Chapter 1:

An Automatic Countercyclical Financing Adjustment for Medicaid

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Recommendation

1.1 Congress should amend the Social Security Act to provide an automatic Medicaid countercyclical financing model, using the prototype developed by the U.S. Government Accountability Office as the basis. The Commission recommends this policy change should also include:

- an eligibility maintenance of effort requirement for the period covered by an automatic countercyclical financing adjustment;
- an upper bound of 100 percent on countercyclical adjusted matching rates; and
- an exclusion of the countercyclical adjusted federal matching rate from services and populations that receive special matching rates (e.g., for the new adult group) or are otherwise capped or have allotments (e.g., disproportionate share hospital payments, territories).

Key Points

- Medicaid is a countercyclical program: enrollment and spending increase when a downturn in the economic cycle leads to growth in the low-income population and the number of people losing employer-sponsored insurance.
- State and federal Medicaid spending supports state economies, and increases in Medicaid spending can counteract other spending reductions during a recession. If state revenue is declining, states can find it hard to finance their share of growing Medicaid expenditures. However, the Medicaid financing formula cannot adjust quickly to reflect lower state revenues, nor does it provide any mechanism for additional federal contributions to stimulate growth during a national recession.
- During prior recessions and the current COVID-19 public health emergency period, Congress temporarily increased the Medicaid federal medical assistance percentage (FMAP) to provide important financial relief to states. However, the timing and targeting of these actions did not allow states to plan and did not necessarily align well with their needs.
- A statutory mechanism to automatically increase the federal share of Medicaid expenditures by adjusting the FMAP formula under certain conditions would allow federal financial stimulus to be directed to states more quickly during economic downturns and would provide states with greater budget predictability.
- The Commission supports an automatic countercyclical adjustment that uses objective, timely indicators of an economic downturn; has a trigger that is sensitive but does not generate frequent adjustments; and targets additional federal financing based on state-level factors. The U.S. Government Accountability Office has developed a countercyclical FMAP model that meets these objectives.
- A temporary increase in federal financing should include appropriate limits and conditions, including a maintenance of effort provision, an upper bound or cap on increased FMAPs, and limits on the application of FMAP to special matching rates.

CHAPTER 1: An Automatic Countercyclical Financing Adjustment for 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 when the economy goes into recession 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, although Medicaid spending can increase in response to changes in economic activity, the federal-state financing formula, which determines how much states must contribute toward Medicaid expenditures, is adjusted only once per year using data across several years. This formula, which normally helps provide budget stability by minimizing year-to-year changes, also constrains the amount the federal share can increase in response to declining state economic conditions.

The Medicaid financing formula also does not provide a mechanism for increasing federal contributions to stimulate growth during a national recession. State Medicaid spending and the additional federal funds provided to match state expenditures go directly into state economies through payments to providers, which then indirectly support many other businesses and contribute to employment, household spending, and state and local tax collections. Reviews of studies examining the relationships between Medicaid and the economy have found that changes in Medicaid spending have corresponding effects throughout the state economy (KCMU 2013). However, although Medicaid provides the largest source of federal funding for states, the federal share cannot be automatically increased to offset reduced state and private spending on health care during a recession.

During the past two major recessions, Congress temporarily increased the Medicaid federal medical assistance percentage (FMAP) as part of a package of financial assistance to states in fiscal stimulus legislation. More recently, it also increased FMAPs for the duration of the emergency period associated with the COVID-19 pandemic. Our review has found that although such actions have provided important financial relief to states, they have not always aligned with the duration or level of state need. In addition, they have not accounted for differences among states in increased demand for Medicaid and states' ability to generate revenue to finance the state share of increased Medicaid expenditures.

Various organizations have suggested that Congress create a statutory mechanism to automatically increase the federal share of Medicaid expenditures by adjusting the FMAP formula if certain conditions are met. This would allow federal financial stimulus to be directed to states more quickly during economic downturns and provide states with greater budget predictability. Further, an automatic countercyclical adjustment to the FMAP formula could be designed to account for both increased enrollment in Medicaid and decreased state revenue, each of which may vary by state. For example, following each of the last two major recessions, the U.S. Government Accountability Office (GAO) suggested options for Congress to consider, including developing a countercyclical FMAP model that uses standard economic indicators to trigger a temporarily enhanced FMAP with state-specific percentage point changes (GAO 2011a, 2006).

