POLICY BRIEF

kaiser commission on medicaid and the uninsured

THE HENRY J. KAISER FAMILY FOUNDATION

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Short Term Options For Medicaid in a Recession

Reports recently confirmed that the country is in the midst of a recession. Currently, 43 states are facing budget shortfalls in FY 2009 or FY 2010, state revenues are coming in lower than projected and unemployment continues to rise, hitting 6.7 percent in November. When the economy falters, demand for Medicaid grows as individuals lose their jobs and job-based health coverage and incomes decline. These caseload increases occur just as state revenues tend to fall. Medicaid is a federal entitlement program that provides health and long-term care coverage to nearly 60 million low-income individuals with financing shared by the states and the federal government. This brief outlines potential short-term actions that could help to bolster the Medicaid program in a time of growing demand, including:

- **Direct federal funding support for Medicaid.** The federal government could provide fiscal relief in the form of an enhanced FMAP for states with conditions that they maintain eligibility. This strategy proved to be successful in helping states to balance their budgets, avoid deeper Medicaid cuts and maintain eligibility during the last economic downturn. In addition, the federal government could provide state fiscal relief by assuming responsibility for payments for Medicare premiums and cost sharing (similar to how the low-income subsidy program is handled under Medicare Part D), the costs for persons with disabilities in the Medicare waiting period and the state "clawback" payment. The new Administration could consider rescinding Medicaid regulations currently under moratorium through Aprill 2009 that shift additional fiscal burdens to the states for Medicaid.

- **Passage of a SCHIP reauthorization bill.** Quick passage of a SCHIP reauthorization with expanded federal funding, new tools and incentives for outreach and enrollment and the removal of the August 17th Directive would provide states with predictable financing and new options to better administer the program as more children need assistance.

- **New guidance to help simplify and ease Medicaid and SCHIP enrollment hurdles**. Congress could consider requiring state Medicaid programs to have a point of entry outside of a local welfare office similar to how states implement stand alone SCHIP programs. A new administration could also issue guidance on simplifying enrollment procedures (such as web-based applications with e-signatures), rescind the regulations related to school based administration, clarify the rules on income disregards, and encourage states to consider disregards for unemployment benefits.

- **Mitigate the enrollment barriers resulting from the DRA imposed citizenship and identity documentation requirements***.* Policy-makers could consider a variety of options to help ease enrollment barriers resulting from the DRA requirements such as expanding the list of acceptable documents, adding to the list of groups exempt from the requirements and allowing for additional data matching. Ultimately, Congress may want to consider repealing this provision.

- **Expand coverage more broadly to those hit by the economic downturn.** Congress could pass legislation or the new Administration could approve waivers to allow states to cover additional populations on an emergency or temporary basis employing strategies used to help people in New York following September 11th and following Hurricane Katrina in affected states. New initiatives could allow states to use an expedited enrollment process to provide Medicaid coverage to individuals unable to find work and employer based health insurance due to the economic downturn.

Additional funding may be required as an incentive for states to adopt new options to broaden or simplify eligibility during an economic downturn. Beyond the immediate actions noted above, Congress and a new Administration could take a number of additional steps to ensure that Medicaid can function as a foundation for broader discussions about national health reform.

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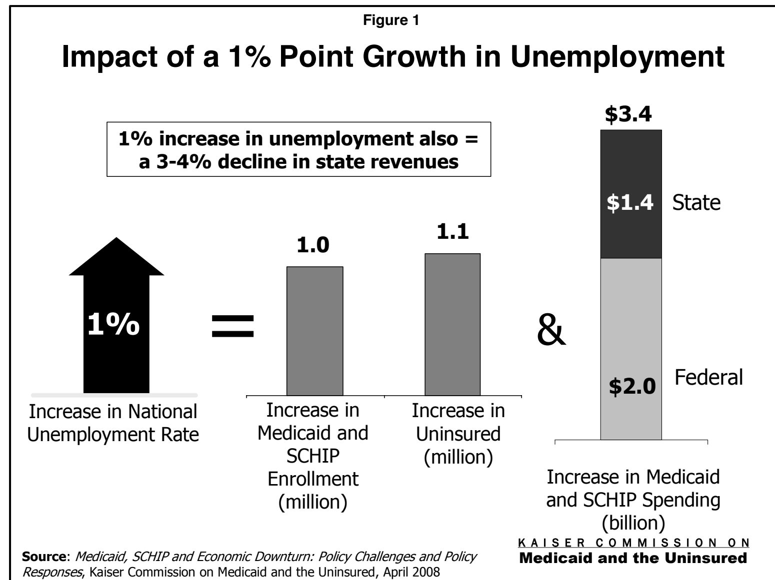
1. Provide States with Medicaid Fiscal Relief

Issue: By design, Medicaid enrollment and spending rise during economic downturns just as state revenues fall. Estimates show that a one percentage point increase in the national unemployment rate translates to a one million person increase in Medicaid and SCHIP enrollment as individuals lose jobs and job-based health insurance. A one percentage point increase in unemployment also equates to a 3-4 percent decline in state revenues making it more difficult for states to pay for increased Medicaid demand.



