

# Considerations for Countercyclical Financing Adjustments in Medicaid

Medicaid is a countercyclical program: enrollment and spending increase when a downturn in the economic cycle leads to rising unemployment and growth in both the low-income population and the number of people losing employer-sponsored insurance. The ability to increase spending in response to current events is seen as an advantage of the program's financing approach and helps Medicaid meet its unique and varied demands as a source of health coverage for low-income populations. However, this financing structure has limited effectiveness as an automatic economic stabilizer. While Medicaid spending can adjust in response to fluctuations in economic activity, the current formula for sharing Medicaid expenditures between states and the federal government does not allow for a rapid increase in federal contributions when state economic conditions decline, nor does it provide a mechanism for additional federal contributions to stimulate growth during a national recession.

In early 2020, the rapid spread of the novel coronavirus (COVID-19) led to declaration of a national emergency and a swift economic contraction as many businesses closed or furloughed workers due to the public health threat. As part of an emergency aid package intended to support workers and businesses through paid sick leave and expanded food assistance and unemployment benefits, Congress provided a temporary enhancement to the Medicaid federal medical assistance percentage (FMAP) and the State Children's Health Insurance Program (CHIP) enhanced FMAP (E-FMAP) in the Families First Coronavirus Response Act (FFCRA, P.L. 116-127). This 6.2 percentage point FMAP increase is provided to states for the duration of the emergency period.

Policymakers at the state and federal levels are now considering additional policy responses to address high levels of unemployment and significant economic contraction that resulted from the need to implement social distancing to respond to the pandemic. The Congressional Budget Office (CBO) estimates that gross domestic product (GDP) will contract by 11 percent in the second quarter of 2020 and the number of people employed will be almost 26 million lower than the number in the fourth quarter of 2019, although the economy is expected to begin recovering during the second half of 2020 and the labor market is projected to materially improve as businesses reopen (CBO 2020a).

This brief provides background information on how Medicaid functions as a countercyclical program, both by design and through congressional intervention, and shows how the program has responded during prior economic downturns. It then discusses the current pandemic situation using a range of potential enrollment scenarios to show the extent to which the FFCRA FMAP increase will offset the costs of additional Medicaid enrollment and what additional federal support might be needed to provide a larger countercyclical effect. Based on our analyses, the 6.2 percentage point increase in FMAP under the FFCRA would generally cover the cost of increases in enrollment under a range of enrollment scenarios, assuming that states can contribute the amount of non-federal share as had been budgeted prior to the pandemic.



However, in FY 2020, most states would need more than a 6.2 percentage point increase under any enrollment growth scenario if they are not able to generate enough revenue to finance the state share of program expenditures. It is important to note that there is little data available at this time on actual enrollment and spending increases resulting from the pandemic, so example scenarios are presented to illustrate the effects of federal intervention, but many unknown factors will affect the actual outcomes.

## Medicaid as a Countercyclical Program

Medicaid enrollment increases when the economy contracts. Program spending increases automatically under the statutory financing formula when demand for Medicaid coverage rises, but has also grown due to congressional action during prior economic downturns to provide assistance to states facing both higher costs and lower revenues. Some policymakers have suggested that Congress could create a permanent statutory mechanism to automatically increase the federal share of Medicaid expenditures, which would allow federal financial stimulus to be directed to states more quickly during economic downturns and provide states with greater budget predictability.

### Medicaid as an automatic stabilizer

Automatic stabilizers are fiscal policies that offset cyclical changes in economic activity (as measured by GDP, unemployment or other indicators) through normal operations, without any additional governmental action. Automatic stabilizers can include graduated tax systems and benefit programs such as Medicaid. Federal programs are better suited to serve as automatic stabilizers because states are generally required to have balanced budgets and cannot run deficits during a downturn (Lee and Sheiner 2019).

Medicaid functions as an automatic stabilizer because program spending can change immediately and directly in relation to what each state spends. That is, if a state spends more, there is a proportional increase in federal spending to match state expenditures, and federal expenditures are not capped. If one state or part of the country experiences economic changes that require an increase in Medicaid expenditures, federal spending in those states can increase without additional action.

However, the effectiveness of Medicaid as an automatic stabilizer is complicated by its financing formula. In fiscal year (FY) 2018, about 63 percent of the Medicaid program was funded by the federal government, and about 37 percent by the states (MACPAC 2019a). The federal share for spending on services is determined by each state's FMAP which is calculated annually using a formula that provides higher matching rates to states with lower per capita incomes relative to the national average (and vice versa). The annual recalculation is intended to account for states' differing abilities to fund Medicaid from their own revenues and uses the most recent rolling three-year average per capita income data to help moderate fluctuations in a state's FMAP over time. This is important to states when a single percentage point change can mean a difference of tens of millions of dollars in federal funding. However, it also means that the per capita income used to calculate FMAPs for a given fiscal year is several years old by the time that fiscal year begins and significant economic trends, including recession-scale decreases in per capita income, are not fully reflected in the FMAP for several years.



In addition, automatic stabilizers are most effective when they increase federal spending; while the open-ended Medicaid financing approach allows states to draw down additional federal funds, this occurs only to the extent that states also increase their spending. Given that states are generally required to have a balanced budget and cannot run deficits, the ability of states to obtain increased federal match as needed to account for additional expenditures does not mean that they will be able to raise enough revenue to cover the state contribution (Lee and Sheiner 2019).

## Medicaid as a fiscal stimulus

A fiscal stimulus is a policy change that encourages economic growth during a recession. Examples include lowering interest rates or increasing government spending. During the past two major recessions, Congress has included temporary increases in the Medicaid FMAP as part of a broader package of financial assistance to states. Congress has also enacted legislation to provide stimulus to individual states experiencing temporary economic effects related to natural disasters by boosting the state's FMAP. Most recently, Congress acted to provide assistance to states in anticipation of both rising health costs and dropping state revenues associated with the COVID-19 national emergency by increasing state FMAPs for the duration of the emergency period.

For example, the U.S. experienced a significant recession between December 2007 and June 2009 (NBER 2019). Seeing a number of indicators during 2008 that signaled an economic downturn (e.g., declining GDP, falling stock market, rising unemployment), in February 2009, Congress enacted the American Recovery and Reinvestment Act (ARRA, P.L. 111-5), providing \$787 billion in federal spending to offset reductions in private spending and bolster the economy. A significant portion of this spending was in the form of an enhanced Medicaid FMAP for nine quarters, retroactive to October 1, 2008. The enhanced FMAP had three components:

- a flat 6.2 percent additional federal share for all states,
- an increased match to hold states harmless from FMAP formula decreases, and
- an additional increase in FMAP for states with higher unemployment rates.<sup>1,2</sup>

The average FMAP increase for states varied by quarter and was highest during the first quarter of FY 2011 when it ranged from 9.1 percent to 15.6 percent and averaged 10.9 percent (unweighted). Congress later amended ARRA to extend the recession adjustment period to June 30, 2011 but phased down the increase in the second and third quarters of FY 2011 to 3.2 percentage points and 1.2 percentage points respectively (P.L. 111-226). CBO estimated that the ARRA provisions provided an additional \$84 billion in federal Medicaid contributions to states between 2009 and 2011 (CBO 2015).

To help ensure that additional federal funds were used as a stimulus and not as a substitution for state spending, Congress included a maintenance-of-effort (MOE) provision in ARRA; that is, in order to receive additional FMAP, states could not implement more restrictive eligibility standards, methodologies, or procedures than those that were in effect in the quarter prior to the period in which the FMAP increase was in effect (i.e., on July 1, 2008). If the state had implemented more restrictive eligibility policies, it could not obtain the increased FMAP until it restored the standards to those in effect on July 1, 2008.



## Permanent Medicaid adjustment mechanisms

Various organizations have suggested that Congress could create a statutory mechanism to automatically increase the federal share of Medicaid expenditures by adjusting the FMAP formula if certain conditions were met. This would allow federal financial stimulus to be directed to states more quickly during economic downturns and provide states with greater budget predictability. For example, following each of the last two major recessions, the U.S. Government Accountability Office (GAO) suggested options for Congress to consider developing a countercyclical FMAP model that uses national economic indicators to trigger a temporarily enhanced federal FMAP (GAO 2011a, GAO 2006). Researchers at The Hamilton Project at the Brookings Institution more recently suggested using a comparison of each state's unemployment rate to its own long-run average to evaluate changes in economic conditions that would initiate an increased FMAP period (Fiedler et al. 2019).

Congress has previously authorized a statutory FMAP adjustment for states that experience economic disruption following major disasters. After Hurricane Katrina in August 2005, the Gulf states of Florida, Louisiana, Mississippi, and Texas all experienced significant economic effects including lost revenue and increased demands on state spending. In 2010, Congress added a provision to the Social Security Act (the Act) to provide an increase in the FMAP to states that have experienced a major, statewide disaster in the previous seven years and for which the current year's FMAP, as determined by the regular formula, is three percentage points or more below the previous year's FMAP (§ 1905(aa) of the Act). Qualifying states receive an adjustment to their annual FMAP rates based on a formula specified in statute.<sup>3</sup> Since 2011, each state has been evaluated annually to see if it qualifies for a disaster adjusted recovery FMAP as part of the process of calculating FMAPs for the subsequent year. In most years, a very small number of states met the requirement that the subsequent year FMAP was less than the current year FMAP and only one state (Louisiana) met both the FMAP decrease and the disaster declaration requirements. No state has qualified for the increased FMAP under this provision since FY 2014.

Between March 20 and April 12, 2020, all states were approved for major disaster declarations that met one requirement of Section 1905(aa) of the Act. However, the FMAP calculations for next fiscal year will not take into account current decreases in per capita income due to data reporting lags; thus, states are unlikely to meet the other requirement (a 3 percentage point or greater decline from the previous year's FMAP). It is possible that states may qualify for a disaster-adjusted increase in future years under the existing formula. It is also possible that, given the FMAP formula (which compares each state's per capita income to the national average), if all states experience an income decrease, the national average will go down and the overall FMAPs will remain relatively constant. Under such circumstances, states will not face the three percentage point FMAP decline needed to qualify for the disaster-adjusted FMAP increase.