In the Commission's judgment, a statutory change is needed to amend the federal financing formula to automatically increase the federal share of Medicaid expenditures if certain economic conditions are met.

Recommendation 1.1

Congress should amend the Social Security Act to provide an automatic Medicaid countercyclical financing model, using the prototype developed by the U.S. Government Accountability Office as the basis. The Commission recommends this policy change should also include:

- an eligibility maintenance of effort requirement for the period covered by an automatic countercyclical financing adjustment;
- an upper bound of 100 percent on countercyclical adjusted matching rates; and
- an exclusion of the countercyclical adjusted federal matching rate from services and populations that receive special matching rates (e.g., for the new adult group) or are otherwise capped or have allotments (e.g., disproportionate share hospital payments, territories).

This chapter begins by explaining Medicaid's role as a countercyclical program and how it functions as both an automatic stabilizer and to provide fiscal stimulus during economic downturns. The chapter then identifies several objectives of a permanent countercyclical financing mechanism and several related policy issues. We describe the features of the model proposed by GAO and examine the extent to which the GAO approach satisfies these objectives. The chapter concludes with the Commission's recommendation and rationale.

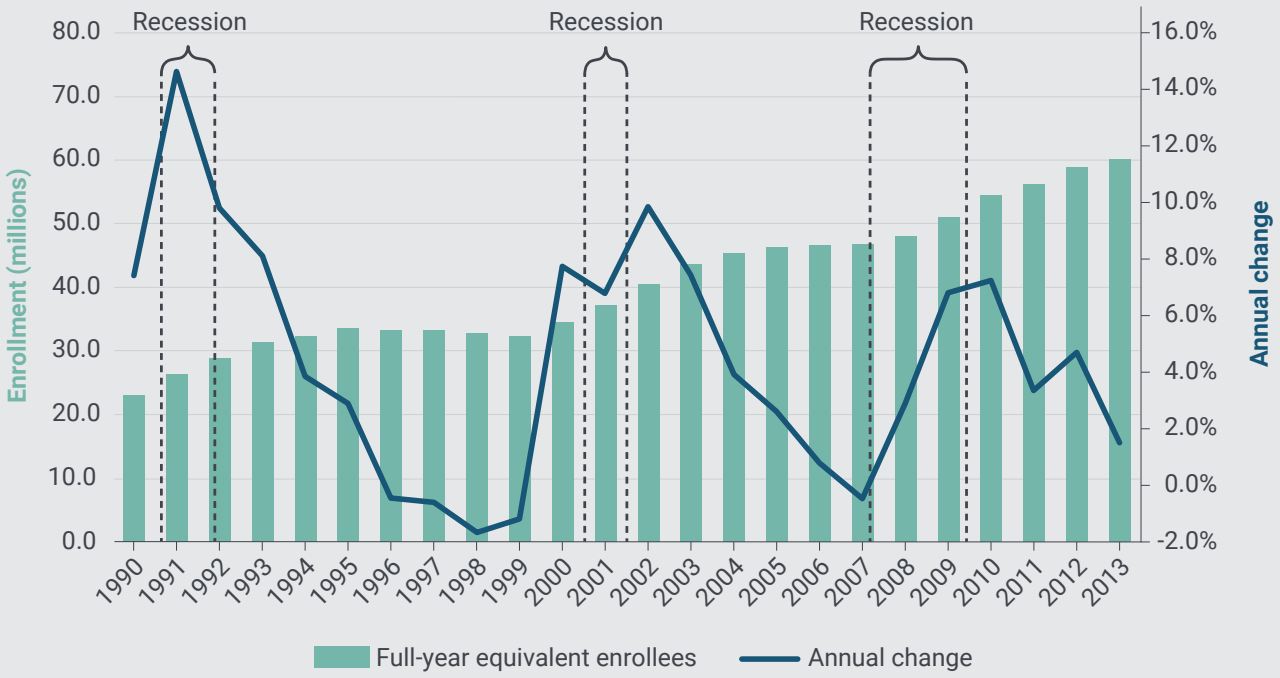
Medicaid as a Countercyclical Program

