# Medicaid's Vital Role in Addressing Health and Economic Emergencies

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**SUMMARY**. Medicaid plays an essential role in helping states respond to crises. Medicaid guarantees federal matching funds to states, which helps with unanticipated costs associated with public health emergencies, like COVID-19, and increases in enrollment that inevitably occur during times of economic downturn. Medicaid's joint federal/state structure, called cooperative federalism, gives states significant flexibility within federal rules that allows states to streamline eligibility and expand benefits, which is especially important during emergencies. Federal emergency declarations give the secretary of Health and Human Services temporary authority to exercise regulatory flexibility to ensure that sufficient health care is available to meet the needs of those impacted. Under federal guidance, states have implemented a variety of options to respond to the COVID-19 pandemic. In addition, Congress enacted short-term legislative responses that increase federal funding for Medicaid and open new pathways for eligibility and payment for some COVID-19 testing. These responses have softened the double blow of the pandemic and its attendant recession, but more federal and state action is necessary. Congress should enact an increase in federal funding that lasts beyond the public health emergency to help states ride out the economic impact of the pandemic; provide extra funding to encourage states to adopt Medicaid expansion; offer states more funding for enrollment efforts to reach newly uninsured populations; and require state and local demographic data collection as a condition of federal funding to inform evidence-based public health efforts. State governments should use all available emergency flexibility options to streamline application and enrollment processes and take advantage of increased federal funding possibilities.

## Key Features of Medicaid

Medicaid is a 55 year old federal-state program that offers federal funds to states to cover medical care for low-income individuals, including children, parents, people with disabilities, and the elderly. Congress designed Medicaid to address poor patients' needs, prescribing benefits and protections that secure both coverage and care. In 2010, the Patient Protection and Affordable Care Act (ACA) expanded Medicaid coverage to other nonelderly adults, though the Supreme Court made expansion optional in 2012 by deciding that mandatory expansion was unconstitutionally coercive ("National Federation of Independent Business v. Sebelius," 2012). Medicaid expansion has narrowed persistent coverage gaps for low wage workers who are less likely to be offered employer sponsored insurance. Medicaid expansion also narrowed insurance coverage gaps for people of color between 2013-2017, closing the gap between Black and white populations from 11 to 5.3 percentage points, and between Hispanic and non-Hispanic white populations from 25.4 to 16.6 percentage points (Chaudry et al., 2019).

To receive federal matching funds, states agree to abide by federal law, which establishes Medicaid's purpose and structure and requires that states implement mandatory features that sustain Medicaid's role as the nation's safety net. Within that federal structure, states have significant flexibility to make health policy choices that further the purposes of the program. Many state preferences are implemented by exercising optional elements that allow states to do more than baseline federal law requires, such as providing expanded eligibility, additional benefits (including prescription drugs), and use of managed care. Many options can be exercised by submitting a "state plan amendment" (SPA), which describes how a state will implement existing features of federal law and requires only cursory review by the Department of Health and Human Services (HHS). In addition, states may also seek waivers from the secretary of HHS to use Medicaid funds to pay for services not otherwise authorized by federal statute and regulations. Under Section 1115 of the Social Security Act, the secretary of HHS can approve waivers for state applications that seek to further the purposes of the Medicaid program through "demonstration projects" that last for a limited period of time.

Section 1915(c) gives the HHS secretary authority to waive statutory and regulatory requirements to operate home and community based (HCB) long term services and support programs.

Four core features are important for understanding Medicaid's flexible, crucial role in an emergency. First, unlike commercial insurance, Medicaid has unique eligibility rules; these include continuous open enrollment that make coverage available at the moment it is needed; eligibility based on income at the point-in-time of application; retroactive coverage for the three months prior to the date of application (for those who would have been eligible); and the option of presumptive eligibility, which allows access to care during the process of documenting eligibility. Second, Medicaid coverage is comprehensive, providing a wider range of benefits, including long term care, that other payers such as Medicare and commercial insurers do not cover. Third, Medicaid strictly limits beneficiary out-of-pocket payments to ensure that costs are not a barrier to coverage or care, and most patients cannot be refused care or lose coverage if they are unable to pay. Fourth, Medicaid contains due process protections and structural safeguards. For example, beneficiaries are entitled to notice before services are reduced or discontinued. Medicaid is a statutory entitlement for beneficiaries and for states.