## Medicaid in an Economic Downturn

During economic downturns states can struggle to generate sufficient tax revenue to finance their share of a growing Medicaid budget line item and still balance their budgets.<sup>4</sup> States may also be limited in the extent to which they can make program cuts (e.g., benefit cuts, provider rate reductions) to offset the cost of growing enrollment. These factors combine to create a need for additional federal funds to support the



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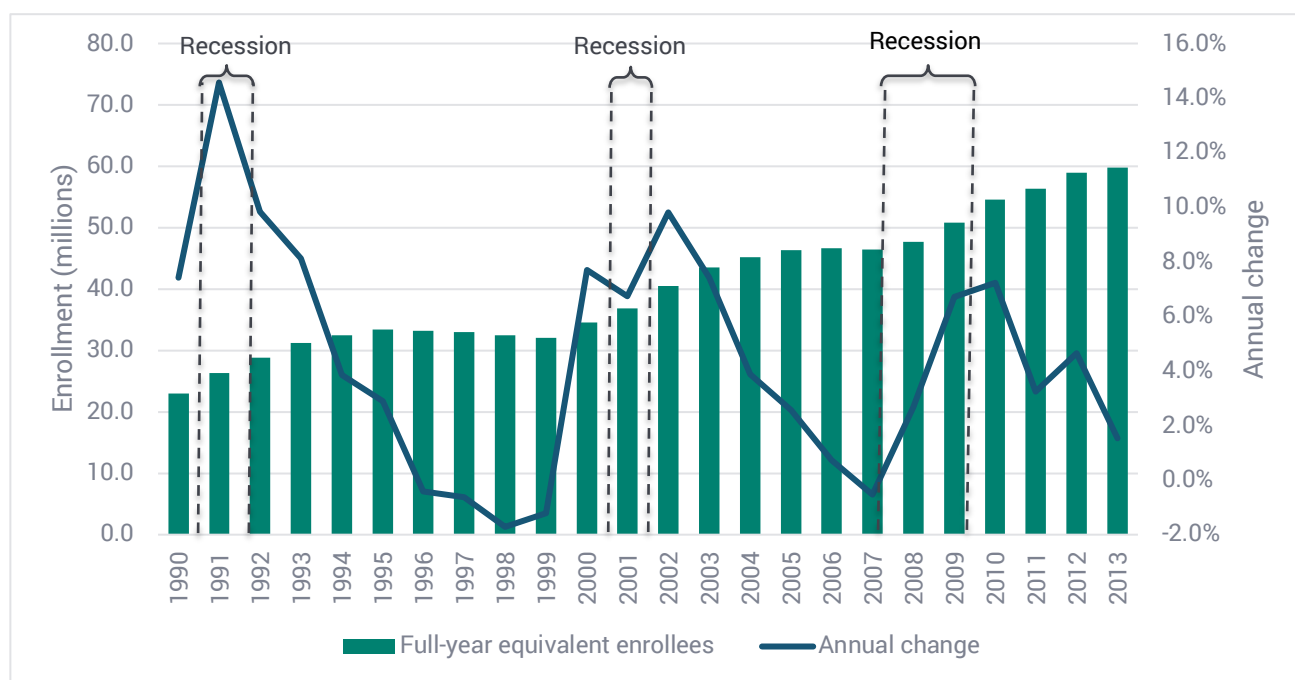
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increased cost of Medicaid during economic downturns. The percentage of Medicaid spending that is borne by the federal government can only be increased through congressional action, which several prior Congresses have chosen to do both to support states and to encourage economic recovery.

## Program growth

Medicaid enrollment tends to increase every year as the size of the U.S. population grows and as eligibility for the program is expanded through federal and state action; between 1990 and 2013 the average growth was about 4 percent a year. However, the rate of enrollment growth changes from year to year and is much greater during economic downturns (Figure 1). For example, for several years prior to the last two recessions, the rate of annual Medicaid enrollment growth was low or even declining. However, at the beginning of each of these downturns, enrollment grew by an annual rate of over 8 percent.

**FIGURE 1.** Medicaid Enrollment and Enrollment Growth by Fiscal Year, 2000–2013



**Source:** MACPAC, 2019, MACStats, Exhibit 10: *Medicaid enrollment and total spending levels and annual growth, FYs 1968–2018.*

During an economic downturn, people are likely to become eligible for Medicaid or seek coverage through the program for several reasons:

- individuals lose jobs or have reduced hours, so they or their family members newly meet the income criteria for Medicaid eligibility (whether or not they have access to other sources of health insurance);
- individuals lose employment and access to employer-sponsored health insurance and may be more likely to apply for public sources of coverage for themselves or family members; and
- individuals may be more likely to apply for public benefits (e.g., Supplemental Security Income, cash assistance, nutrition assistance) that directly link to Medicaid eligibility or allow cross-enrollment.



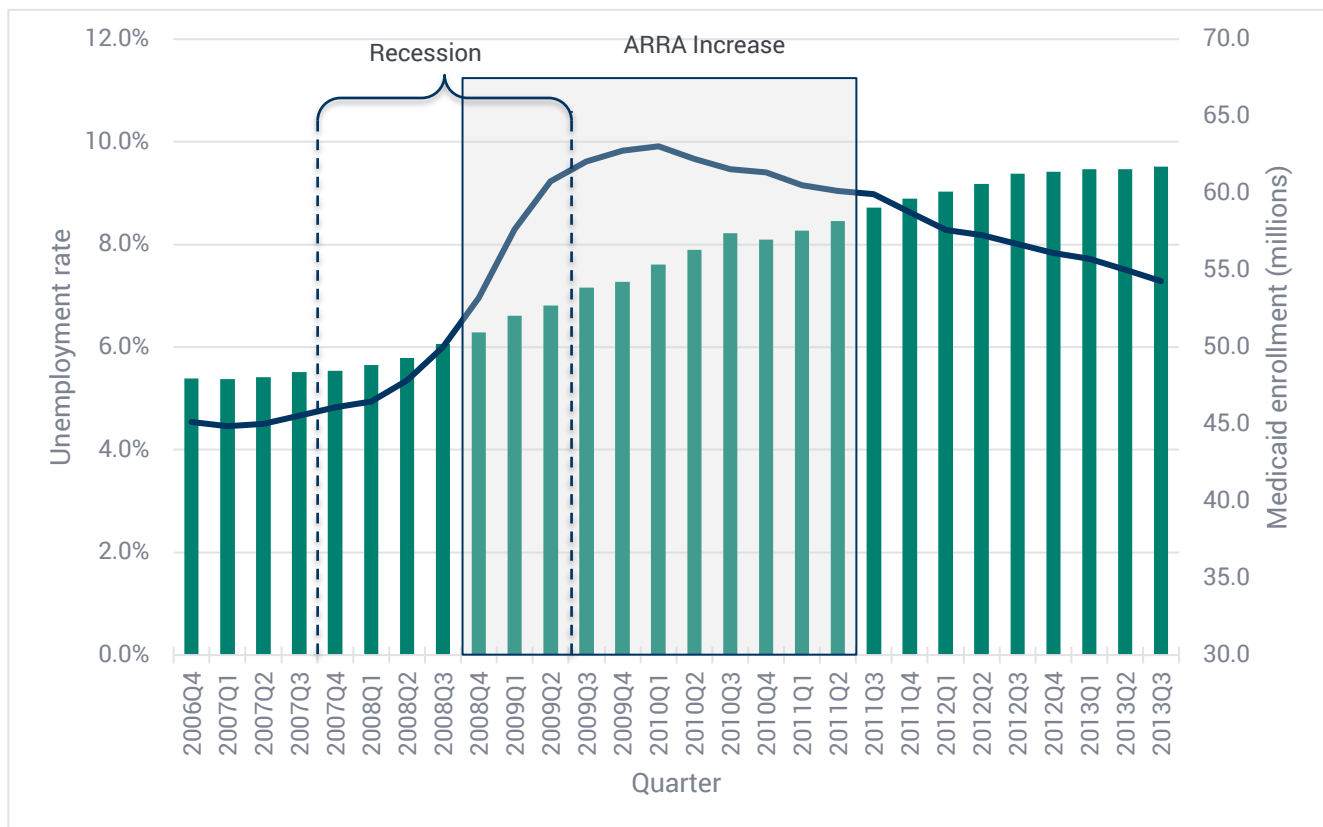
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States can reduce state spending by eliminating optional eligibility groups or restricting eligibility criteria. However, as a condition of federal financing, Congress can impose MOE requirements on states to prevent them from implementing more restrictive eligibility policies during or after a recession. MOE requirements can even contribute to enrollment growth, as individuals who otherwise would have lost coverage might remain on the rolls for the duration of the MOE period.

Finally, employment growth tends to lag general economic growth following a recession, so individuals who obtain Medicaid during a downturn may not return to private coverage until long after the end of the official recession. For all of these reasons, states can continue to experience higher than average rates of enrollment growth for several years after the end of an official recessionary period (Figure 2).

**FIGURE 2.** Unemployment Rate and Medicaid Enrollment by Quarter, Official Recessionary Period, and Period of ARRA Increase, 2006–2013



**Notes:** ARRA is the American Recovery and Reinvestment Act (P.L. 111-5). GDP is gross domestic product. The National Bureau of Economic Research declared a recession between December 2007 and June 2009. ARRA increased the federal medical assistance percentage between October 2008 and December 2010. Public Law 111-226 amended ARRA to extend the recession adjustment period to June 30, 2011.

**Sources:** MACPAC analysis of U.S. Bureau of Labor Statistics, 2020, Local area unemployment statistics: Monthly employment status of the civilian noninstitutional population, seasonally adjusted and Medicaid Statistical Information System (MSIS) enrollment data.



## State revenues and spending options

During an economic downturn, state revenue often declines due to reduced sales tax and income tax collections. Following the recession in 2008, each 1 percent rise in unemployment led to a 3 to 4 percent decrease in state general fund revenues (Dorn et al. 2008). Other recent estimates suggest that each 1 percentage point increase in unemployment leads to a \$41 billion drop in state tax revenues plus an increase in Medicaid costs, for a total impact of \$45 billion (Fiedler et al. 2019). Such revenue declines require states to make difficult choices about how to reduce Medicaid spending if they cannot generate enough revenue to finance the state share of program expenditures.

State Medicaid programs generally have three levers to reduce Medicaid spending: cut provider rates, cut benefits, or cut eligibility. As noted in MACPAC's [June 2016 report to Congress](#), when facing fiscal pressures, states often prefer to reduce or freeze provider rates before making other program cuts, such as benefit or eligibility changes that affect beneficiaries more directly (MACPAC 2016). For example, during the 2007–2009 economic downturn, almost every state cut or froze provider rates, particularly for hospitals and nursing facilities (Smith et al. 2010). In addition, 14 states implemented and 5 proposed eligibility restrictions (e.g., more restrictive treatment of income and assets, elimination of optional coverage groups) (Smith et al. 2009). To reduce effects on beneficiaries, Congress included an MOE provision in the 2009 stimulus bill, and ultimately only one state implemented an eligibility cut in 2009 (Smith et al. 2009).<sup>5</sup>

## Medicaid and the COVID-19 Response

In March 2020, the rapid spread of COVID-19 led to the declaration of a national emergency and a swift economic contraction as many businesses closed or furloughed workers. Although the unemployment rate had been near a 50-year low, it increased by nearly a full percentage point in March and is projected by the CBO to average about 15 percent from April to September 2020, meaning about 19 million fewer working people (CBO 2020b). In response to the economic crisis precipitated by the public health emergency, Congress enacted FFCRA, which provided a temporary enhancement to the Medicaid FMAP and the CHIP E-FMAP.<sup>6</sup>

This temporary increase gave states and territories an additional 6.2 percentage points of federal share for the entire quarter in which the emergency period was first declared until the last day of the quarter on which the emergency period is in effect.<sup>7</sup> (There is currently no expiration date for the emergency period.) An MOE is in effect, such that states cannot receive the enhanced FMAP if they implement more restrictive eligibility standards, methodologies, or procedures (including under a waiver) or higher premiums than were in effect on January 1, 2020. States must provide coverage to enrollees, including persons newly determined eligible during this period, until the end of the emergency period. Finally, states must agree to provide coverage for testing and treatments associated with COVID-19 (including vaccines, specialized equipment, and therapies) without cost sharing.



