid enrollees from its primary care case management program into managed care in its FY 2009 budget. This move will leave beneficiaries without a primary care provider who is paid specifically to help them coordinate their medical care, which is essential for this population. In October 2008, the Agency for Health Care Financing proposed further cuts in response to Governor Crist's request to cut the agency's budget. This proposal includes eliminating adult vision, hearing, and dental services for FY 2010.[30]
- **Georgia** reduced the number of people who could participate in home- and community-based care programs in FY 2009. These programs allow the elderly and people with disabilities to receive care in the community rather than in an institution. The lack of funding for additional slots means that many will remain on a waiting list for these services.

  The state may consider eliminating dental benefits for pregnant women in Medicaid and children covered by PeachCare (its CHIP program) for FY 2010.[31]
- **Maine**'s Governor Baldacci issued an executive order in November 2008 requiring state agencies to adopt immediate budget reductions. In response, the state Department of Health and Human Services developed a list that includes reducing the benefit package for parents with incomes between 100 and 200 percent of poverty (between $17,600 and $32,200 for a family of three in 2008) who are enrolled in MaineCare (its Medicaid program) for FY 2009.[32] The specific services to be dropped have not yet been identified.
- **Massachusetts** cut funding in FY 2009 for the Community First Initiative Medicaid waiver, which would have allowed elderly and disabled beneficiaries to move out of nursing homes and be treated in community-based settings.[33]
- **Minnesota** capped enrollment for the Minnesota Disability Health Options Medicaid waiver program, which provides coordination of medical care for people with disabilities. For FY 2009, the state also capped its Community Alternatives for Disabled Individuals waiver and its Traumatic Brain Injury waiver, both of which allow people with disabilities to be cared for in a community setting rather than a nursing home or institution.[34]
- **Nevada** eliminated Medicaid adult vision services and severely limited coverage for personal care services for people with severe disabilities in FY 2009. As part of the same budget, it reduced coverage for dental services and eliminated coverage for vision

and orthodontic services in Nevada Check Up (its CHIP program) for FY 2009. In its FY 2010 budget request, the state agency is proposing to continue all of these cuts.[35] In addition, in order to save money in FY 2009, the Nevada legislature is proposing to expand its preferred drug list to include anticonvulsant medications, antirejection medications (for transplant recipients), antidiabetic medications, antihemophilic medications, antipsychotic medications (for the mentally ill), and HIV medications. These cuts could mean reduced access to vital prescription medications for people who are very ill.

- **New York**'s Governor Paterson is proposing to add antidepressants to its Medicaid preferred drug list for FY 2009 and FY 2010.[36]
- **Rhode Island** limited coverage for prescription drugs to generics for FY 2009.[37] Rhode Island is currently negotiating a waiver with the Centers for Medicare and Medicaid Services (CMS) that would allow the state to establish a much more stringent standard that individuals must meet before qualifying for long-term care and to turn people away who do not meet that standard if the state is short on funds. It is also proposing to expand the classes of prescription drugs that are subject to the preferred drug list to include antipsychotic medications.
- **South Carolina** enacted a limit on prescription and refill quantities for all children and adults in its Medicaid program to a maximum 31-day supply, and it limited the ability of adults to receive medically necessary prescriptions above this cap for FY 2009.[38] It also capped its Community Choices waiver, which provides home and personal care services to the elderly and people with disabilities. Capping this waiver means that individuals will be put on a waiting list for these services.
- **Tennessee** limited private duty nursing services in FY 2009 for adults aged 21 or older who are ventilator-dependent or who have a functioning tracheotomy and need certain other kinds of nursing care.[39] The state also placed limits on the number of hours a person can receive services provided by a home health aid or nurse.[40]
- **Utah** eliminated Medicaid coverage of occupational therapy, physical therapy, speech and hearing services, vision care, and chiropractic services for the remainder of FY 2009 and for FY 2010.[41]

Increases in Cost-Sharing

A small number of states are considering increasing how much people must pay out of pocket to participate in Medicaid or CHIP or to get health care services. Increasing cost-sharing does not actually raise much revenue for states—it saves money because people are simply more likely to delay or forgo services, or they are unable to pay their new,

higher premiums and therefore lose their coverage altogether.[42] In the short term, denying care to patients may save money, but those who go without needed care may eventually end up in the emergency room with complicated, costly conditions that could have been prevented with proper medical attention. The detrimental effects of imposing even modest cost-sharing on low-income people are well-documented.[43] So far, five states have enacted or are proposing increased cost-sharing in Medicaid or CHIP.