Financing for Medicaid is shared by the states and the federal government. The current federal matching assistance percentage (FMAP) formula does not provide an effective "countercyclical" adjustment to increase federal assistance to states during economic downturns. This formula is based on states per capita income relative to the national average. The federal share of Medicaid averages 57 percent but can range from a floor of 50 percent to 76 percent in the poorest state (Mississippi). The data used to calculate the FMAP is lagged and therefore may not reflect the most current economic situation.

During the economic downturn that began in 2001, Congress provided $20 billion in federal fiscal relief to states; $10 billion in the form of an enhanced FMAP from April 2003 through June 2004. In exchange for the enhanced FMAP, states were required to maintain eligibility levels. This fiscal relief proved instrumental in helping states to address budget shortfalls, avoid making additional and deeper reductions in their Medicaid programs and to preserve eligibility; however, some studies argued that the relief was provided too late.

Options: Establish Countercyclical Financing Assistance. Similar legislation to provide temporary FMAP assistance is currently under consideration. Policy makers are still debating the level of federal relief, how it is distributed, if the enhanced FMAP applies to Medicaid or Medicaid and SCHIP, and the specifics of the maintenance of effort for eligibility. In November 2008, the National Governor's Association called for $40 billion in Medicaid relief over a two year period. Legislation could also be crafted to provide an automatic adjustment to the FMAP triggered by economic conditions to generate additional federal resources to help states. An automatic FMAP adjustment was included in Senator Baucus' "A Call to Action: Health Reform 2009" although the plan does not include details except to refer to the 2006 report from the Government Accountability Office (GAO) which recommended consideration of two factors in setting a trigger — the number of states experiencing an increase in unemployment and the magnitude of that increase.[1]

[1] Senator Baucus, "A Call to Action: Health Reform 2009" November 12, 2008. http://finance.senate.gov/healthreform2009/home.html

Options: Shift Medicare Related Expenses from Medicaid to the Federal Government. Medicaid pays for a variety of Medicare related expenses. Medicaid pays for premiums and cost sharing for low-income Medicare beneficiaries. Medicaid provides coverage during the waiting period for low-income individuals with disabilities under age 65 who must wait 29 months from the date of onset of disability until they can receive Medicare. Medicaid also finances a portion of Medicare coverage for prescription drugs for individuals who are dually eligible for Medicare and Medicaid through a payment to the federal government referred to as the "clawback". As part of the Medicare Modernization Act, prescription drug coverage for the duals was transitioned from Medicaid to Medicare Part D on January 1, 2006.

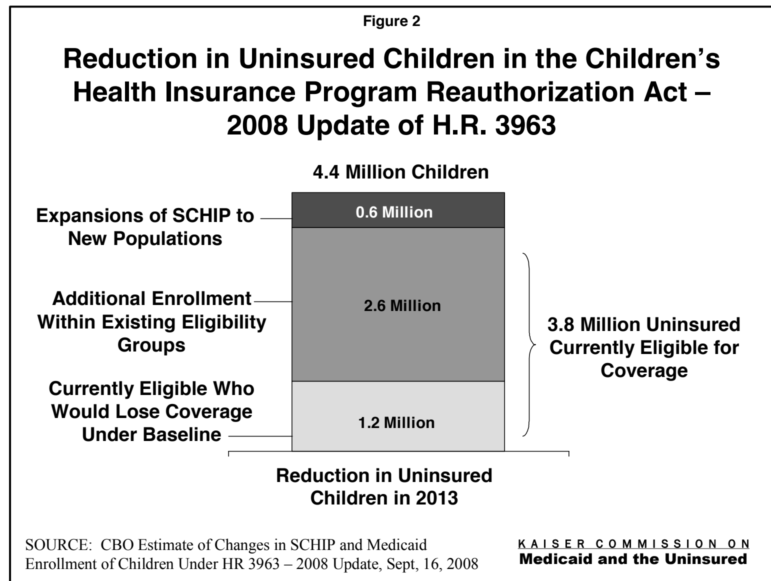
To provide additional (and permanent) fiscal relief to the states, the federal government could assume responsibility for these Medicare-related expenses that are now paid for by the states through Medicaid. Shifting the state share of Medicaid payments for Medicare premiums and cost sharing would be similar to the Low-Income Subsidy benefit associated with Medicare Part D where the federal government assumes the premium and cost sharing amount for Medicare prescription drugs for low-income beneficiaries. In addition, shifting the costs for persons with disabilities in the Medicare waiting period and the "clawback" payment to the federal government would provide needed state fiscal relief both in this short term economic crunch and through future economic downturns. These initiatives could help offset the costs of additional Medicaid coverage and enrollment.