States are guaranteed uncapped federal matching funds to help cover the cost of all approved Medicaid services and administration. The Federal Medical Assistance Percentage (FMAP) ranges from 50% to 83% for most services and is based in part on the per capita income of each state, so states with lower incomes relative to the national average have the highest federal match. The FMAP formula reflects states' differing capacity to fund Medicaid, which is usually the second biggest item in a state budget (behind education).

Medicaid spending is also countercyclical. It increases when the economy is weak and more people enroll and decreases when the economy recovers. Federal FMAP support is essential to help states weather recessions and emergencies, because the same events that spark increased enrollment also cause reduced state tax revenue and put pressure on states to cut enrollment, services, or payment to reduce their Medicaid costs. Notably, most state constitutions require balanced budgets, so states rely on the federal government's ability to deficit spend during economic downturns.

States' FMAPs are recalculated annually based on the most recent three years of state per capita income relative to the national average; so, FMAPs for 2020 are based on calendar years 2015-2017. This means that the FMAP formula alone cannot generate immediate relief in a crisis.

Realizing this, Congress has often temporarily increased the federal match by several percentage points (enhanced FMAP or "eFMAP") to help states through economic crises. For example, the Jobs and Growth Tax Relief Reconciliation Act of 2003 increased the FMAP by 2.95 percentage points for five quarters to address the relatively mild downturn of 2001. The American Recovery and Reinvestment Act of 2009 (ARRA) helped states through the more disruptive Great Recession by providing a minimum eFMAP increase of 6.2 percentage points plus additional state-specific bumps tied to unemployment rates for nine quarters. In 2010, the ARRA eFMAP increase ranged from 6.94 to 13.87 percentage points across states (KFF, 2011). In return for the eFMAP, both laws imposed a "maintenance of effort" requirement so that states could not cut eligibility during the downturns.

Since 2017, one of the most contentious issues for Medicaid has been the Trump administration's novel policy of encouraging states to use Section 1115 demonstration waivers to impose new requirements to make it more difficult for adults eligible under the ACA Medicaid expansion to enroll. HHS has approved waivers allowing 10 states to impose work reporting requirements and other barriers to enrollment including eliminating retroactive eligibility, imposing enforceable premiums, and more frequent eligibility renewal (KFF, 2020). So far, courts have struck down work requirement waivers because HHS failed to consider the decreased coverage they would cause. In Arkansas, the only state to implement such a waiver, 18,000 people (about 25% of those subject to the work requirement) lost coverage in the first five months (*Gresham v. Azar,* 2020).

Despite such attempts to thwart Medicaid expansion and the ACA, over 400 studies show that Medicaid as a whole, and the expansion provided by the ACA in particular, safeguards coverage and access to care for low-income individuals. Medicaid expansion is a crucial tool in improving both individual and public health that addresses social determinants of health and entrenched disparities in health, improving coverage, access, and health for Black and other communities of color, as well as stabilizing state budgets (Guth et al., 2020). Prior to the pandemic, 36 states and the District of Columbia expanded Medicaid eligibility under the ACA. The 14 states that had not expanded before the pandemic began faced an insurance coverage gap exceeding two million people before the pandemic, a number that is steeply increasing as the pandemic progresses and could reach more than 20 million uninsured depending on the pace of the unemployment rate (Garrett & Gangopadhyaya, 2020). These choices are particularly important for communities of color, which are infected and dying at higher rates from COVID-19 (Oppel et al., 2020).

As uninsurance has skyrocketed during the pandemic, nonexpansion states' preexisting health and economic disparities have deepened due to the confluence of the pandemic, the sudden recession it created, and the disparate impact on low-income populations (see Chapter 14 discussing the uninsured). The Congressional Budget Office predicts the national unemployment rate will reach 16% in 2020 and will average at least 10.1% through 2021 (Swagel, 2020). Nonexpansion states' residents tend to depend on sectors that have been hit hard by the recession such as agriculture, retail, and other low-wage jobs, which are less likely to provide employment benefits like health insurance. These same states experience high levels of chronic diseases and other health disparities that inflame the impact of the novel coronavirus.