- **California** increased the monthly premiums for children in its Healthy Families (CHIP) program by $2-3 per child.[44] Governor Schwarzenegger is proposing to require new cost-sharing for aged, blind, and disabled Medi-Cal (Medicaid) enrollees whose annual incomes are between 100 percent and 127 percent of poverty (between $10,400 and $13,200 for a single adult in 2008). This cost-sharing would be in effect for the remainder of FY 2009 and for FY 2010.[45]
- **Georgia**'s Department of Community Health, in response to a request from Governor Perdue to reduce spending by 5 percent in FY 2010, is proposing to increase PeachCare (its CHIP program) premiums by 10 percent and to start charging premiums for children between the ages of two and five.[46]
- **Maine** enacted an annual $25 enrollment fee for each parent in families with incomes above 150 percent of poverty ($26,200 for a family of three) in FY 2009 in MaineCare (its Medicaid program).[47]
- **Rhode Island** increased premiums for families with incomes between 150 percent and 250 percent of poverty (between $26,400 and $44,000 for a family of three in 2008) from 3 percent of income to 5 percent in its FY 2009 budget. This increased cost-sharing is expected to cause nearly 300 families to lose RIteCare (its Medicaid program) coverage.[48] In addition, the state is currently negotiating a waiver with CMS that would allow it to increase cost-sharing even more for families with incomes above 150 percent of poverty, to institute a $45 monthly premium for families with incomes between 133 percent ($23,408 for a family of three in 2008) and 150 percent of poverty, and to charge new copayments for families with incomes below 133 percent of poverty.
- **Vermont** increased Dr. Dynasaur (its CHIP program) premiums from $40 to $60 per household per month for families with incomes between 225 percent and 300 percent of poverty (between $39,600 and $52,800 for a family of three in 2008) in FY 2009. The Department for Children and Families was given the authority to further increase the premium to $72 for these families if it deems it necessary to do so for budgetary reasons.[49]

Cuts in Payments to Providers

The most common type of cut that states have already enacted is a reduction in provider reimbursement rates. Fourteen states have enacted such cuts, and six of them are considering additional provider cuts. Although reducing provider payments does not directly reduce coverage for people in Medicaid and CHIP, reducing provider rates can reduce access to care if fewer providers choose to participate in Medicaid or CHIP, or if participating providers reduce the number of patients they will accept.[50] In some areas of the country, and for some specialties, it can already be difficult to find a provider who accepts Medicaid patients, and cutting provider payments will only make it more difficult for enrollees to get the services they need.

- **California** reduced payments in FY 2009 to providers and hospitals that serve a large number of Medicaid enrollees. For the remainder of FY 2009 and for FY 2010, Governor Schwarzenegger is proposing to reduce public hospital funding by $57.9 million dollars.
- **The District of Columbia** postponed a FY 2009 planned increase in primary and specialty care reimbursement rates until April 2009.[51]
- **Florida** reduced Medicaid FY 2009 funding for pharmacies, non-emergency transportation, behavioral health services, inpatient and outpatient hospital services, and Medicaid HMOs. The state also reduced reimbursement rates and placed a freeze on staffing standards for nursing homes, which will likely lead to staff layoffs and delays in maintenance on facilities. In addition, administrative fees for doctors participating in MediPass (a primary care case management program) were cut by one-third. Finally, the state froze KidCare (its CHIP program) reimbursement rates to providers.[52]

  For FY 2010, the Agency for Health Care Administration has proposed to further cut payments to hospitals, nursing homes, HMOs, and health departments in response to Governor Crist's request that the Agency reduce Medicaid expenditures.[53]
- **Georgia** delayed FY 2009 Medicaid and PeachCare (its CHIP program) provider payment increases until July 2009. For FY 2010, the Department of Community Health has indicated that it may need to continue the delay in provider payment increases, as well as reductions in Medicaid reimbursements for injectable drugs and durable medical equipment.[54]
- **Illinois** lengthened the amount of time that it takes to pay health care providers such as doctors, pharmacies, nursing homes, and hospitals for Medicaid services in FY 2009. The backlog of unpaid bills totals almost $4 billion and could reach $5 billion early next year.[55]

- **Maine**'s Department of Health and Human Services, in order to implement Governor Baldacci's executive order to immediately reduce the agency's budget, plans to cut Medicaid reimbursement rates for care management services for individuals who receive home care services.[56]
- **Maryland** cut Medicaid payments to nursing homes for services provided to the elderly and disabled to fill a FY 2009 mid-year budget gap.[57]
- **Massachusetts** reduced Medicaid payments to providers by more than $200 million to fill a FY 2009 mid-year budget gap.[58]
- **Minnesota** reduced its Medicaid spending by $25 million by cutting payment rates and delaying payments for hospitals, and by cutting reimbursement to pharmacies. In addition, the state delayed expected rate increases of $13.3 million for long-term care providers and nursing homes. These cuts were enacted to fill a budget gap in FY 2009, and the state is proposing to continue these reductions and delays for FY 2010.[59]
- **Nevada** cut Medicaid payment rates for hospitals by 5 percent and eliminated a planned rate increase for physicians for FY 2009. For FY 2010, the state agency has proposed continuing these rate cuts, imposing an additional 5 percent rate cut on hospitals, and reducing the hourly rate for personal care attendants (PCAs).[60]