Options: Review Medicaid Regulations Under Moratorium through April 2009. In 2007, CMS moved forward with a number of major regulatory initiatives intended to promote the integrity of the Medicaid program by closing perceived "loopholes" used by states to engage in excessive claiming of federal Medicaid funds. However, members of Congress, states, beneficiaries and providers raised concerns that these changes would constitute an unprecedented reversal of long-standing Medicaid policy that would have serious negative consequences for state budgets and for beneficiaries. These regulations could shift significant amounts of federal Medicaid spending to the states. As a result of these widespread concerns, Congress imposed a one-year moratorium on six of the new Medicaid regulations in legislation for the supplemental war appropriations bill (HR 2642). In the absence of future congressional action, some of these regulations could take effect as early as April 2009. A new Administration could review the regulations subject to the moratoria and others proposed by the Bush Administration and rescind or withdraw regulations that would unduly shift Medicaid spending from the federal government to the states, especially during a period of economic distress.

2. Reauthorize the SCHIP Program

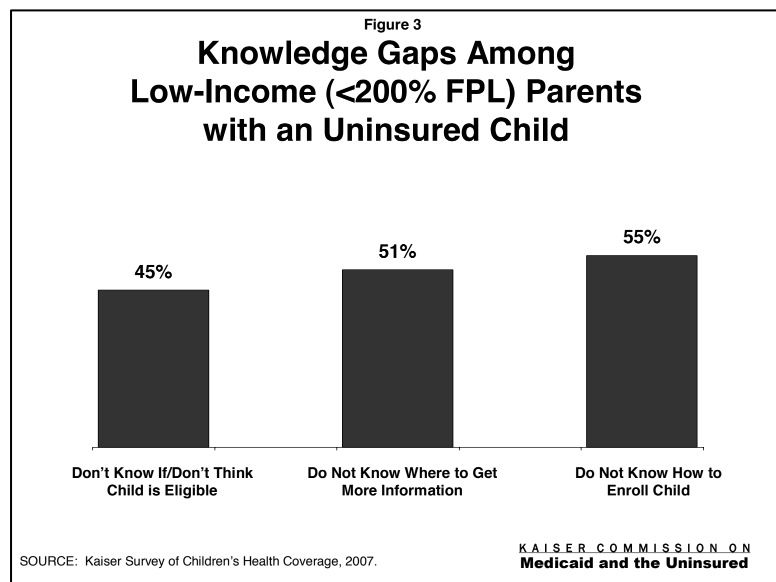
Issue: Despite bi-partisan efforts to reauthorize the SCHIP program during the 110th Congress, President Bush vetoed two comprehensive reauthorization bills and the House failed to override the veto. Ultimately, Congress and President Bush extended SCHIP through March 2009 with funding to maintain current eligibility levels. In addition, CMS issued guidance, often referred to as the August 17th Directive, that limits states' ability to expand SCHIP coverage for children with family incomes above 250 percent of poverty. The temporary reauthorization and uncertainty about long-term availability of federal financing makes it difficult for states to administer a program that has proved critical in providing affordable health care to low-income children. The directive resulted in several states scaling back or delaying program expansions, even when the state legislature had approved such expansions and also called into question states' ability to maintain coverage levels beyond 250 percent of poverty.

Options: Enact a SCHIP Reauthorization Bill. With the extension of the SCHIP program expiring on March 31, 2009, the new Congress could quickly pass a SCHIP reauthorization bill that would be signed by the new President. Policy makers are considering updating the Children's Health Insurance Program Reauthorization Act (CHIPRA). CBO estimates show that CHIPRA would have covered over 4 million children who otherwise would have been uninsured at a cost of $35 billion, financed from an increase in the tobacco tax. Most of the individuals that would receive coverage were eligible, but not enrolled in the program. The bill would have also provided new tools and incentives for outreach and enrollment and would override the guidance in the August 17th Directive on crowd-out. Particularly in an economic downturn it is critical for states to be able to confidently administer their SCHIP and Medicaid programs as they serve as an important safety-net for individuals losing employer based coverage. Stabilizing federal fiscal and policy support for SCHIP and Medicaid by quickly reauthorizing the SCHIP program will help states administer the programs to ensure that they are available during a time of growing demand.