## Program growth

Information on enrollment growth is needed to evaluate policy responses or whether additional policy interventions are needed, but little is known yet about enrollment growth due to the pandemic. Early reports from a small number of states noted that the number of Medicaid applications in March and April 2020 was higher than normal and may indicate a future enrollment surge. For example, New Jersey Medicaid received 45,000 Medicaid applications in April 2020, compared to 5,000 applications in April 2019, and in Pennsylvania, Medicaid enrollment increased by about 50,000 from March to April 2020 compared to an increase of about 10,000 from March to April 2019 (Feldman 2020). States report enrollment data to the Centers for Medicare & Medicaid Services (CMS) 45 days after the end of the month and it is publicly released one month later, so 50-state information on enrollment changes from the beginning of the pandemic period will not be available until July at the earliest. In addition, many newly unemployed individuals may have maintained employer-sponsored coverage through March or April, so increases in Medicaid enrollment may lag unemployment trends.

It is possible to project potential enrollment growth using observations from prior downturns and applying them to the current situation. However, there are many differences between the last major nationwide recession and now that make it difficult to estimate the increases in enrollment that may occur during the national emergency period covered by FFCRA. Unlike prior recessions, this economic contraction occurred quickly and simultaneously in every state, leading to a rapid jump in unemployment rather than a more gradual increase over time. In addition, the MOE provisions in FFCRA are more expansive than those included in prior legislation, requiring states to maintain the eligibility standards that were in effect on January 1, 2020 but also prohibiting states from terminating individuals enrolled in the program as of March 18, 2020, or those who become enrolled during the emergency period, unless the individual voluntarily terminates eligibility or is no longer a resident of the state (CMS 2020).<sup>8</sup> Finally, there are coverage options created under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) that were not available during prior economic downturns, including the health insurance marketplaces and Medicaid coverage for adults in states that have chosen the optional adult expansion. These differences suggest that we should consider a range of potential scenarios to account for uncertainty in the extent to which differences between the last recession and the current situation may affect the accuracy of enrollment projections.

For example, analysts at Health Management Associates (HMA) estimated that the reduction in Medicaid disenrollment due to the MOE requirements associated with FFCRA will increase enrollment by 3 to 4 million, regardless of the duration of the public health emergency (HMA 2020a). They also estimated how the economic downturn could affect enrollment in Medicaid, the ACA marketplace, and employer-sponsored coverage between 2020 and 2022 under three scenarios:

- the moderate scenario assumes unemployment peaks at 15 percent, with 70 percent of jobs recovered by the third quarter of 2020 and the remainder recovered over another 12 to 24 months;
- the heavy scenario assumes unemployment peaks at 18 percent, with 60 percent of jobs recovered by the second quarter of 2021 and the remainder recovered over another 24 to 48 months; and
- the severe scenario assumes unemployment peaks at 22 percent, with 50 percent of jobs recovered by the fourth quarter of 2021 and the remainder recovered over another 36 to 60 months.<sup>9</sup>





Overall, HMA estimated that Medicaid enrollment could increase by 5 to 18 million by the end of 2020 (HMA 2020a). Based on the most recent data from the U.S. Bureau of Labor Statistics, the May 2020 unemployment rate was 13.3 percent, a 1.4 percentage point decrease from April (BLS 2020a).<sup>10</sup> It is too soon to know whether unemployment will continue to decline.

## State revenues and spending options

Just as it is important to know how much demand there is for Medicaid in terms of enrollment, it is also important to assess the extent to which states can fund their share of these expenditures from their own revenues. Preliminary data from March 2020, the first month in which states began to experience widespread shutdowns, showed a 1.3 percent decline in total state taxes (Urban 2020). In addition, because the Internal Revenue Service and states delayed income tax deadlines from April to July, states presumably collected less income tax revenue than expected in April (the most important month for income tax payments) as many filers delayed estimated or final payments (Urban 2020). Some estimate that future state revenue declines are also likely to be substantial. For example, Moody's Analytics has projected that FY 2021 state revenues could be 18 to 23 percent lower than FY 2020 (Greenblatt 2020). The Center for Budget and Policy Priorities has estimated that state budget shortfalls could reach 15 percent in the current fiscal year (ending on June 30 in most states) and more than 25 percent in fiscal year 2021 (CBPP 2020). As noted earlier, the CBO has estimated that GDP will contract by 11 percent in the second quarter of this year, which will have a substantial effect on state revenues (CBO 2020a).

Generally, states balance Medicaid program growth and the availability of state revenue by making programmatic changes as appropriate: expanding the program when there is a surplus, and cutting provider rates, benefits, or eligibility when there is a deficit. Currently, states are constrained from using all three of these levers to reduce spending. First, all health care providers, but particularly Medicaid providers, are struggling financially as a result of both reduced demand resulting from stay-at-home orders associated with the public health emergency and with the additional costs of infection control. While Congress allocated \$100 billion to support providers affected by COVID-19 through the Coronavirus Aid, Relief, and Economic Security Act (CARES Act, P.L. 116-136), the majority of these funds were distributed to institutional providers based on Medicare revenues and were not used to support providers such as deemed disproportionate share hospitals, physician practices, health centers, children's hospitals, and other providers serving Medicaid and other low-income patients (MACPAC 2020). In the meantime, a number of states increased Medicaid payments for some providers, such as direct care workers in nursing facilities (NASHP 2020). Similarly, while some states may cut some optional benefits, many states are expanding coverage for telehealth, waiving premiums and cost sharing, and extending coverage to the uninsured for COVID-19 testing (NASHP 2020). Finally, as noted above, due to the MOE provision in the FFCRA, states cannot reduce eligibility if they want to receive the enhanced FMAP.

This leaves the federal government as the primary source of funding to cover both the increased demand for Medicaid and the revenue shortfall that states are experiencing. In the short term, states are already using the additional federal contribution to fill their revenue gaps without making program cuts. For example, Colorado plans to reduce state Medicaid spending by \$183 million in May and June (the last two months of the current fiscal year) by taking advantage of reduced outpatient utilization and increased federal contributions (Schmelzer 2020). Alaska reduced state Medicaid spending by \$31 million in April by



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applying the additional federal contributions to the Medicaid budget (Roubein and Goldberg 2020). However, using increased federal contributions to backfill reduced state share may not work over the longer term if state revenues continue to decline and enrollment continues to grow.

## Estimated effect of FFCRA FMAP increase

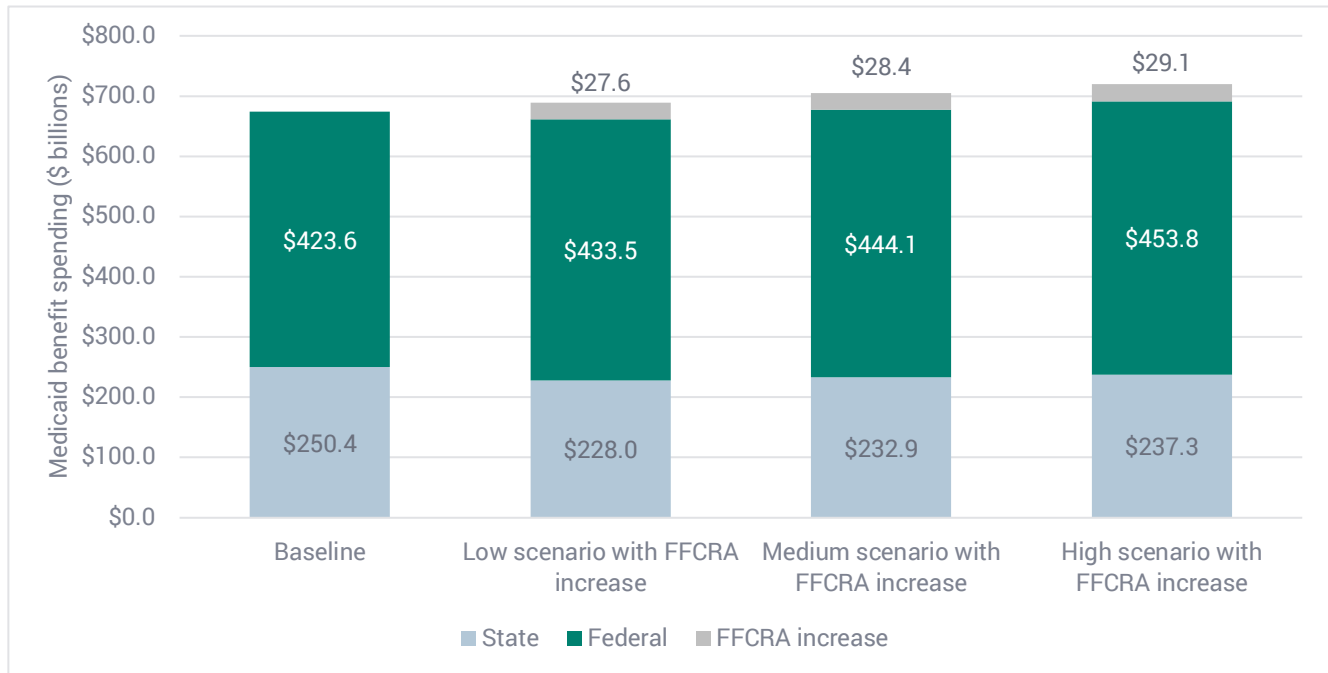
We used the FYs 2020 and 2021 Medicaid spending projections submitted by states to CMS on the CMS-37 program budget report in February 2020 to estimate the effect the 6.2 percentage point increase in FMAP under the FFCRA would have on states' budgets. Based on the CMS-37 submissions, combined state and federal Medicaid spending was anticipated to be \$674.0 billion (\$250.4 billion state, \$423.6 billion federal) in FY 2020 and \$689.9 billion (\$254.4 billion state, \$435.5 billion federal) in FY 2021. Because the CMS-37 projections submitted in February were developed prior to the COVID-19 pandemic, these projections do not incorporate any estimates of spending changes related to enrollment caused by the economic downturn or public health emergency. Given the lack of any other systematic data on state spending, we used the February 2020 state projections as the baseline for comparison.