  As a result of these cuts, some specialists, including nearly all pediatric orthopedic surgeons, have dropped Medicaid patients, and the University Medical Center (UMC) in Las Vegas is closing down a number of programs, including high-risk obstetrics, prenatal care, outpatient oncology, and outpatient dialysis. UMC is the sole source of care for Medicaid enrollees in the Las Vegas area for some of these services.
- **New Hampshire** reduced payments for inpatient and outpatient hospital services, nursing homes, behavioral health providers, and providers who treat people with disabilities.[61]
- **New York** reduced payments to Medicaid managed care organizations and managed long-term care insurers for FY 2009.[62] Governor Paterson is proposing additional cuts to fill budget gaps for FY 2009 and FY 2010, including a freeze on scheduled Medicaid provider rate increases for the rest of calendar years 2008 and 2009, as well as a reduction in reimbursements for pharmacies, hospitals, nursing homes, home health agencies, long-term care services, and adult day transportation.[63]
- **South Carolina** cut its FY 2009 payment rates to providers, including nursing homes, by approximately $12 million.[64]
- **Utah** reduced its payments to providers and HMOs, and it rolled back the increase that providers were to get for inflation for FY 2009 and FY 2010.[65]

Other Types of Cuts

Not all Medicaid and CHIP cuts can be neatly categorized. In some cases, a governor may have announced a reduction in spending, but the state agency has not yet had time to announce what policy change will implement that reduction. In other cases, the state may have identified a reduction that did not fit neatly into the above categories.

- **Kansas:** The Kansas Health Policy Authority announced that it planned to cut $3.6 million from the CHIP program to close a mid-year gap for FY 2009. However, since that announcement was made, the Authority has been reviewing its budget and may announce additional cuts. The Authority and Governor Sebelius are currently working on a specific plan to achieve sufficient spending reductions.[66]
- **Rhode Island** instituted mandatory managed care for children in foster care, children with adoption subsidies, and children who receive coverage under the Katie Beckett waiver in FY 2009.[67] In addition, the state is asking the federal government for additional Medicaid funds "up front" in exchange for an agreement that would put a "hard cap" on the amount of federal Medicaid funding the state could spend over a five-year period. Essentially, Rhode Island is asking the federal government if it can turn its Medicaid program into a block grant (rather than an entitlement). This would have a serious detrimental effect on Rhode Islanders in the future.
- **Tennessee's** Governor Bredesen announced unspecified cuts of up to $400 million to the TennCare (Medicaid) program to fill budget gaps in the current and next fiscal years.[68]

Lost Opportunities

In addition to cutting current Medicaid and CHIP programs, several states are also delaying plans to expand children's health coverage due to the confluence of the fiscal crisis, uncertainty about CHIP reauthorization and funding levels after March 31, 2009 (when the current federal authorization for the program expires), and harmful policies promulgated by the Bush Administration.[69] (This information is not included in Table 1.)

- **North Dakota** has not implemented its planned Healthy Steps (the state's CHIP program) expansion from 140 percent to 150 percent of poverty.
- **Iowa** and **Kansas** have children's coverage expansions planned for 2009 that can only proceed if CHIP is reauthorized with adequate federal funding.
- Still other states, like **New York** and **Wisconsin**, are using scarce state dollars to fund children's coverage expansions without federal support. These states moved forward after the Bush Administration refused to provide federal funding for these expansions in 2007.

Lack of federal support for expansions of children's health coverage has meant that children who otherwise would have had health coverage and access to critical health care services have been left uninsured. State action to correct this problem has been hampered by the failure of legislation to reauthorize and expand CHIP, which included additional funding for states to expand coverage for uninsured children. Moreover, expansion efforts in some states have been blocked by the Bush Administration. For more information about these harmful policies, see *Detour on the Road to Kids Coverage* (available on our Web site at http://www.familiesusa.org/assets/pdfs/detour-kids-coverage.pdf).

