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STRENGTHENING MEDICAID

Stabilizing Medicaid Financing During Economic Downturns

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Overview

The challenge: Financing Medicaid coverage when state finances are strained

Maintaining Medicaid coverage during downturns in the economic cycle is a significant policy challenge for states. In recessions, states struggle to finance the cost of Medicaid coverage, which increases as people lose jobs and the health coverage that comes with them, becoming eligible for Medicaid. At the same time, state revenues, mirroring the weak economy, generally become stagnant or decline. Medicaid is a major item in all states' budgets and also the largest source of federal grant support to states. As such, financing Medicaid is one of the most intractable expenditure problems most states face during recessions, making it difficult to maintain health coverage.

Unlike the federal government, the overwhelming majority of states have balanced budget requirements. Consequently, during recessions, states face difficult decisions. They can raise taxes or cut services to the public at the time that many people need the services most.

States have continued to accumulate a steadily increasing share of expenditures as fiscal balances—accumulated surpluses plus "rainy day funds"—but during a significant recession states can deplete these reserves rapidly. During the last state fiscal crisis, states quickly depleted such balances from the historically high level of 10 percent of expenditures nationally in FY 2000 to three percent by FY 2003. By the end of FY 2006, these had reached 11 percent, but that share is rapidly declining as economic growth weakens.[1]

Federal lawmakers often recognize that state fiscal stress during economic downturns produces unwanted responses, and in most recessions the federal government has found ways to support state and local governmental efforts. These have ranged from the massive infusion of funds in the 1970s (primarily for the Comprehensive Employment and Training Act (CETA), the Department of Commerce's Local Public Works program and the Treasury's Antirecession Fiscal Assistance) to the more modest "jobs bill" of 1983.

From states' perspective, the likelihood of any relief is unpredictable; delays in the federal legislative process can make any relief "too little too late." In addition, only recently has relief focused specifically on states' ability to maintain their Medicaid programs, recognizing that states' federal Medicaid matching rates do not adjust in a timely manner to changing state economic conditions. States do what they can within their limited fiscal capacity, but absent support from the more fiscally capable federal government, which unlike the vast majority of states can run deficits, Medicaid eligibility levels, benefits, and provider payment levels can all suffer. State and federal policymakers concerned with maintaining the stability of the nation's health care system need to consider approaches for helping to support Medicaid coverage before the next recession. Automatic mechanisms would accomplish this goal most effectively.

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Ad hoc federal fiscal relief makes it difficult for states to plan and avoid cuts to programs like Medicaid.

The federal government has a number of built-in fiscal stabilizers that operate through both the tax system and spending programs to help individuals (e.g., unemployment insurance, Food Stamps). Similarly, the federal government has built a structure to assist state and local governments with physical disasters.

In comparison, fiscal relief packages for state and local governments generally occur in a haphazard and inconsistent fashion. The most recent such federal effort occurred in 2003 with the enactment of the Jobs and Growth Tax Relief Reconciliation Act (JGTRRA). This law, which responded to the severe state fiscal crisis of 2001 to 2004, provided $20 billion in state fiscal relief, which was divided equally between general purpose assistance and a temporary increase in the federal medical assistance percentage (FMAP) for Medicaid for five fiscal quarters. To receive the increased FMAP, states could not reduce Medicaid eligibility during the time the fiscal relief was in effect. All states met this requirement.[2] Eligibility levels for Medicaid were maintained as a result of the fiscal relief, although states continued to take other cost-control actions in Medicaid.

The fiscal relief, while quite valuable, did not come until well into the fiscal crisis, and after many states had already made cuts to Medicaid and other programs to balance their budgets. Uncertainty as to whether states would receive federal assistance contributed to these cuts. Creating a more reliable intergovernmental financing structure would better support states and maintain health coverage for people in need.

To build on the success of JGTRRA while providing more stable assistance during economic downturns, the federal government could establish in law an automatic mechanism to help states maintain health coverage during recessions, similar to the automatic mechanism that helps states provide unemployment benefits to individuals during recessions. State and federal policymakers concerned with maintaining the stability of the nation's health care system need to consider approaches for helping to support Medicaid coverage before the next recession. Automatic mechanisms would accomplish this goal most effectively. Tying the additional support to states' maintaining Medicaid eligibility, as JGTRRA did, would ensure that Medicaid coverage is available during a recession for people who need it.

Four alternatives

This paper identifies four potential approaches for maintaining Medicaid coverage by providing federal fiscal relief to states during recessions. Federal policymakers' choices from among these options will depend in part on the tradeoffs among them, and the extent to which they are interested in: (1) targeting assistance to only those states that face the most difficult economic conditions; (2) providing assistance to a large set of states when those states face difficult economic conditions; or, (3) assisting all states. In addition, policymakers will need to determine the amount of fiscal relief provided, the threshold (or "trigger") that determines when this relief will be provided, the duration of any fiscal relief, and whether fiscal relief should be limited to Medicaid or also include more general state fiscal relief.