In short, Medicaid's cooperative federalism structure allows states great flexibility in designing their program, which leads to variable

coverage and benefits across states, which in turn exacerbates disparities in coverage, access to care, and health outcomes. Further, nonexpansion states cannot respond to the novel coronavirus effectively because they are missing a vital tool.

## Medicaid's Role in the COVID-19 Pandemic

### Immediate Response – Medicaid's Flexibility Allowed States to Quickly React

The secretary of HHS declared a COVID-19 public health emergency (PHE) effective January 27, 2020, which triggered special authority for HHS to issue emergency grants, enter into contracts, access emergency funds, and increase regulatory flexibility. Separately, the president declared a national emergency effective March 1, 2020, which made additional federal money available. The two declarations permitted the secretary of HHS to issue emergency-related waivers under Section 1135 of the Social Security Act.

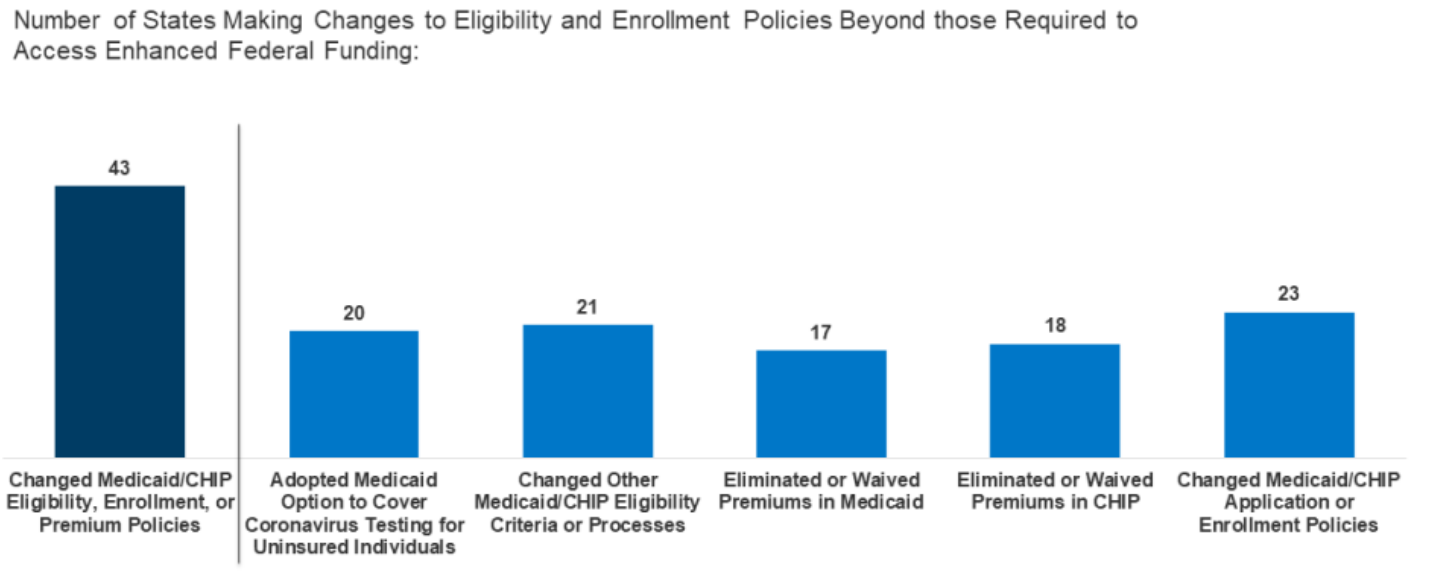
For the duration of the PHE, HHS and states have both their usual and additional Medicaid flexibility to respond to the crisis:

- **Section 1135** of the Social Security Act authorizes the HHS secretary to waive or modify certain Medicaid requirements at a state's request to ensure that sufficient health care services and providers are available during an emergency.
- States with Section 1915(c) waivers for home and community based (HCB) long term care services and supports, which help people to avoid nursing homes and other institutionalization, can quickly get approval to amend those waivers with an **Appendix K** emergency preparedness response request. HHS developed this standalone guidance specifically to help states identify existing Section 1915(c) authority of use during emergencies.
- **Disaster Relief SPAs** allow states to make time-limited changes to their state plans to address access and coverage issues during the COVID-19 emergency.
- States can also use **Section 1115** of the Social Security Act, which authorizes the HHS secretary to waive certain Medicaid provisions to allow states to implement demonstration projects. CMS issued new guidance for states seeking to implement temporary COVID-19 related demonstrations.
- Section 6008 of the **Families First Coronavirus Response Act** (Families First Act) provides congressional authorization for an enhanced FMAP during the PHE, contingent on states maintaining eligibility and enrollment in Medicaid. The Act also gives states the option to cover COVID-19 testing and testing related services for uninsured people with a 100% FMAP.