Medicaid, CHIP, and State Economies

■ Increasing Support for Medicaid

While Medicaid's role in providing critical health care services is clear, what is often overlooked is the unique role that Medicaid plays in stimulating state business activity and state economies. Every dollar a state spends on Medicaid pulls new federal dollars into the state—dollars that would not otherwise flow into the state. These new dollars pass from one person to another in successive rounds of spending. For example, health care employees spend part of their salaries on groceries, which adds to the income of grocery store employees, enabling them to spend part of their salaries on new shoes, which enables shoe store employees to spend additional money on home improvements, and so on. The new dollars pass from one person to another in successive rounds of spending, generating additional business activity, jobs, and wages that would not otherwise be produced. Economists call this the "multiplier effect." The magnitude of the multiplier effect varies from state to state, depending on how the dollars are spent and on the economic structure of, and conditions in, the state.

In early December, the National Governors Association met with President-elect Obama and asked for $40 billion in aid for state Medicaid programs. The President-elect and his transition team have indicated that aid to states for Medicaid is something that they would support in the next economic recovery package.[70] Congressional intent is also clear; multiple pieces of legislation have been introduced in 2008 to increase the FMAP, and each bill has grown successively larger in the amount of support it provides as the true scope of the economic crisis (and hence, state need) becomes increasingly apparent. The most recent bill (S. 3689) was introduced by Senators Reid and Byrd in November and, although it was not considered on the Senate floor, it would have increased each state's matching rate by eight percentage points for five quarters, costing an estimated $37.8 billion—close to the governors' request. Table 3 shows the economic impact the Reid-Byrd bill would have had on each state in terms of new business activity, jobs, and wages. A detailed methodology is available upon request.

During the last significant economic downturn in 2003, Congress included an FMAP increase in its economic stimulus package. As a condition of receiving this additional support, states were not allowed to reduce their Medicaid eligibility levels. These funds were a vital source of economic support at that time, helping state economies ride out the downturn *and* helping the most vulnerable families obtain and keep Medicaid coverage. Many states may not have to make the cuts that they are currently considering (or indeed, may not be permitted to make them, in the case of eligibility changes) if this Congress is expeditious in passing an economic recovery package in January that includes an increase in federal funding for Medicaid.

Increasing Support for CHIP

The 111th Congress will inherit a crucial piece of unfinished business from its predecessors: reauthorizing the State Children's Health Insurance Program. Although Congress passed legislation to do just that on two occasions in 2007, President Bush vetoed these bills, and the program was temporarily extended until the end of March 2009. CHIP is an extremely successful and popular program that the vast majority of policy makers believe should continue. Reauthorization *must* happen as quickly as possible in the new year, and it belongs in the economic recovery package.

State policy makers are now formulating their budgets for next year, and they face great uncertainty about how much funding will be available for CHIP. Reauthorization should provide states with significant new federal funding—as the bills passed in 2007 did—and should reauthorize the program for five years. Less funding or a shorter time frame would almost guarantee mounting cuts to the program over the next year. State policy makers need to know that federal funding for the program is sufficient and stable in order to plan their budgets for the coming years.

It is most appropriate that the first legislative opportunity to reauthorize CHIP in the new year will likely be the economic recovery package, because increasing federal support for CHIP will also have a directly stimulative effect on state economies. Just like Medicaid, CHIP draws down additional federal dollars—between $1.86 and $4.91 for every dollar of state spending. As these new dollars enter and circulate through state economies, they contribute to the multiplier effect described earlier with respect to Medicaid. CHIP served more than 7 million children in 2007,[71] and it could cover a large portion of the nation's 8.6 million uninsured children, but only if the program is reauthorized before states are forced to make massive cuts during their legislative sessions (many of which end by March).

CONCLUSION

Congress must act quickly, both to help states recover from the economic crisis and to help working families who are struggling to make ends meet. Both of these goals are served by providing states with a significant, temporary increase in the federal matching rate for Medicaid, coupled with a full reauthorization of the State Children's Health Insurance Program.

Medicaid and CHIP have always been state-federal partnerships; both state and federal policy makers share in the responsibility of designing the programs and funding them. But, unlike the federal government, most state governments must balance their budgets each year. This makes paying for Medicaid and CHIP during economic downturns particularly difficult. The federal government can play—and in the past, *has played*—an important role in shoring up states during fiscal downturns so that states do not have to make harmful cuts. This January, when the 111th Congress convenes, the first order of business is likely to be passing an economic recovery package. This package can simultaneously boost state economies *and* protect health coverage for low-income families by including two things:

- A temporary increase in the federal Medicaid matching rate, or FMAP; and
- A five-year reauthorization of CHIP, with a significant increase in federal funding.

In this time of economic crisis, working families need Medicaid and CHIP more than ever. Moreover, expanding Medicaid and CHIP would help states recover from this economic crisis more quickly.

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