We then applied the HMA enrollment projections to estimate potential increases in overall Medicaid spending and the split between state and federal spending, including the additional 6.2 percentage point FMAP increase under the FFCRA. Our low, medium, and high scenarios correspond to HMA's moderate, heavy, and severe scenarios respectively. More detail on our methodology can be found in Appendix A.

Under all three enrollment growth scenarios for FY 2020, overall and federal spending would increase but state contributions would be lower than the baseline (i.e., estimates on the most recent CMS-37 submission), which suggests that the additional FMAP contributions would help cover both the cost of increased enrollment and some decrease in state revenues (Figure 3). In particular for FY 2020, states benefit from receiving the FFCRA increase for three quarters (January through September) while the enrollment increases would primarily be for two quarters (April through September).



**FIGURE 3.** Federal and State Medicaid Benefit Spending with FFCRA Increase under Different Enrollment Growth Scenarios, FY 2020



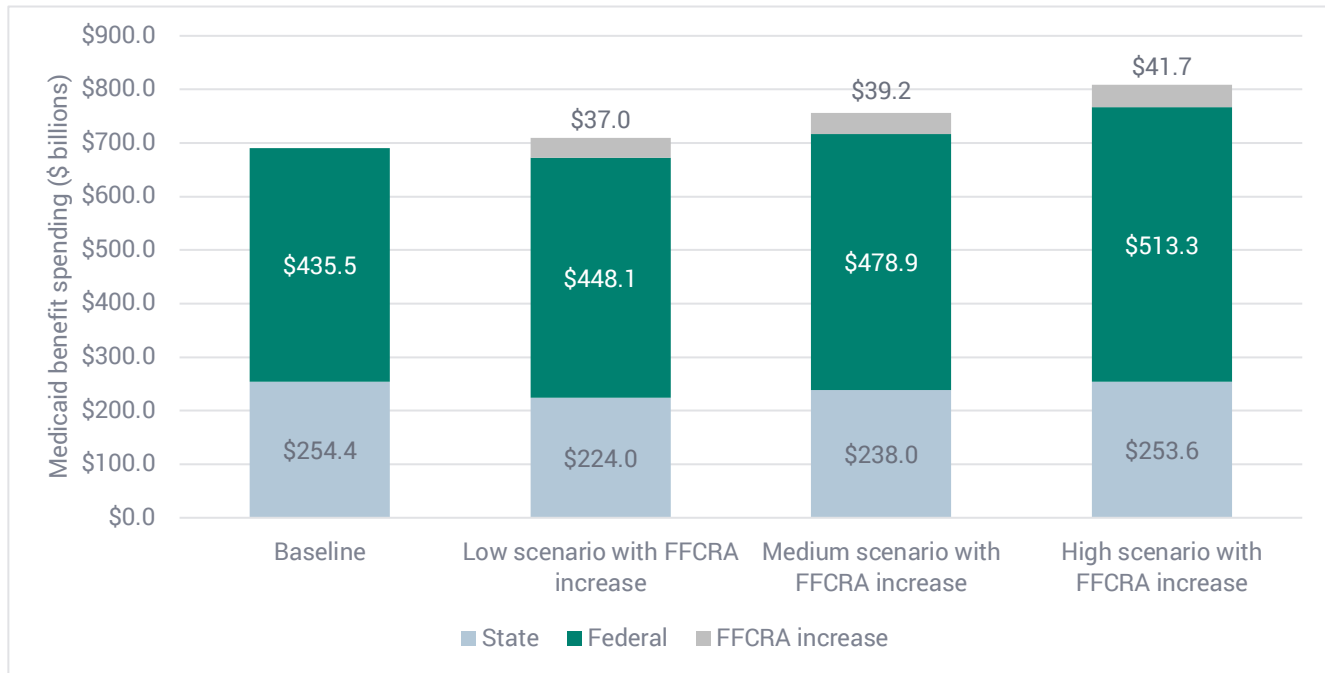
**Notes:** Excludes territories and CHIP. FY is fiscal year. FFCRA is Families First Coronavirus Response Act of 2020 (P.L. 116-127). The baseline represents the states' projections of Medicaid funding requirements for FYs 2020 and 2021 submitted on the CMS-37 in February 2020. FFCRA provides a temporary 6.2 percentage point federal medical assistance percentage (FMAP) increase during a public health emergency. The Secretary of the U.S. Department of Health and Human Services public health emergency determination was issued on January 31, 2020 with an effective date of January 27, 2020, meaning the FMAP increase is effective January 1, 2020. The FMAP increase does not apply to the Medicaid expansion population or other services such as those received at an Indian Health Service facility that already receive a higher matching rate. Estimates shown here assume the FFCRA increase goes through the end of the fiscal year. The low, medium, and high scenarios correspond to Health Management Associates' moderate, heavy, and severe scenarios respectively. Quarterly enrollment projections were averaged to estimate average monthly enrollment for the fiscal year.

**Sources:** MACPAC, 2020, analyses of CMS-37 Medicaid program budget report as of February 15, 2020; CMS-64 VIII group net expenditures and enrollment reports as of April 14, 2020; and 2007–2013 Medicaid Statistical Information System (MSIS) enrollment and spending data. MACPAC, 2020, MACStats, *Exhibit 6: Federal Medical Assistance Percentages and Enhanced FMAPs by State, FYs 2017–2021*. OACT, CMS, 2020, 2018 Actuarial report on the financial outlook for Medicaid, <https://www.cms.gov/files/document/2018-report.pdf>. HMA, 2020b.

In FY 2021, assuming that the FFCRA FMAP increase is in place for the entire year, states are less likely to experience a decrease in state spending due to the fact that these additional enrollees would be enrolled for the entire year instead of the six months we modeled for FY 2020 (Figure 4). Under the low and medium enrollment growth scenarios, overall and federal spending would increase but state contributions would be lower than the baseline, which suggests that the additional FMAP contributions would help cover both the cost of increased enrollment and some decrease in state revenues. Under the high enrollment growth scenario, overall and federal spending would increase and state contributions are about the same as the baseline, which suggests that the additional FMAP contributions already authorized under the FFCRA would largely just cover the cost of increased enrollment.



**FIGURE 4.** Federal and State Medicaid Benefit Spending with FFCRA Increase under Different Enrollment Growth Scenarios, FY 2021

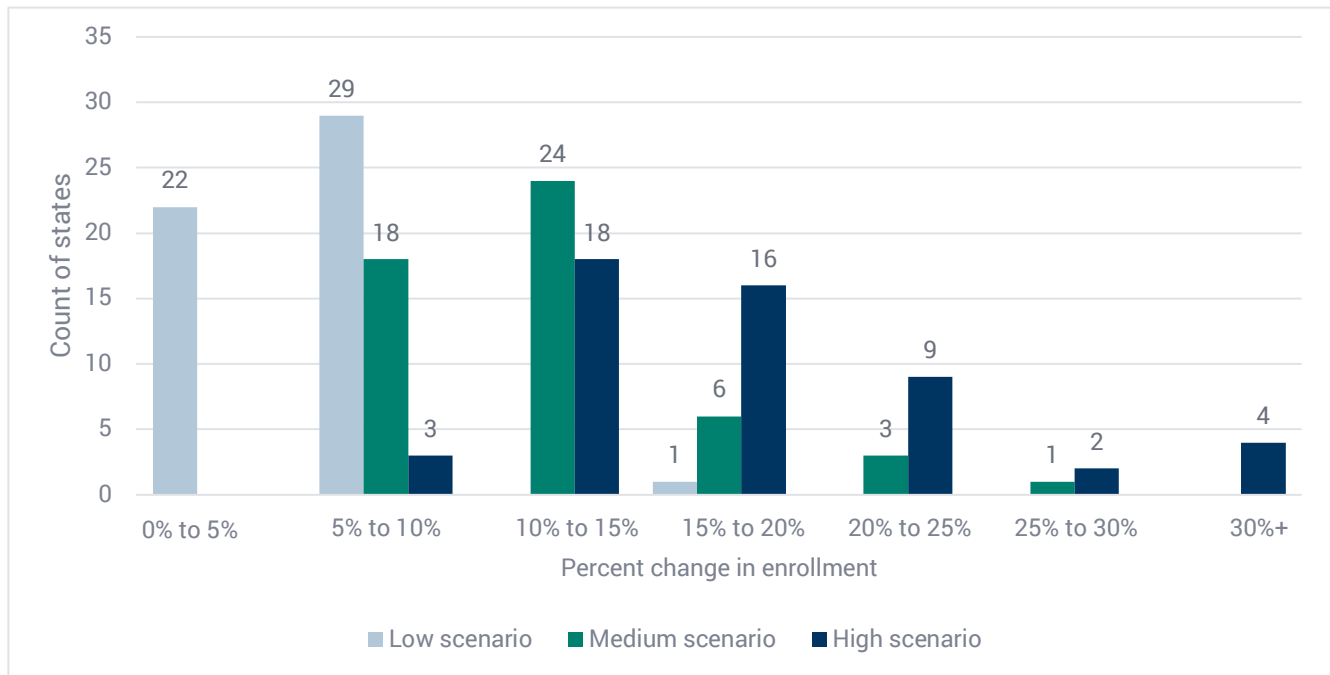


**Notes:** Excludes territories and CHIP. FY is fiscal year. FFCRA is Families First Coronavirus Response Act of 2020 (P.L. 116-127). The baseline represents the states' projections of Medicaid funding requirements for FYs 2020 and 2021 submitted on the CMS-37 in February 2020. FFCRA provides a temporary 6.2 percentage point federal medical assistance percentage (FMAP) increase during a public health emergency. The Secretary of the U.S. Department of Health and Human Services public health emergency determination was issued on January 31, 2020 with an effective date of January 27, 2020, meaning the FMAP increase is effective January 1, 2020. The FMAP increase does not apply to the Medicaid expansion population or other services such as those received at an Indian Health Service facility that already receive a higher matching rate. Estimates shown here assume the FFCRA increase goes through the end of the fiscal year. The low, medium, and high scenarios correspond to Health Management Associates' moderate, heavy, and severe scenarios respectively. Quarterly enrollment projections were averaged to estimate average monthly enrollment for the fiscal year.