Alternative one has a state-specific trigger. It automatically aids fiscally distressed states if their economies are substantially at variance from that of the country as a whole, but adds substantial numbers of states if the overall economy declines in a recession.

Alternative two has a national trigger based on a minimum of 23 states' experiencing unemployment increases. It would therefore assist only a large group of states experiencing fiscal stress. It would not benefit an individual suffering state or a small group of fiscally stressed states, and also would not benefit all states.

Alternative three uses the national unemployment rate as a trigger mechanism. It benefits all states when the national unemployment rate exceeds 5.5 percent, under the assumption that fiscal stress affects all states during a recession, even though a specific state may do better than others. It provides benefits for a longer period than some other approaches, but less relief except in peak quarters.

Finally, *alternative four* mirrors the benefits provided under JGTRRA, which provided $10 billion for Medicaid and $10 billion for the general delivery of services. Making this approach to fiscal relief permanent would both assist states in funding Medicaid during times of fiscal stress and alleviate fiscal strains on other state programs. JGTRRA did not have a trigger mechanism, but the same 5.5 percent trigger used for alternative three could be appropriate for this approach.

FEDERAL Alternative 1:

Automatically increase the federal Medicaid matching rate to any state experiencing an excessive unemployment rate.

This alternative would increase a state's Medicaid matching rate by one tenth of a percentage point (.10) for each one-tenth of a percentage point a state's total civilian unemployment rate is excessive. "Excessive" could be defined as exceeding 120 percent of the national average or as being more than 10 percent higher than it was in the previous year.[3] An alternative would provide targeted assistance to states in the most extreme need. Because it relies on unemployment data that is produced regularly and in a timely manner, this alternative would limit delays in providing assistance to states. On the other hand, because it helps only states with extremely high unemployment rates, it would not help states with unemployment rates that are high but not "excessive."

In the relatively robust economy of 2006, five states had an unemployment rate more than 20 percent higher than the national average of 4.6 percent, and would have received FMAP increases in FY 2008—Alaska, Kentucky, Michigan, Mississippi, and South Carolina. No state would qualify currently under the year-to-year change criterion, but this would change in a declining economy.

FEDERAL Alternative 2:

Automatically increase the federal Medicaid matching rate when a large group of states have high unemployment rates.

This alternative, which was recently suggested by the Government Accountability Office (GAO), would begin when 23 or more states showed a quarterly state unemployment rate increase of 10 percent or more over the equivalent quarter for the previous fiscal year.[4] The FMAP increase would automatically renew in the following quarters only if the 23-state criterion is met. This approach would also provide timely aid, and be more extensive than *Alternative 1*. It is probably most useful during periods when economic growth is regionally diverse, with many states needing aid. GAO estimates that, based on the depth of the 2001 recession, increased federal assistance would have totaled $4.2 billion.

FEDERAL Alternative 3:

Automatically increase the federal Medicaid matching rate to all states when the national unemployment rate is high.

This alternative would provide an automatic FMAP adjustment to all states for a fiscal quarter whenever national unemployment for that quarter exceeds a national benchmark, for example, 5.5 percent. FMAP increases would be paid to states in the quarter following the quarter for which unemployment data become available.

Under this approach, each state's FMAP would increase by 0.25 percentage points for each tenth of a percentage point (or fraction thereof) that the national unemployment rate exceeds the benchmark for that quarter. In the 2001 recession, this would have provided FMAP increases beginning in the fourth quarter of calendar year 2001 and lasting through the second quarter of 2004, with a maximum increase of 2.75 percentage points in two quarters in 2003.

This alternative assists all states when state fiscal stress is national in scope. The amount of the FMAP increase—and therefore the amount of fiscal relief—provided under this approach is relatively modest, but increases in proportion to the increases in unemployment and would remain in effect for as long as the national unemployment rate remains high. If the amount of fiscal relief provided through this automatic mechanism proves to be too small, Congress could at its discre-

tion provide an additional FMAP increase through an emergency supplemental appropriation.

FEDERAL Alternative 4:

Automatically increase the federal Medicaid matching rate and provide grant funds to all states.

This approach most closely mirrors that of JGTRRA, which provided two streams of $10 billion each—one for general budget support allocated to states on the basis of their population and another for increasing each state's FMAP 2.50 percentage points from its FY 2002 level. This alternative recognizes that the fiscal stress, caused by the combination of lower state revenues and increased Medicaid spending, causes stress both on the Medicaid program and other programs in states' budgets and provides for adjustments for both.