3. Improve Eligibility Simplification and Outreach

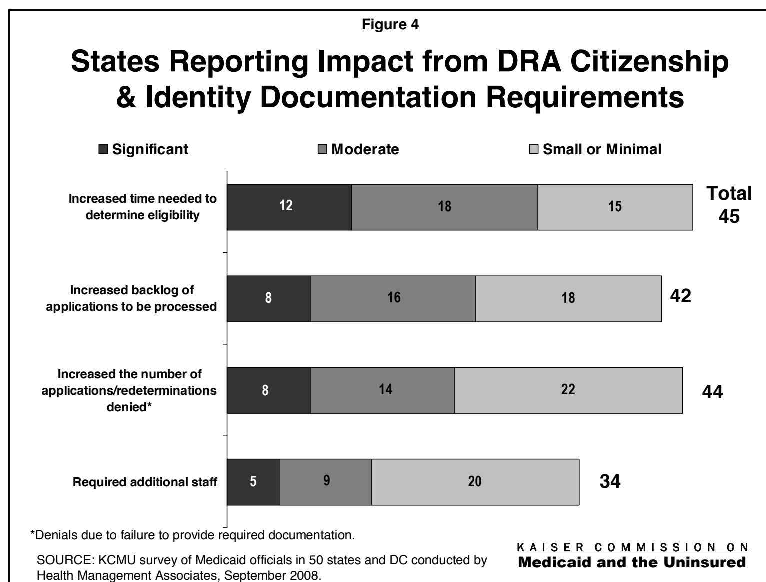
Issue: Many who are eligible for Medicaid and SCHIP are not enrolled in the programs. Some proven enrollment strategies have not been adopted in all states and states may be unaware of newer approaches. Due to the downturn in the economy, many people are likely to turn to Medicaid for assistance for the first time and may be unaware of how or where to enroll. Additional outreach could target individuals who have lost their jobs and may qualify for coverage for their family or for their children; however, as states feel the crunch of increased demand and fewer resources to dedicate to coverage, outreach and staff to process applications often get cut.



Options: Improve Enrollment/Renewal Process and Outreach. Beyond the new tools (like express-lane eligibility), fiscal incentives for enrolling eligible individuals, and dedicated funds for outreach included in the CHIPRA bill that the 111th Congress may take up quickly, there are other options to simplify enrollment especially during a time of increased program need. First, Congress could consider requiring Medicaid programs to have a point of entry for enrollment and renewal at the state level outside of a local welfare office similar to how states implement stand alone SCHIP programs. This could ease enrollment for individuals applying for the first time and who are unfamiliar with public assistance. A new administration could also issue guidance to promote flexibility that states currently have to simplify enrollment procedures highlighting strategies like web-based applications with e-signatures. The new Administration could also rescind the regulations issued by President Bush related to school based administration and assure states that school-based outreach and enrollment for Medicaid is permitted and encouraged. Guidance could also clarify the rules on income disregards and encourage states to consider disregards for unemployment benefits. These benefits often disqualify individuals applying for Medicaid, yet they may have lost their employer coverage and not have the resources necessary to purchase other coverage.

4. Mitigate the Burdens of Citizenship Documentation

Issue. The new citizenship identity and documentation requirements enacted as part of the DRA have imposed significant Medicaid enrollment barriers, largely for citizens applying for coverage. In addition, the requirements make it difficult for states to simplify the Medicaid enrollment process which is critical for ensuring that individuals in need can apply and receive coverage in a timely manner. Medicaid directors reported delays in processing applications, backlogs and denials for individuals who qualify for coverage.