**Sources:** MACPAC, 2020, analyses of CMS-37 Medicaid program budget report as of February 15, 2020; CMS-64 VIII group net expenditures and enrollment reports as of April 14, 2020; and 2007–2013 Medicaid Statistical Information System (MSIS) enrollment and spending data. MACPAC, 2020, MACStats, *Exhibit 6: Federal Medical Assistance Percentages and Enhanced FMAPs by State, FYs 2017–2021*. OACT, CMS, 2020, 2018 Actuarial report on the financial outlook for Medicaid, <https://www.cms.gov/files/document/2018-report.pdf>; HMA, 2020b.

**State effects.** While nationally the FFCRA FMAP increase would cover the enrollment increase under all three scenarios for FYs 2020 and 2021, this is not the case for all states. States would experience different decreases in state spending compared to the baseline, depending on their original FMAP. (In FY 2020 state contributions range from 16.82 percent to 50.00 percent, so an FMAP increase that reduces state share by 6.2 percentage points provides a much larger reduction in state share for states with high FMAPs and smaller state shares, and has a smaller effect on the one-quarter of states that have a 50 percent FMAP.)<sup>11</sup> Additionally, not all states are projected to have the same level of enrollment increase (Figures 5 and 6).

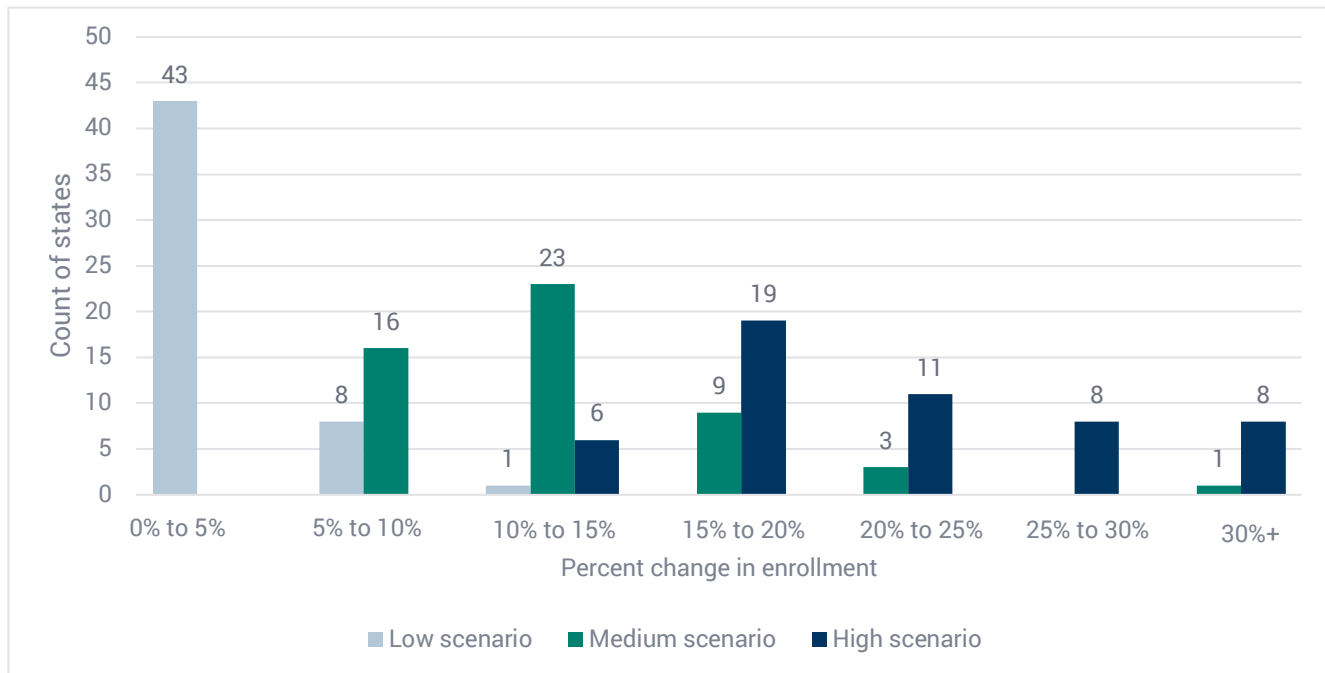


**FIGURE 5.** Number of States by Percent Change in Enrollment under Different Growth Scenarios, FY 2020

**Notes:** Excludes territories and CHIP. Quarterly enrollment projections from Health Management Associates (HMA) were averaged to estimate average monthly enrollment for the fiscal year. The low scenario corresponds to HMA's moderate scenario; the medium scenario corresponds to HMA's heavy scenario; and the high scenario corresponds to HMA's severe scenario.

**Source:** MACPAC, 2020, analysis of HMA 2020b.



**FIGURE 6.** Number of States by Percent Change in Enrollment under Different Growth Scenarios, FY 2021

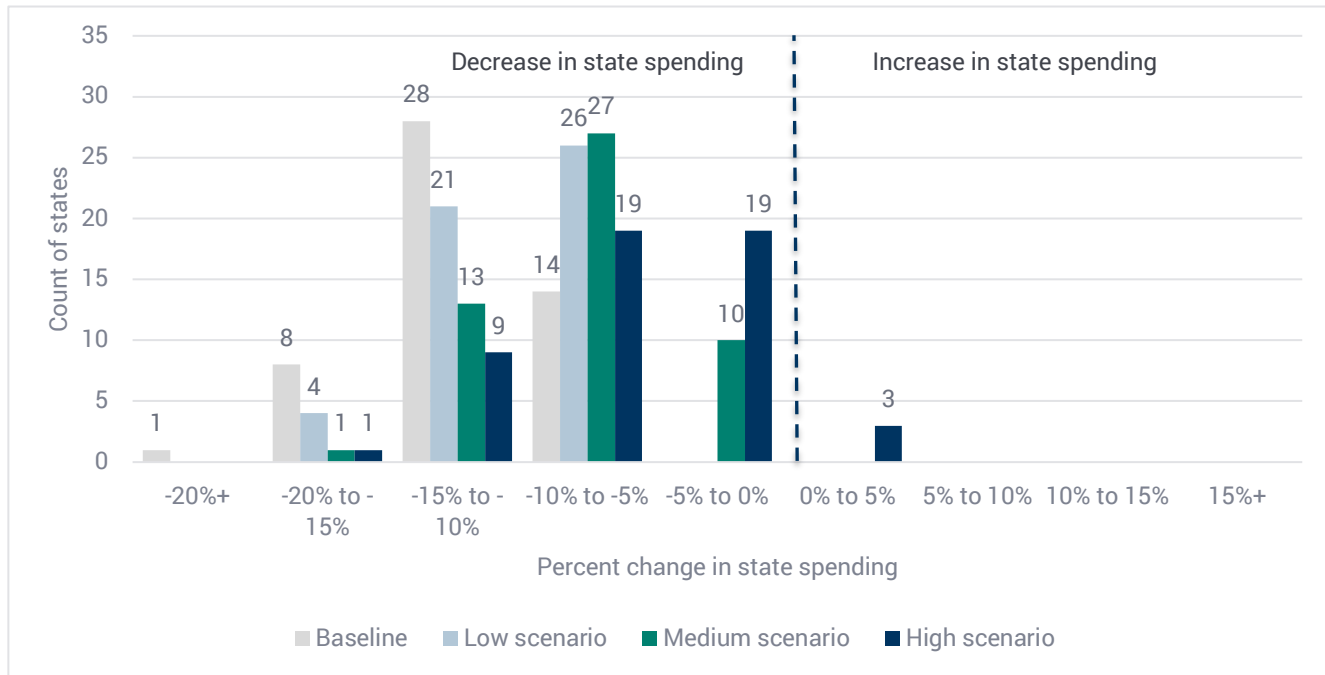
**Notes:** Excludes territories and CHIP. Quarterly enrollment projections from Health Management Associates (HMA) were averaged to estimate average monthly enrollment for the fiscal year. The low scenario corresponds to HMA's moderate scenario; the medium scenario corresponds to HMA's heavy scenario; and the high scenario corresponds to HMA's severe scenario.

**Sources:** MACPAC, 2020, analysis of HMA 2020b.

We can estimate the extent to which the FMAP increase will help cover the cost of increased enrollment at the state level by looking at whether state spending will increase compared to the baseline under the three scenarios. As noted above, the effect of a 6.2 percentage point FMAP increase depends in part on the state's original FMAP. With no enrollment increase, the FFCRA increase in FY 2020 would have reduced state spending for all states between 8.0 and 20.4 percent compared to the baseline, with most states (37 states) receiving a reduction of greater than 10 percent (Figure 7). Under the low- and medium-growth scenarios, all states would still experience a decrease in state spending compared to the baseline, but most states would receive a reduction of less than 10 percent (26 states under the low scenario and 37 states under the medium scenario). Under the high-growth scenario, 38 states would receive a reduction in state spending of less than 10 percent and 3 states would experience an increase in state spending.



**FIGURE 7.** Number of States by Percent Change in State Share with FFCRA Increase under Different Enrollment Growth Scenarios, FY 2020