Medicaid is an open-ended entitlement program that functions as an automatic stabilizer with countercyclical effects: enrollment demand and, consequently, spending increase when a downturn in the economic cycle leads to rising unemployment, which in turn contributes to both increases in the low-income population and the number of people losing employer-sponsored insurance. Similar to other countercyclical programs such as unemployment insurance, increased demand for Medicaid coverage may vary by state. States also differ in their ability to generate revenue to finance the state share of increased Medicaid expenditures resulting from enrollment growth and their willingness to implement measures to reduce expenditures during a downturn.

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 (before the expansion of Medicaid to include adults under age 65 with incomes up to 133 percent of the federal poverty level in 2014), the average growth was about 4 percent per year. However, the rate of enrollment growth changes from year to year and is much greater during economic downturns (Figure 1-1). For example, prior to each of the last recessions, the rate of annual Medicaid enrollment growth was low or even declining but at the beginning of each of these downturns, enrollment quickly grew to an annual rate of about 8 percent or more.

FIGURE 1-1. Medicaid Enrollment and Enrollment Growth by Fiscal Year, 1990–2013



Note: Enrollment shows full-year equivalent enrollees, which also may be referred to as average monthly enrollment.

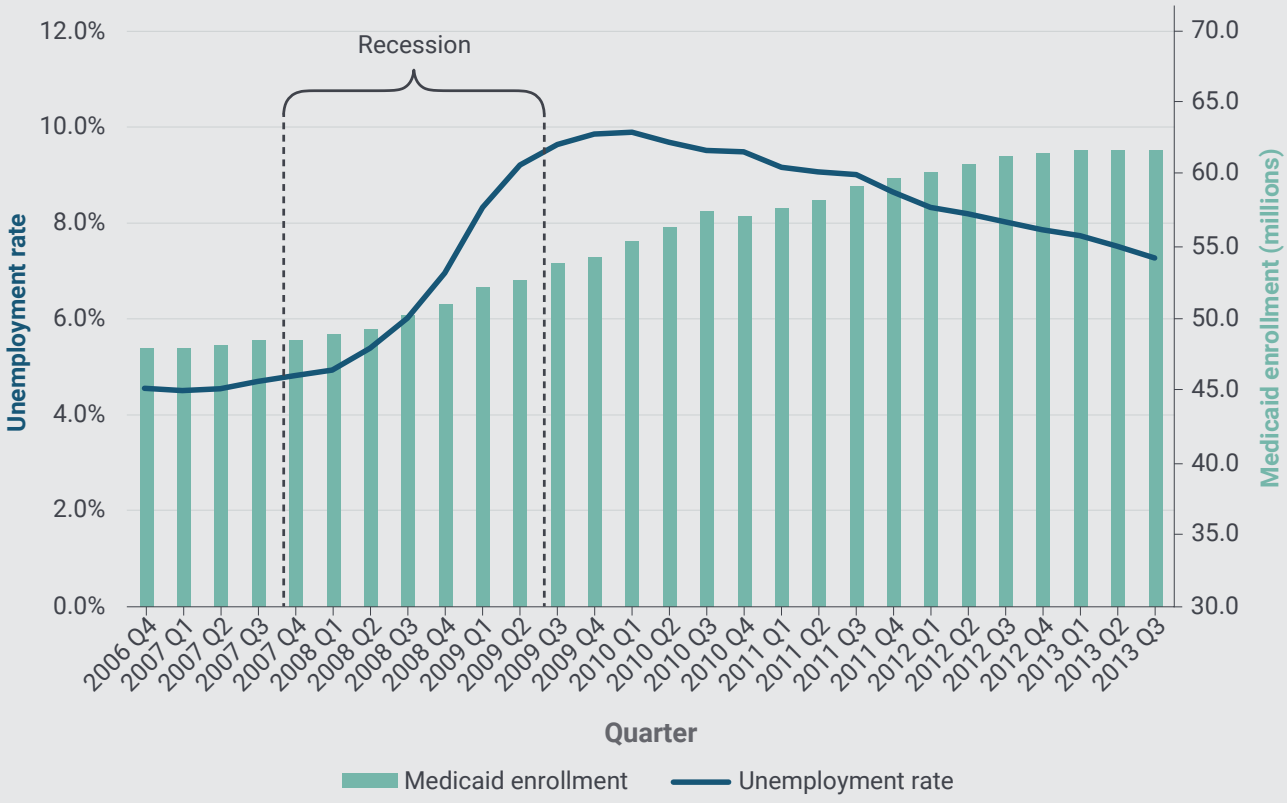
Source: MACPAC 2019.