To facilitate use of these waivers and options, CMS updated its web-based Disaster Response Toolkit, originally prepared to respond to hurricanes and other natural disasters. CMS also created templates for states to use these legal authorities targeted to COVID-19.

All 50 states and the District of Columbia have used some combination of these flexibilities to respond to the COVID-19 emergency. In most cases, states have maintained or expanded eligibility, adapted administration of the program to maximize availability of acute and ICU beds and key equipment like ventilators, and physically separated COVID-19 patients from others. States have also instituted new policies to facilitate access to providers and to assure, and sometimes enhance, provider payment.

Figure 13.1. State Eligibility and Enrollment Policy Changes to Facilitate Access to Medicaid/CHIP Coverage in Response to COVID-19, as of May 21, 2020.




NOTES: This table only includes SPA approvals issued to and administrative actions taken by states (including DC) for Medicaid and CHIP. Where states have taken more than one action within a category under multiple authorities, action is counted as taken under SPA authority. States may be pursuing other actions to address COVID-19 through authorities not included in this analysis.
SOURCE: KFF analysis of approved SPAs and the Medicaid Disaster Relief SPA Template posted on Medicaid.gov, analysis of state verification plans, as well as analysis of Medicaid actions to address COVID-19 posted on state websites.

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The three most common changes states have made are suspending premiums and cost sharing requirements, removing prior authorization requirements, and expanding use of telehealth (Perkins & Somers, 2020). All states have agreed to maintain Medicaid eligibility and enrollment to obtain the Families First enhanced FMAP. Forty-three states have eased eligibility rules even further, including expanding eligibility, eliminating or waiving premiums, and streamlining application and enrollment processes (Dolan & Artiga, 2020).

The COVID-19 emergency Medicaid response also paused the Trump administration's Section 1115 waiver initiatives that create barriers to enrollment for Medicaid expansion adults. To receive the Families First Act enhanced FMAP, states must comply with five maintenance of effort requirements to assure continuous Medicaid coverage. States may not cut Medicaid eligibility or impose more restrictive eligibility procedures; charge higher premiums; disenroll currently or newly enrolled beneficiaries (unless they die, move, or request to be disenrolled); and must cover COVID-19 testing and treatment without cost sharing. These requirements prevent states from instituting new barriers to coverage and from disenrolling anyone for the duration of the PHE.

Section 1135 waivers, disaster relief SPAs, and the Families First Act enhanced FMAP expire when the PHE ends. A PHE declaration remains in effect for 90 days and can be renewed multiple times. The original declaration was renewed April 26, 2020. Unless the PHE is extended again, states will lose many of the Medicaid tools they are using to respond to COVID-19 on July 24.