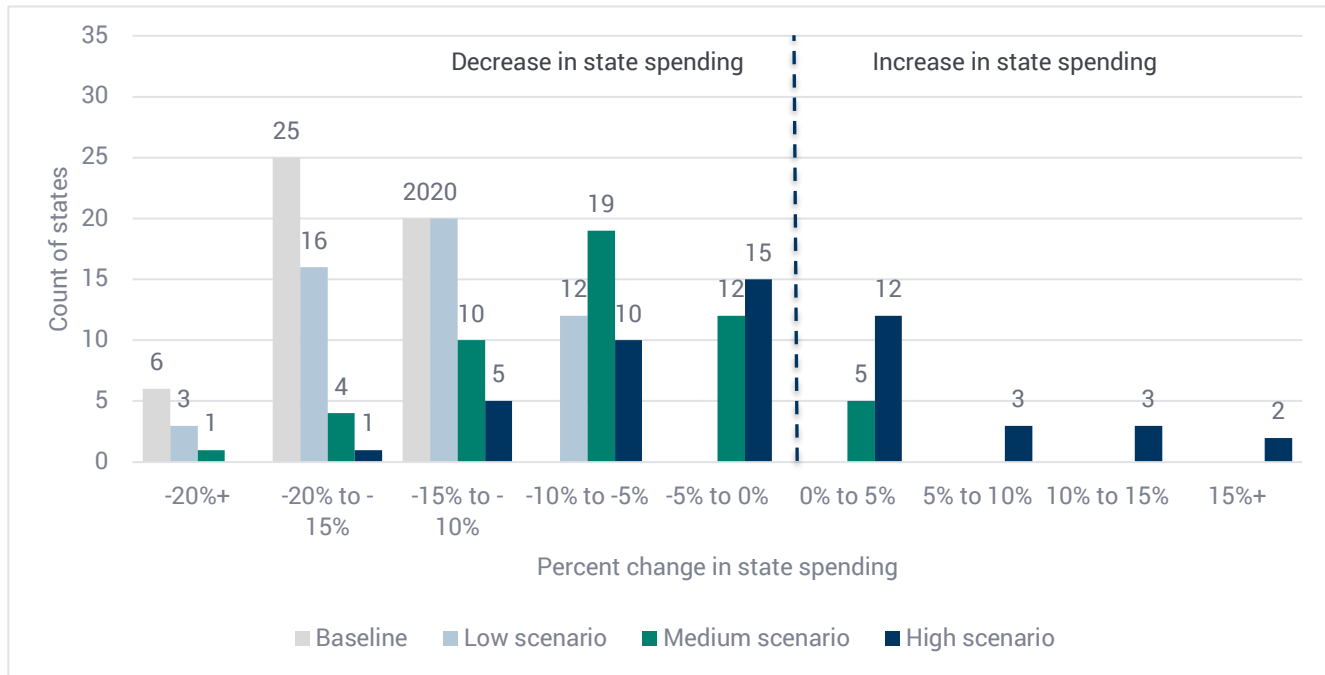
**Notes:** Excludes territories and CHIP. FFCRA is Families First Coronavirus Response Act of 2020 (P.L. 116-127). The baseline represents the states' projections of Medicaid funding requirements for FYs 2020 and 2021 submitted on the CMS-37 in February 2020. FFCRA provides a temporary 6.2 percentage point federal medical assistance percentage (FMAP) increase during a public health emergency. The Secretary of the U.S. Department of Health and Human Services public health emergency determination was issued on January 31, 2020 with an effective date of January 27, 2020, meaning the FMAP increase is effective January 1, 2020. The FMAP increase does not apply to the Medicaid expansion population or other services such as those received at an Indian Health Service facility that already receive a higher matching rate. Estimates shown here assume the FFCRA increase goes through the end of the fiscal year. The low, medium, and high scenarios correspond to Health Management Associates' moderate, heavy, and severe scenarios respectively. Quarterly enrollment projections were averaged to estimate average monthly enrollment for the fiscal year.

**Sources:** MACPAC, 2020, analyses of CMS-37 Medicaid program budget report as of February 15, 2020; CMS-64 VIII group net expenditures and enrollment reports as of April 14, 2020; and 2007–2013 Medicaid Statistical Information System (MSIS) enrollment and spending data. MACPAC, 2020, MACStats, *Exhibit 6: Federal Medical Assistance Percentages and Enhanced FMAPs by State, FYs 2017–2021*. OACT, CMS, 2020, 2018 Actuarial report on the financial outlook for Medicaid, <https://www.cms.gov/files/document/2018-report.pdf>; HMA, 2020b.

Assuming the FFCRA increase were in place for all of FY 2021 and there were no enrollment increases, all states would experience a decrease in state spending of greater than 10 percent compared to the 2021 baseline, ranging from 10.4 to 27.3 percent (Figure 8). Under the low-growth scenario, the majority of states (39) would still experience a decrease in state spending, but 12 states would experience a decrease of less than 10 percent. Under the medium- and high-growth scenarios, most states—46 and 31 respectively—would experience a decrease in state spending; however, 5 states under the medium scenario and 20 states under the high scenario would need to increase state spending over the baseline.



**FIGURE 8.** Number of States by Percent Change in State Share with FFCRA Increase under Different Enrollment Growth Scenarios, FY 2021



**Notes:** Excludes territories and CHIP. FFCRA is Families First Coronavirus Response Act of 2020 (P.L. 116-127). The baseline represents the states' projections of Medicaid funding requirements for FYs 2020 and 2021 submitted on the CMS-37 in February 2020. FFCRA provides a temporary 6.2 percentage point federal medical assistance percentage (FMAP) increase during a public health emergency. The Secretary of the U.S. Department of Health and Human Services public health emergency determination was issued on January 31, 2020 with an effective date of January 27, 2020, meaning the FMAP increase is effective January 1, 2020. The FMAP increase does not apply to the Medicaid expansion population or other services such as those received at an Indian Health Service facility that already receive a higher matching rate. Estimates shown here assume the FFCRA increase goes through the end of the fiscal year. The low, medium, and high scenarios correspond to Health Management Associates' moderate, heavy, and severe scenarios respectively. Quarterly enrollment projections were averaged to estimate average monthly enrollment for the fiscal year.

**Sources:** MACPAC, 2020, analyses of CMS-37 Medicaid program budget report as of February 15, 2022; CMS-64 VIII group net expenditures and enrollment reports as of April 14, 2020; and 2007–2013 Medicaid Statistical Information System (MSIS) enrollment and spending data. MACPAC, 2020, MACStats, *Exhibit 6: Federal Medical Assistance Percentages and Enhanced FMAPs by State, FYs 2017–2021*. OACT, CMS, 2020, 2018 Actuarial report on the financial outlook for Medicaid, <https://www.cms.gov/files/document/2018-report.pdf>; HMA, 2020b.

## FMAP increase needed to provide additional state fiscal relief

Based on our analyses, the 6.2 percentage point increase in FMAP under the FFCRA would generally cover the cost of increases in enrollment due to the economic downturn under all three of our enrollment scenarios. However, our baseline assumes that the states will contribute the amount of non-federal share as had been budgeted prior to the pandemic. However, we now know that states are projecting substantial shortfalls in general revenue that would make it difficult for them to contribute these anticipated amounts. Given the significant reduction in state revenue expected in 2020 and 2021, several states have already begun to make budget cuts for 2020, including Medicaid reductions (Roubein and Goldberg 2020,



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Schmelzer 2020). Apart from the effect this may have on enrollees and providers, cuts in state spending can also deepen and lengthen an economic downturn. To avoid this, Congress authorized FMAP increases in prior recessions.

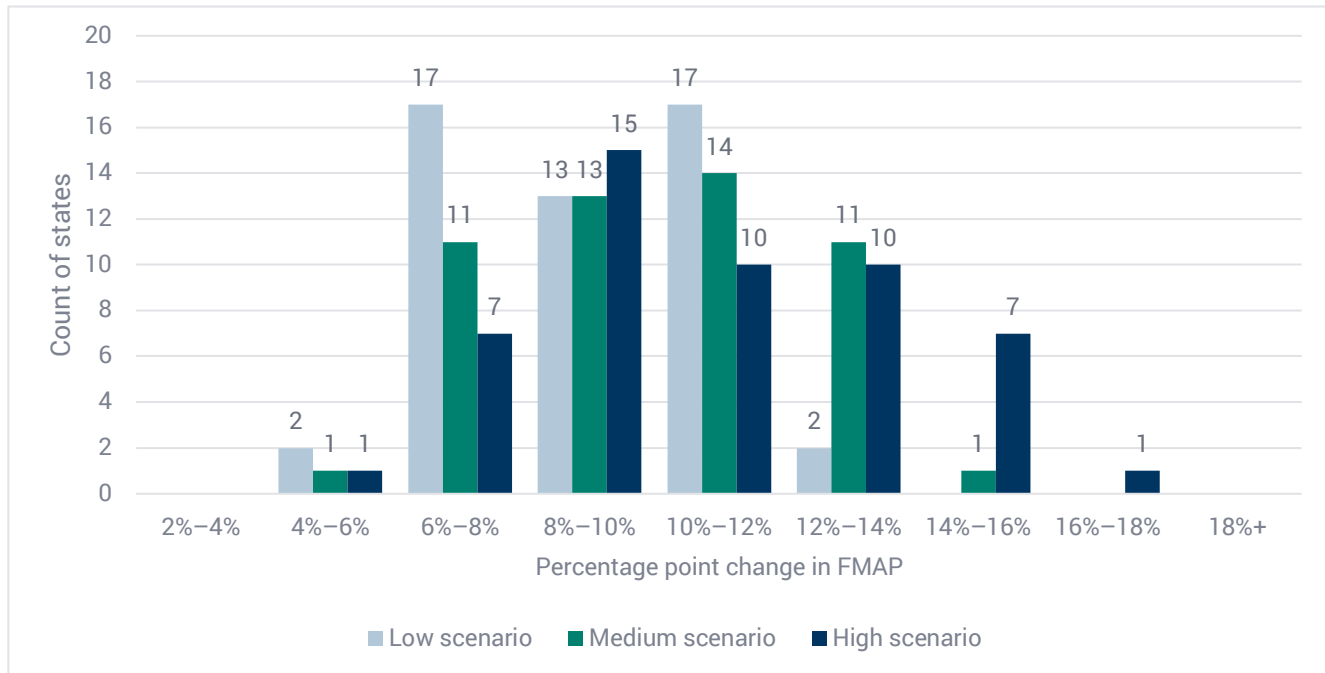
Additional stimulus or support to states could be provided by further increasing the FMAP in some states. We calculated the FMAP increase that would be required in each state to cover the increase in enrollment under the three growth scenarios, and also reduce state spending 15 percent compared to the FYs 2020 and 2021 baseline projections. Because a percentage point increase in FMAP provides a greater reduction in state spending for states with a higher FMAP, this means that the amount needed will vary by state.

We found that for FY 2020, most states would need between a 6 to 12 percentage point increase in the FMAP under the low-growth scenario and an 8 to 14 percentage point increase under the medium-growth scenario to cover both the increase in enrollment and provide a 15 percent reduction in state spending compared to the baseline (Figure 9). Under the high-growth scenario, a majority of states would need a 10 percentage point or higher increase.

Note that for some states, this means that they would need more than the 6.2 percentage point increase provided under the FFCRA, but some states would require less as these percentages are in total, not in addition to the FFCRA increase. An 8 to 14 percentage point FMAP increase is similar to the amount states received during the last recession; as noted above, the increase under ARRA varied by state and by quarter depending on a number of factors; at its highest point, the increase ranged from 9.1 percent to 15.6 percent (MACPAC 2014).