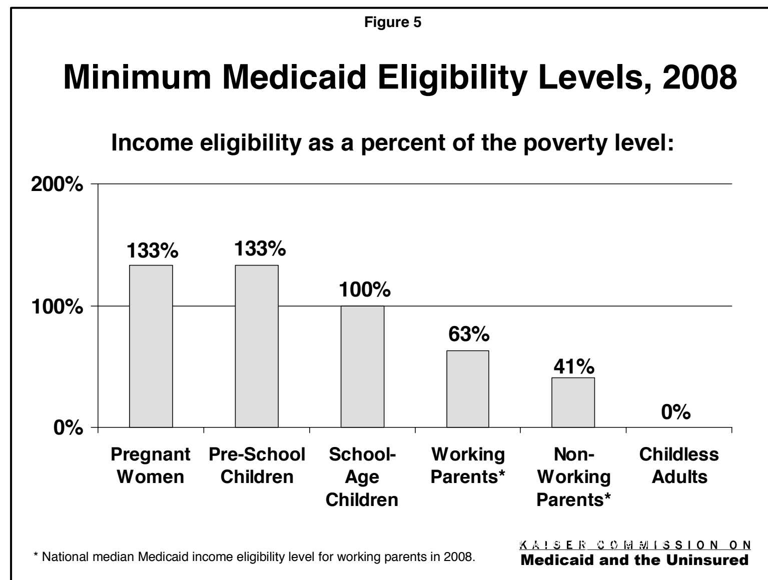


Options: Mitigate the Burdens of the Citizenship and Identity Documentation Requirements. A variety of administrative and legislative options exist to help mitigate the burdens of the DRA citizenship and identity documentation requirements and remove enrollment barriers. A new Administration could immediately clarify how states can implement the use of the document "hierarchy of reliability" in the least restrictive manner and promote the use of electronic matching with Vital Records databases. New regulations could be proposed to: exempt additional groups from the citizenship documentation requirement (including children leaving foster care, babies born to women receiving Medicaid at the time of their birth); expand the list of acceptable documents an

individual can use to prove citizenship and identity; allow data matching with additional databases such as Social Security; allow applicants to submit copies of documents (not originals); allow the use of school records (without verification) or an affidavit of identity on the application for a child under age 16. Legislative changes could allow applicants to receive benefits (and provide payments to states) during the "reasonable opportunity" period — the time applicants may take to obtain needed documents and could exempt family planning waiver participants or allow family planning providers to grant presumptive eligibility for the waiver and allow participants to submit documents at a later date. Ultimately, Congress may consider repealing this provision.

5. Expand Medicaid to Additional Populations Affected by the Recession

Issue. To be eligible for Medicaid, individuals must meet both income and categorical requirements. The federal government sets minimum standards and states generally have flexibility to expand beyond these minimums. While eligibility levels under Medicaid tend to be generous for children, eligibility levels for parents are much lower and adults without dependent children are not eligible for Medicaid even if they have very low-incomes. These requirements and other exclusions limit Medicaid's ability to reach more low-income uninsured adults and minimum eligibility levels have not kept up with the cost of health care. While reform of Medicaid eligibility rules might be a subject for broader health reform, Congress and the new Administration may consider some intermediary steps that could help states meet the growing demands for affordable health care during the economic recession.



Options: Broaden and Simplify Eligibility Criteria. Congress could pass legislation or the new Administration could approve waivers to allow states to cover additional populations on an emergency or temporary basis. This program could be set up similar to the Disaster Relief Medicaid Program used in New York following September 11th. The program used a simplified, expedited application process with higher income and expanded eligibility guidelines. In September 2005, the Bush Administration released a Medicaid waiver initiative to assist states in providing temporary Medicaid coverage and federal funding for uncompensated care related to evacuees from Hurricane Katrina. Unlike the New York program, the Katrina waivers did not broaden eligibility to cover adults without dependent children. New legislation or a waiver initiative could allow states to use an expedited enrollment process to provide Medicaid coverage to individuals or families unable to find work and employer based health insurance due to the economic downturn. Congress could create a new eligibility option under Medicaid or set aside funding for such coverage. Alternatively, the new

administration could design an expedited waiver template and waiver budget neutrality requirements that generally apply to Medicaid waivers to help states finance this coverage.

Conclusion

As the economic situation continues to worsen, demand for Medicaid and SCHIP will grow but states will find it difficult to finance increases in enrollment as revenues become more strained. A variety of options exist for a new Congress and Administration to consider to provide immediate relief to states and to help bolster Medicaid and SCHIP as more people seek assistance through these programs and states face financing challenges. Looking ahead to a discussion of broader health reform, policy makers are likely to consider additional options to ensure that Medicaid can continue to provide coverage to low-income families as well as to the elderly and individuals with disabilities. Policy makers are also likely to debate how Medicaid's role can be expanded to serve as a better foundation for any broader health reform effort and strengthened to continue to address key roles outside the scope of health reform such as providing and financing long-term care, mental health and support safety-net providers.

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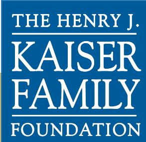

The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bi-partisan group of national leaders and experts in health care and public policy.