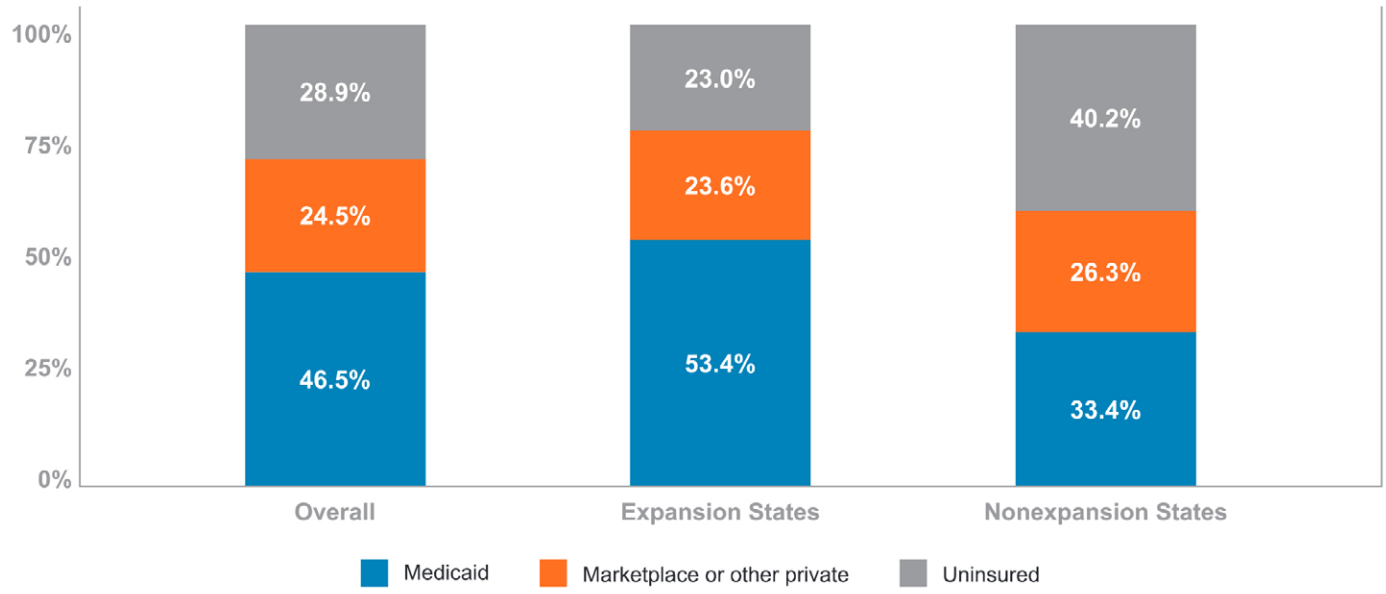
We cannot yet know whether the emergency options and waivers states have used protected access and continuity of care during the first wave of the pandemic. Some disaster relief SPAs and 1135 waiver requests were vague, making it difficult to unpack exactly what states are doing. It is also not clear how effectively emergency changes were communicated to enrollees and providers, a particularly salient question during a time when many state workers were working remotely and spotty communication added to the challenges of emergency response. For example, the Trump administration's refusal to open enrollment on the federal health insurance exchange (discussed in Chapter 12) closed a door to enrollment in two-thirds of states and thwarted coherent information about emergency insurance coverage choices for those losing jobs. This choice also impacts Medicaid, because advertising open enrollment encourages engagement with the system through a no-wrong-door application process that can lead to Medicaid enrollment. These issues are particularly acute in a time of emergency.

### Looking Forward: COVID-19, Recession, Job Loss, and Enrollment Spikes

The economic fallout of COVID-19 is predicted to be worse than the Great Recession of 2009, with significant implications for Medicaid. The ACA has better positioned state Medicaid and Children's Health Insurance (CHIP) programs to respond to events like COVID-19 by expanding coverage in many states and mandating streamlined and modernized eligibility and enrollment systems for all states. However, eligibility and enrollment policies vary greatly across states, and millions of people will fall through holes in the safety net.

Where a person lives—and whether that state has expanded Medicaid—will dictate coverage or uninsurance. People newly

Figure 13.2. Estimated Coverage Types of People Losing Employee-Sponsored Health Insurance




*Sources: Urban Institute analysis based on 2017 and 2018 American Community Survey data and 2019 and 2020 monthly Current Population Survey data.*
*Notes: Medicaid coverage is inclusive of CHIP coverage for children. Coverage changes modeled for US population under age 65.*

unemployed during the pandemic will have an easier time qualifying for Medicaid in the states that have expanded Medicaid eligibility. According to a recent study by the Urban Institute, in Medicaid expansion states more than half of people losing employer sponsored insurance are expected to enroll in Medicaid and less than a quarter are expected to become uninsured. In non-expansion states, only about one-third are expected to gain Medicaid coverage while about 40% are expected to become uninsured (Garrett & Gangopadhyaya 2020).

The most significant choice non-expansion states can make to create coverage for people made jobless because of COVID-19 is to adopt the ACA's Medicaid expansion. To encourage states to expand, Congress should provide holdout states with a 100% federal match similar to the one the ACA provided in 2014.

Even in expansion states, almost a quarter of those losing employer coverage because of COVID-19 are predicted to become uninsured. In 2018, nearly a quarter of uninsured adults and children were eligible for Medicaid or CHIP but not enrolled (Artiga et al., 2020). Outreach efforts are needed to let newly uninsured people know about available Medicaid and CHIP options.