**FIGURE 9.** Number of States by Change in FMAP Required to Decrease State Spending 15 Percent Compared to Baseline under Different Enrollment Growth Scenarios, FY 2020



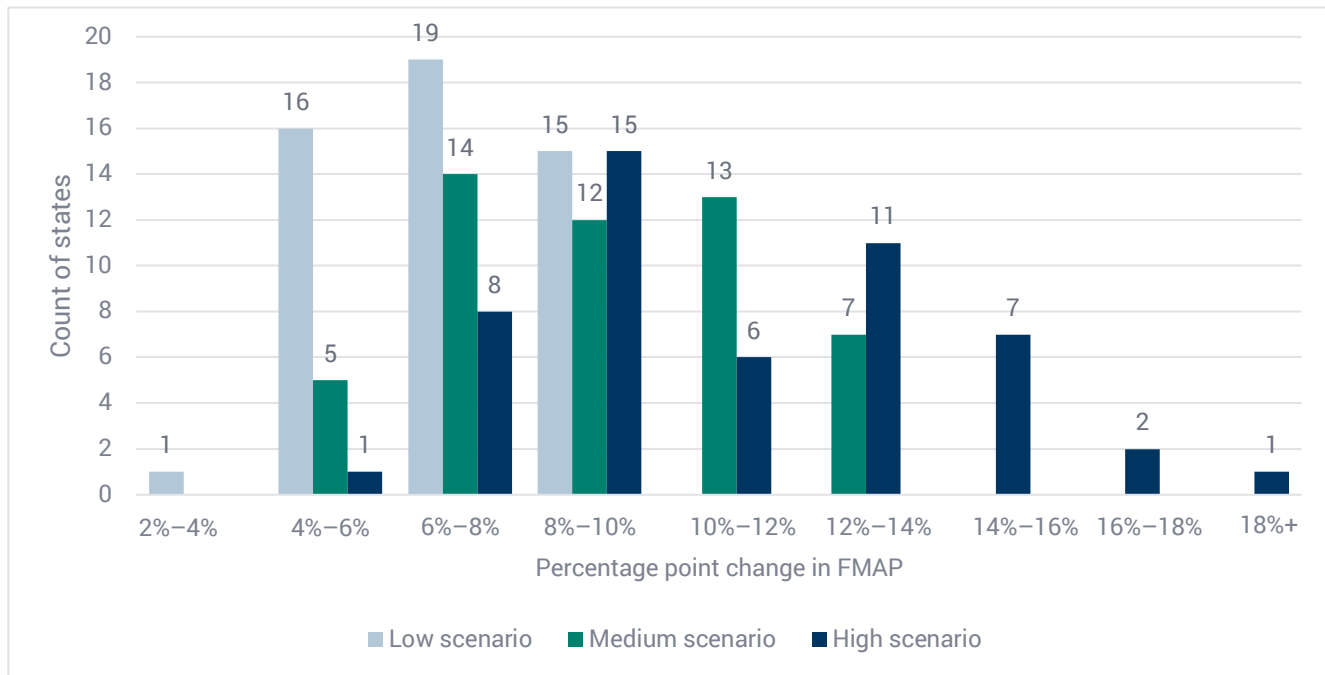
**Notes:** FFCRA is Families First Coronavirus Response Act of 2020 (P.L. 116-127). FMAP is federal medical assistance percentage. Excludes territories and CHIP. The baseline represents the states' projections of Medicaid funding requirements for FYs 2020 and 2021 submitted on the CMS-37 in February 2020. Modeling assumes the FMAP increase would be implemented in the same manner as the FFCRA and go through the end of the fiscal year. Enrollment increase scenarios are based on Health Management Associates modeling. The low, medium, and high scenarios correspond to Health Management Associates' moderate, heavy, and severe scenarios respectively. Quarterly enrollment projections were averaged to estimate average monthly enrollment for the fiscal year.

**Sources:** MACPAC, 2020, analyses of CMS-37 Medicaid program budget report as of February 15, 2020; CMS-64 VIII group net expenditures and enrollment reports as of April 14, 2020; and 2007–2013 Medicaid Statistical Information System (MSIS) enrollment and spending data. MACPAC, 2020, MACStats, *Exhibit 6: Federal Medical Assistance Percentages and Enhanced FMAPs by State, FYs 2017–2021*. OACT, CMS, 2020, 2018 Actuarial report on the financial outlook for Medicaid, <https://www.cms.gov/files/document/2018-report.pdf>; HMA, 2020b.

For FY 2021, we estimate that most states would need between a 4 to 10 percentage point increase in the FMAP under the low-growth scenario to cover both the increase in enrollment and provide a 15 percent reduction in state spending compared to the baseline (Figure 10). This assumes the public health emergency, and thus the FMAP increase, lasts through the entire fiscal year. If the FMAP increase does not last through this period, the percentage point increase would need to be larger. For the medium-growth scenario, most states would need between an 8 to 14 percentage point increase. For the high-growth scenario, a majority of states would need an FMAP increase of greater than 8 percentage points.



**FIGURE 10.** Number of States by Change in FMAP Required to Decrease State Spending 15 Percent Compared to Baseline under Different Enrollment Growth Scenarios, FY 2021



**Notes:** FFCRA is Families First Coronavirus Response Act of 2020 (P.L. 116-127). FMAP is federal medical assistance percentage. Excludes territories and CHIP. The baseline represents the states' projections of Medicaid funding requirements for FYs 2020 and 2021 submitted on the CMS-37 in February 2020. Modeling assumes the FMAP increase would be implemented in the same manner as the FFCRA and go through the end of the fiscal year. Enrollment increase scenarios are based on Health Management Associates modeling. The low, medium, and high scenarios correspond to Health Management Associates' moderate, heavy, and severe scenarios respectively. Quarterly enrollment projections were averaged to estimate average monthly enrollment for the fiscal year.

**Sources:** MACPAC, 2020, analyses of CMS-37 Medicaid program budget report as of February 15, 2020; CMS-64 VIII group net expenditures and enrollment reports as of April 14, 2020; and 2007–2013 Medicaid Statistical Information System (MSIS) enrollment and spending data. MACPAC, 2020, MACStats, *Exhibit 6: Federal Medical Assistance Percentages and Enhanced FMAPs by State, FYs 2017–2021*. OACT, CMS, 2020, 2018 Actuarial report on the financial outlook for Medicaid, <https://www.cms.gov/files/document/2018-report.pdf>; HMA, 2020b.

## Endnotes

<sup>1</sup> The hold harmless provision (§ 5001(a) of the Social Security Act (the Act)) held that for FY 2009, if a state's FY 2009 FMAP was less than the state's FY 2008 FMAP, the FMAP increase would be added to the FY 2008 FMAP. For example: if the FY 2008 FMAP was 60 percent and the FY 2009 FMAP was 58 percent, the 6.2. percentage point increase was applied to the 60 percent FMAP level applicable in FY 2008. For the first calendar quarter of FY 2011, if the state's FY 2011 FMAP was less than the FMAP for FY 2008, FY 2009 or FY 2010, the FMAP increase for the first calendar quarter of FY 2011 were applied to the greater of the FMAP level of the previous fiscal years.



<sup>2</sup> For states that qualified, the unemployment bonus (§ 5001(c)(3) of the Act) was weighted 35 percent and the FMAP increase was weighted 65 percent. ARRA increased the federal share by 5.5, 8.5, or 11.5 percent based on a state's peak three-month unemployment compared to the lowest three-month unemployment rate for that state since the beginning of 2006. The assistance was based on tiers of unemployment growth from 1.5–2.5 percent, 2.5–3.5 percent, or more than 3.5 percent.

<sup>3</sup> Some expenditures, including disproportionate share hospital (DSH) payments and expenditures that already receive enhanced FMAP rates, do not qualify for the disaster adjusted recovery FMAP rate.

<sup>4</sup> Enrollment growth is the primary driver of both short-term and long-term Medicaid spending growth. Prior MACPAC analysis found that the majority of historical growth in real Medicaid spending (adjusted for health care price inflation) can be attributed to enrollment. From FYs 1975 to 2012, more than two-thirds (70.7 percent) of growth in real Medicaid benefit spending was due to increases in the number of enrollees (MACPAC 2016).

<sup>5</sup> If the state had implemented more restrictive eligibility policies, it could not access the increased FMAP until such standards, methodologies, or procedures were restored to those in effect on July 1, 2008. States were given until June 30, 2009 to reverse any known MOE violations and could receive the enhanced FMAP retroactively to October 1, 2008. The increased FMAP period under which the MOE applied expired on June 30, 2011. In March 2010, Congress enacted the Patient Protection and Affordable Care Act (ACA, 111-148, as amended), which extended the Medicaid MOE requirements to 2014, applied them to CHIP, and carried the MOE forward to 2019 for children.

<sup>6</sup> The E-FMAP in section 2105(b) of the Act is calculated using the FMAP as defined in the first sentence of section 1905(b) as a base. Therefore, generally, as the 1905(b) FMAP increases for a state, the E-FMAP also increases for the state (although not in the exact same amount).

<sup>7</sup> The additional FMAP applies only to a state's regular federal match, not to the enhanced 90 percent match rate for the adult expansion population. The temporary enhanced FMAP also applies to the territories, which normally would mean that they would exhaust their annual federal allotments more quickly, but the FFCRA includes additional territorial federal allotments to supplement the annual allotments.

<sup>8</sup> This requirement to maintain continued coverage applies to beneficiaries who might otherwise have coverage terminated after a change in circumstances such as individuals who age out of a Medicaid eligibility group during the emergency period, who lose receipt of benefits that may affect their eligibility (e.g., Supplemental Security Income, foster care assistance payments), and whose whereabouts become unknown.

<sup>9</sup> Note that HMA provides two versions of unemployment rate in their analysis. For ease of comparison to frequently cited statistics reported by the U.S. Bureau of Labor Statistics (BLS), we refer to HMA's equivalent BLS unemployment rate.

<sup>10</sup> FAQs from BLS released with the May 2020 unemployment statistics note a potential issue concerning how some employees who were temporarily laid off reported their status. Some workers who were not at work during the entire reference week were not classified as unemployed on temporary layoff in May. Rather, they were classified as employed but absent from work. BLS analysis of the underlying data suggests that most of these workers should have been classified as unemployed on temporary layoff. This issue also occurred with the March and April statistics. If these individuals had been classified as unemployed on temporary layoff, the overall unemployment rate would have been about 3 percentage points higher than reported in May and almost 5 percentage points higher in April (BLS 2020b, 2020c).

<sup>11</sup> For example, if a state has a 70 percent FMAP, then the 6.2 percentage point increase would drop the state share from 30 percent to 23.8 percent—about a 21 percent drop. If a state has a 50 percent FMAP, the state share drops from 50 percent to 43.2 percent, a 12 percent drop.