Because JGGTRA did not provide for automatic fiscal relief, it had no trigger. A trigger of an unemployment rate of 5.5 percent seems appropriate in the structure of today's economy. If used, this alternative could be time-limited, for example, to six consecutive quarters. This would be sufficient in most recessions, and could be revisited for a temporary extension in especially deep recessions, as has been done for unemployment benefits. Relative to *Alternative 3*, this approach would provide more fiscal relief, but the time period over which this relief would be provided would be subject to a predetermined limit. In addition, the $10 billion that is allocated directly to the state would not provide direct assistance to Medicaid, but would help states fund other state programs at a time of fiscal stress.

Conclusion

The fiscal relief provided to states through JGTRRA was a success and should be replicated by providing automatic federal fiscal relief to states during recessions. This would make it easier for states to maintain Medicaid coverage. Regardless of how the assistance is provided, a "maintenance of effort" requirement ensuring that states maintain their Medicaid eligibility levels is a critical component of any fiscal relief approach, as it was in JGTRRA. Approaches to accomplishing fiscal relief include assisting *selected* states based on individual states' unemployment rates, or systematically assisting *all* states based on national economic conditions. Discrete elements of the different approaches identified in this paper, including the trigger that makes such assistance available, the level of federal support provided, and the time period over which such assistance is provided, could be combined to develop additional approaches.

FOR MORE INFORMATION

• National Academy of State Health Policy, **Analyzing the Impact of Adjusting the Federal Medical Assistance Percentage to Improve the Countercyclical Impact**. This issue paper by Vic Miller identifies several approaches to changing the structure of the federal matching rate as part of a larger 2005 project entitled **Making Medicaid Work for the 21st Century**. It is available at: http://www.nashp.org/Files/FMAP_countercyclical_final_1.31.05.pdf

• Government Accountability Office, **Medicaid: Strategies to Help States Address Increased Expenditures After Economic Downturns, October 2006,** (GAO report number GAO 07-97). This report analyzes three proposals to provide a greater level of federal assistance to states during economic downturns. It is available at: http://www.gao.gov/highlights/d0797high.pdf

• Kaiser Commission on Medicaid and the Uninsured, **Financing Health Coverage: The Fiscal Relief Experience**. November 2005. This paper examines states' experience with the fiscal relief provided by the 2003 Jobs and Growth Tax Relief Reconciliation Act. It is available at: http://www.kff.org/medicaid/7434.cfm.

ENDNOTES

1. National Governors Association and National Conference of State Legislatures, "Fiscal Survey of the States," (various editions).

2. V. Wachino, M. O'Malley, & R. Rudowitz, "Financing Health Coverage: The Fiscal Relief Experience," Kaiser Commission on Medicaid and the Uninsured, (November 2005).

3. This alternative combines two options presented by Vic Miller and Andy Schneider in "The Medicaid Matching Formula: Policy Considerations and Options for Modification," AARP Public Policy Institute, (September 2004).

4. Government Accountability Office, "Medicaid: Strategies to Help States Address Increased Expenditures during Economic Downturns," (October 2006); GAO explains the elements of this approach as follows: *"We chose these two threshold values—23 or more states and increased unemployment rates of 10 percent or more—to work in tandem to ensure that the national economy had entered downturn and that the majority of states were not yet in recovery from the downturn."*

About this Project

The Center for Children and Families (CCF) at the Georgetown University Health Policy Institute, working with health policy consultant Vikki Wachino, is initiating a project, **"Strengthening Medicaid"** designed to develop fresh ideas to strengthen the Medicaid program and to engage policymakers and stakeholders at the state and federal levels in discussion about how these ideas might be translated into policies. These approaches will focus on (1) promoting access to high-quality, cost effective care that meets beneficiaries' needs; (2) improving coverage options; and (3) assuring sustainable financing while ensuring that available resources are used in the most efficient way. These approaches, which will be presented through a series of short policy papers, will represent some of the best ideas from a number of experts in different areas, including some who will bring their expertise from outside of Medicaid to the Medicaid context. The policy papers are edited by Joan Alker, Deputy Executive Director of CCF and consultant Vikki Wachino.

To visit our project website, please go to http://ccf.georgetown.edu/strengtheningmedicaid/

About the Author

Mr. Miller has spent 35 years working and writing on the federal budget and Medicaid finance. At the federal level, he has worked at the Office of Management and Budget, the Treasury Department and the Senate Budget Committee. In 1981, he founded and was the initial director of Federal Funds Information for States (FFIS), a joint service of the National Governors Association and the National Conference of State Legislatures, that tracks federal funds for the states. After a decade of working internationally, he has returned to FFIS as Senior Fellow for Intergovernmental Finance. Apart from FFIS, Mr. Miller has written on Medicaid finance for a wide variety of clients, including (in part) the Steelman Commission, the Pepper Commission, the Institute of Medicine, AARP, the Kaiser and Robert Wood Johnson Foundations, the National Academy for State Health Policy and a variety of states.

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