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.

Finally, employment growth tends to lag behind general economic growth following a recession, so individuals who obtain Medicaid during a downturn may not gain employment or private coverage until long after the end of the official recession (Mattoon et al. 2010). For all of these reasons, states may continue to experience higher than average enrollment for several years after the end of an official recessionary period (Figure 1-2).

FIGURE 1-2. Unemployment Rate and Medicaid Enrollment by Quarter, Official Recessionary Period, 2006–2013



Notes: Q4 is fourth quarter. Q1 is first quarter. Q2 is second quarter. Q3 is third quarter. Enrollment shows the number of Medicaid beneficiaries ever enrolled in the quarter. The National Bureau of Economic Research declared a recession from December 2007 through June 2009.

Source: MACPAC, 2021, analysis of BLS 2020 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 percentage point rise in unemployment led to a 3 percent 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 effect on state budget needs of $45 billion (Fiedler and Powell 2020, 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. They generally have three levers to reduce Medicaid spending: cut provider rates, cut benefits, or cut eligibility. During the 2001 recession, many states introduced premiums and enrollment caps for some children, scaled back outreach and administrative simplifications, and otherwise sought to reduce enrollment to limit state spending despite the additional FMAP available through the Jobs and Growth Tax Relief Reconciliation Act (JGTRRA,

P.L. 108-27) (CCF 2017).[1] In response, Congress included a maintenance of effort (MOE) provision in the 2009 stimulus bill, requiring states to maintain existing Medicaid eligibility standards to receive enhanced federal funding. Although almost every state cut or froze provider rates during the 2007–2009 economic downturn, only one implemented an eligibility cut (Smith et al. 2009).[2]

Medicaid as an Automatic Stabilizer and Fiscal Stimulus

The ability of the open-ended federal Medicaid financing approach to automatically match increases in state spending in response to growing demand helps Medicaid meet its unique and varied roles as a source of health coverage for low-income populations. However, although the program tends to operate as an economic stabilizer, the current formula for sharing Medicaid expenditures between states and the federal government does not allow rapid and targeted increases in federal contributions when state economic conditions decline, nor does it provide additional federal contributions to stimulate growth during a national recession. In addition, there is no statutory mechanism to automatically adjust the FMAP formula during an economic downturn to account for increased enrollment in Medicaid or decreased state revenue. Therefore, Congress stepped in during prior recessions to provide temporary increases in the Medicaid FMAP to states as part of federal fiscal stimulus.

Medicaid as an automatic stabilizer

Automatic stabilizers are fiscal policies that offset cyclical changes in economic activity—as measured by gross domestic product (GDP), unemployment, or other indicators—through normal operations, without any additional governmental action. Automatic stabilizers can include graduated tax systems that lower tax rates as income brackets decline so individuals can keep a higher share of their income when their pay decreases as well as income-support and benefit programs that enroll anyone who is eligible and applies. 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 on the part of Congress.

This open-ended Medicaid financing approach allows states to draw down additional federal funds, but only to the extent that states also increase their spending. States' ability to obtain increased federal funds 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). In an economic downturn, declining revenues can affect the ability of states to finance the state share. Almost every state is required to balance its budget each year, and even in a downturn, states generally limit themselves to financing deficits only with accumulated reserves (Lee and Sheiner 2019). Thus, even though the federal government is not required to balance its budget each year and can appropriate expenditures in excess of anticipated revenues, the ability of Medicaid to function as an automatic stabilizer during a downturn is limited by the extent to which states can appropriate their share of program expenditures.