## References

- Center on Budget and Policy Priorities (CBPP). 2020. *States grappling with hit to tax collections*. Washington, DC: CBPP. <https://www.cbpp.org/research/state-budget-and-tax/states-grappling-with-hit-to-tax-collections>.
- Centers for Medicare & Medicaid Services (CMS). 2020. Families First Coronavirus Response Act: Increased FMAP FAQs updated as of 4/13/2020. Baltimore, MD: CMS. <https://www.medicaid.gov/state-resource-center/downloads/covid-19-section-6008-faqs.pdf>.
- Congressional Budget Office (CBO). 2020a. *Interim economic projections for 2020 and 2021*. Washington, DC: CBO. <https://www.cbo.gov/system/files/2020-05/56351-CBO-interim-projections.pdf>.
- Congressional Budget Office (CBO). 2020b. *CBO's current projections of output, employment, and interest rates and a preliminary look at federal deficits for 2020 and 2021*. Washington, DC: CBO. <https://www.cbo.gov/publication/56335>.
- Congressional Budget Office (CBO). 2015. *Estimated impact of the American Recovery and Reinvestment Act on employment and economic output in 2014*. Washington, DC: CBO. <https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/49958-ARRA.pdf>.
- Feldman, N. 2020. Public health insurance claims soar in Pennsylvania, New Jersey, and Delaware. *WHYY*, May 25. <https://whyy.org/articles/public-health-insurance-claims-soar-in-pa-n-j-and-del>.
- Fiedler, M., J. Furman, and W. Powell III. 2019. *Increasing federal support for state Medicaid and CHIP programs in response to economic downturns*. Washington, DC: The Hamilton Project and the Washington Center for Equitable Growth. [http://www.hamiltonproject.org/papers/increasing\\_federal\\_support\\_for\\_state\\_medicaid\\_and\\_chip\\_programs\\_in\\_response](http://www.hamiltonproject.org/papers/increasing_federal_support_for_state_medicaid_and_chip_programs_in_response).
- Greenblatt, A. 2020. Absent fed help, state budgets will be the worst in decades. *Governing*, April 27. <https://www.governing.com/finance/Absent-Fed-Help-State-Budgets-Will-Be-the-Worst-in-Decades.html>.
- Health Management Associates (HMA). 2020a. COVID-19 impact on Medicaid, Marketplace, and the uninsured, May 2020 update. Lansing, MI: HMA. <https://www.healthmanagement.com/blog/hma-updates-forecast-of-covid-19-impact-on-medicaid-marketplace-uninsured/>.
- Health Management Associates (HMA) 2020b. E-mail to MACPAC, June 3.
- Medicaid and CHIP Payment and Access Commission (MACPAC). 2019a. Exhibit 5: Medicaid as a share of states' total budgets and state-funded budgets. In *MACStats: Medicaid and CHIP databook*. December 2019. Washington, DC: MACPAC. <https://www.macpac.gov/publication/medicaid-as-a-share-of-states-total-budgets-and-state-funded-budgets>.
- Medicaid and CHIP Payment and Access Commission (MACPAC). 2019b. Technical guide to MACStats. In *MACStats: Medicaid and CHIP databook*. December 2019. Washington, DC: MACPAC. <https://www.macpac.gov/publication/technical-guide-to-macstats/>.
- Medicaid and CHIP Payment and Access Commission (MACPAC). 2016. Chapter 2: Addressing Growth in Medicaid Spending: State Options. In *Report to the Congress on Medicaid and CHIP*. March 2016. Washington, DC: MACPAC. <https://www.macpac.gov/wp-content/uploads/2016/06/Addressing-Growth-in-Medicaid-Spending-State-Options.pdf>.
- Medicaid and CHIP Payment and Access Commission (MACPAC). 2014. Table 14. Federal Medical Assistance Percentages (FMAPs) and Enhanced FMAPs (E-FMAPs) by state, selected periods in FY 2011–FY 2015. In *MACStats: Medicaid and CHIP program statistics*. March 2014. Washington, DC: MACPAC. <https://www.macpac.gov/wp-content/uploads/2015/03/March-2014-MACStats.pdf>.
- National Academy of State Health Policy (NASHP). 2020. *State Medicaid and CHIP strategies to protect coverage during COVID-19*. Washington, DC: NASHP. <https://nashp.org/state-medicaid-and-chip-strategies-to-protect-coverage-during-covid-19>.



Medicaid and CHIP Payment  
and Access Commission  
[www.macpac.gov](http://www.macpac.gov)

- National Bureau of Economic Research (NBER). 2019. *US business cycle expansions and contractions*. Cambridge, MA: NBER. <https://www.nber.org/cycles.html>.
- Roubein, R. and D. Goldberg. 2020. States cut Medicaid as millions of jobless workers look to safety net. *Politico*, May 5. <https://www.politico.com/news/2020/05/05/states-cut-medicaid-programs-239208>
- Schmelzer, E. and S. Tabachnik. 2020. Gov. Jared Polis limits evictions, cuts immediate state spending by \$228.7 million. *The Denver Post*, May 1. <https://www.denverpost.com/2020/05/01/polis-coronavirus-covid-state-spending>.
- Smith, V., K. Gifford, E. Ellis, et al. 2010. *Hoping for economic recovery, preparing for health reform: A look at Medicaid spending, coverage and policy trends—results from a 50-state Medicaid budget survey for state fiscal years 2010 and 2011*. Washington, DC: Kaiser Commission on Medicaid and the Uninsured. <https://www.kff.org/wp-content/uploads/2013/01/8105.pdf>
- Smith, V., K. Gifford, E. Ellis, et al. 2009. *The crunch continues: Medicaid spending, coverage, and policy in the midst of a recession*. Washington, DC: Kaiser Family Foundation. <https://www.kff.org/wp-content/uploads/2013/01/7985.pdf>.
- U.S. Bureau of Labor Statistics (BLS). 2020a. The employment situation—May 2020. Washington, DC: BLS. <https://www.bls.gov/news.release/pdf/empsit.pdf>
- U.S. Bureau of Labor Statistics (BLS). 2020b. Frequently asked questions: The impact of the coronavirus (COVID-19) pandemic on the employment situation for May 2020. Washington, DC: BLS. <https://www.bls.gov/cps/employment-situation-covid19-faq-may-2020.pdf>.
- U.S. Bureau of Labor Statistics (BLS). 2020c. Frequently asked questions: The impact of the coronavirus (COVID-19) pandemic on the employment situation for April 2020. Washington, DC: BLS. <https://www.bls.gov/bls/employment-situation-covid19-faq-april-2020.htm>.
- U.S. Government Accountability Office (GAO). 2011a. Improving responsiveness of federal assistance to states during economic downturns. Report no. GAO-11-395. Washington, DC: GAO. <https://www.gao.gov/assets/320/317266.pdf>.
- U.S. Government Accountability Office (GAO). 2006. Strategies to help states address increased expenditures during economic downturns. Report no. GAO-07-97. Washington, DC: GAO. <https://www.gao.gov/assets/260/252693.pdf>.
- Urban Institute Tax Policy Center (Urban). 2020. Monthly state revenues highlights: March 2020. Washington, DC: Urban Institute. [https://www.urban.org/sites/default/files/monthlystrh\\_march2020.pdf](https://www.urban.org/sites/default/files/monthlystrh_march2020.pdf).



## Appendix A: Methodology

To estimate the effect of that the 6.2 percentage point increase in federal medical assistance percentage (FMAP) under the Families First Coronavirus Response Act (FFCRA, P.L. 116-127) and enrollment increases would have on states' budgets, we established a baseline of spending for fiscal years (FYs) 2020 and 2021 using the projections states submitted to the Centers for Medicare & Medicaid Services (CMS) on the CMS-37 program budget report in February 2020. Because the CMS-37 projections submitted in February were developed prior to the impact of the novel coronavirus (COVID-19) pandemic being known, these projections do not incorporate any estimates of spending changes related to enrollment caused by the economic downturn.

We estimated the baseline spending for each eligibility group using the CMS-37 projection for each state. For the new adult group, we applied the proportion of new adult group spending to total spending from the FY 2019 CMS-64 to the CMS-37 amount. For the other eligibility groups, we distributed the remaining spending to children, disabled, aged, and adults not in the new adult group based on the distribution of spending across these groups in FY 2013 using Medicaid Statistical Information System (MSIS) and CMS-64 data (MACPAC 2019b). We then estimated baseline enrollment by eligibility group using December 2019 enrollment from the CMS-64 enrollment report as a proxy for full-year equivalent (FYE) enrollees. We used enrollment for the new adult group as reported, and distributed the remaining enrollment to children, disabled, aged, and adults not in the new adult group based on the distribution of enrollment across those groups in FY 2013. We divided the FY 2020 spending by enrollment for each eligibility group to calculate spending per FYE.

To estimate the effect of potential enrollment increases, we obtained state-level estimates from the Health Management Associates (HMA) projections described earlier (HMA 2020b). In a May 2020 update, HMA developed projections for changes in Medicaid enrollment for 2020 through 2022 under three scenarios:

- the moderate scenario assumes unemployment peaks at 15 percent, with 70 percent of jobs recovered by the third quarter of 2020 and the remainder recovered over another 12 to 24 months;
- the heavy scenario assumes unemployment peaks at 18 percent, with 60 percent of jobs recovered by the second quarter of 2021 and the remainder recovered over another 24 to 48 months; and
- the severe scenario assumes unemployment peaks at 22 percent, with 50 percent of jobs recovered by the fourth quarter of 2021 and the remainder recovered over another 36 to 60 month.<sup>1</sup>

The HMA enrollment estimates were provided by quarter. We assumed the individuals in each quarter would be enrolled for all three months and averaged the quarters to calculate FYEs for the fiscal year. Using data on the change in enrollment by eligibility group between 2007 and 2010 during the last economic downturn, we made assumptions about how the increase in enrollment would be distributed across eligibility groups to reflect that enrollment increases during an economic downturn would be predominately in the child and adult groups. Overall, we estimated that just over half (52 percent) of the increase in enrollment would be for adults and about 37 percent for children, although this differed between expansion states (about 59 percent adults including the new adult group and 30 percent children)

and non-expansion states (about 52 percent children and 33 percent adults). We added the HMA projections to our 2020 baseline to create enrollment projections for the low, medium, and high scenarios. In expansion states, we distributed the enrollees between those in the new adult group and those not in the new adult group based on the current distribution between these populations in each state.

To calculate the additional spending attributable to increased enrollment, we used the HMA moderate, heavy, and severe scenarios to develop low, medium, and high projections respectively. We multiplied the spending per FYE estimates by eligibility group from our baseline scenario by our estimates of enrollment increases by eligibility group from the HMA projections for FYs 2020 and 2021.

We assumed that the cost characteristics of the new enrollees would be the same as the historical experience in each eligibility group and that spending per enrollee would not change, as we do not have systematic data to document any increase due to COVID-19 related costs or decrease due to reduced utilization under stay-at-home orders. We also assumed that the estimated state share for FYs 2020 and 2021 would not decrease. It is highly likely that there will be large changes in per enrollee spending and state contributions over the next two years; however, we chose to focus on changes in only one variable (enrollment) and hold the other two steady in order to focus on enrollment effects. If per enrollee medical assistance costs increase or state contributions decrease, the estimates here would understate the level of federal contribution that would be needed to address the fiscal crisis.

## Endnote

<sup>1</sup> Note that HMA provides two versions of unemployment rate in their analysis. For ease of comparison to frequently cited statistics reported by the U.S. Bureau of Labor Statistics (BLS), we refer to HMA's equivalent BLS unemployment rate.