Expansion states also should consider other options for increasing Medicaid eligibility. Beyond the ACA Medicaid expansion, states can increase Medicaid income eligibility above 133% of the federal poverty limit (FPL) and receive the Families First Act enhanced FMAP rate. For example, as part of its COVID-19 response, New Mexico expanded eligibility for adults up to 200% FPL (Dolan & Artiga, 2020). Also, states have the option to eliminate the five-year waiting period so that immigrant children and pregnant women lawfully residing in the United States can qualify for Medicaid and CHIP. Another option allows state to provide prenatal care to women regardless of immigration status by extending CHIP coverage through the "unborn child" option (see Chapter 33, Immigration).

To provide adequate financial support for all states, additional federal measures are necessary. The Families First Act offers states an enhanced FMAP during the PHE. However, the Families First Act bump is only about half of the relief that the ARRA provided. The Health and Economic Recovery Omnibus Emergency Solutions (HEROES) Act, which passed the House on May 16, 2020, echoes the ARRA's approach and provides a 14 percentage point increase beginning July 1, 2020 through June 30, 2021, but the bill has stalled.

The Families First Act enhanced FMAP, like earlier temporary FMAP enhancements, applies to Medicaid spending that is reimbursed at the state's regular FMAP and indirectly enhances states' CHIP funding. It does not apply to administrative expenses or to Medicaid spending that is already subject to an increased match, including ACA expansion adults (90%), family planning services (90%), services received through Indian Health Services (100%), Medicare cost-sharing assistance for Qualified Individuals (100%), and home health services (90%). This is the first temporary FMAP increase since the ACA Medicaid expansion went into effect, so it is not clear how the failure to include an enhanced FMAP for ACA expansion adults will impact state budgets.

If the PHE declaration is lifted while the economic impact of COVID-19 is still in full force, millions of people will remain out of work and state revenues will continue to be in crisis. Tying the duration of the enhanced FMAP to state jobless rates or other economic conditions, rather than the PHE declaration, would link the eFMAP to the economic drivers of Medicaid enrollment increases. Moreover, using state-specific indicators, like the ARRA did, would amplify the pandemic's geographically disparate impact and states' varying approaches to reopening businesses.

Additionally, Congress should require that states and localities collect consistent demographic data collection as a condition of receiving federal health care funding. This would expand data collection beyond the racial and ethnic data required by section 4302 of the ACA and could be tied to Medicaid or Centers for Disease Control and Prevention (CDC) funding. Better data collection is necessary given wide inconsistencies revealed during the pandemic that complicate responding to the emergency and understanding its impacts. Data regarding race, ethnicity, socioeconomic status, and other key identifying characteristics should not left to the whim of state and local health departments. Reliable evidence is necessary to inform preparation for current and future public health efforts.

Medicaid's federalism structure divides responsibility for low-income populations' medical care between national and state governments and has been both a facilitator and a barrier in the coronavirus response. Medicaid's reliance on state policymaking has allowed some states to use Medicaid's flexibility to respond robustly to the pandemic and others to barely respond, resulting in avoidable risk to health and life.

# Recommendations for Action

## Federal government:

- Congress should increase the enhanced FMAP by several percentage points and extend it for the duration of the COVID-19 related economic downturn; any enhanced FMAP should condition the extra money on states' implementation of maintenance of effort requirements that prevent cutting eligibility and enrollment.
- Congress should provide a financial incentive of a 100% FMAP for the first three years of Medicaid expansion to encourage remaining states to adopt the ACA's Medicaid expansion.
- Congress should offer states an enhanced FMAP for administrative costs for outreach and enrollment efforts to communicate with newly uninsured people who have lost coverage because of COVID-19.
- Congress, HHS, or CDC should require enhanced demographic data collection as a condition of federal health care funding, at all times, so that data regarding key identifying characteristics are collected consistently by state or local health departments.

## State governments:

- States should continue to use the flexible waiver and SPA options offered during the PHE to maintain or expand eligibility and streamline application and enrollment processes.
- States should take advantage of the SPA options that allow them to expand eligibility, at least during the PHE, to additional uninsured adults and children. These options include raising income eligibility levels and eliminating the five-year waiting period so that immigrant children and pregnant women lawfully residing in the United States can qualify.

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