In addition, although Medicaid is largely financed by the federal government—in fiscal year (FY) 2019, about 64 percent of Medicaid expenditures were federal—the formula for determining each state's share also limits the effectiveness of Medicaid as an automatic stabilizer (MACPAC 2020a). 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 formula is intended to account for states' differing abilities to fund Medicaid from their own revenues, and the annual recalculation 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, given that 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 data used to calculate FMAPs for a given fiscal year are several years old by the time the fiscal year begins and that substantial redistributions of income across states are not fully reflected in the FMAP for several years.[3] Further, because the formula considers each state relative to the national average, a state can experience a recession and still see its FMAP decline if that state's per capita income drop is smaller than other states, no matter how painful it is locally.

Medicaid as a support for fiscal stimulus

A fiscal stimulus is a policy change that encourages economic growth during a recession, such as lowering interest rates or increasing government spending. Additional federal contributions to Medicaid can have a stimulative effect on the economy and encourage economic growth to the extent that these expenditures exceed any decreases in state and private spending on health care. Even if federal contributions only replace prior spending, by mitigating the need for program cuts and covering the cost of newly enrolled individuals, they can blunt the effects of a recession or shorten its duration.

As noted earlier, during the past two major recessions, Congress 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 federal stimulus to individual states experiencing temporary economic effects related to natural disasters by boosting the state's FMAP.[4] Most recently, Congress provided additional assistance to states in anticipation of both rising health costs and dropping state revenues associated with COVID-19 by increasing state FMAPs for the duration of the public health emergency (PHE).

2001 recession. The United States experienced a recession from March to November 2001, but many other indicators showed a weak economy over a longer period, between 2000 and 2003 (NBER 2003). In May 2003, Congress enacted the JGTRRA, which increased each state's FMAP by 2.95 percent (JGTRRA § 401(a)). States began receiving enhanced funding in June 2003, when the recession was over and the economy was expanding, although unemployment and Medicaid enrollment were still increasing (GAO 2011a). The Congressional Budget Office (CBO) estimated that the enhanced FMAP would provide states about $10 billion in additional federal funding over 2003 and 2004 (CBO 2003).

2007–2009 recession. The country experienced another recession from December 2007 through June 2009 (NBER 2020). 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). ARRA provided $787 billion in federal spending to offset reductions in private spending and bolster the economy. A substantial portion of this spending was in the form of an enhanced Medicaid FMAP for nine quarters, retroactive to October 1, 2008. This policy was structured to provide the following:

- a flat 6.2 percentage point increase in the FMAP for all states;
- an increased match to hold states harmless if they would otherwise experience a drop in their FMAP under the normal FMAP formula (which compares states to the national average);[5] and
- an additional change in FMAP for states with particularly high unemployment rates (i.e., decreasing the state share by 5.5 percent, 8.5 percent, or 11.5 percent based upon a state's peak three-month unemployment

rate compared to the lowest three-month unemployment rate of that state since the beginning of 2006).[6]

As in the prior recession, congressional action lagged behind declining economic conditions. By the time the ARRA changes went into effect, the recession had been underway for five quarters (GAO 2011b). The funding was available retroactively, so that states could claim enhanced match for expenditures incurred as of October 1, 2008. However, many states began making program cuts, including provider payment cuts, before ARRA was enacted and retroactive funding became available (Smith et al. 2009).

The average FMAP increase for states under ARRA varied by quarter and was highest during the first quarter of FY 2011, when it ranged from 9.1 to 15.6 percentage points and averaged 10.9 percentage points (unweighted). Congress 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, § 201). CBO estimated that the enhanced Medicaid FMAP provided through ARRA (as amended) increased federal Medicaid expenditures by $84 billion between 2009 and 2011 (CBO 2015).

An important aspect of the ARRA Medicaid provisions was the MOE requirement. To receive additional FMAP, states had to ensure that their eligibility policies, including eligibility standards, methodologies, and procedures, were no more restrictive during this period than those in effect in the quarter prior to the funding period (i.e., on July 1, 2008). If the state 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.

2020 recession. In early 2020, the rapid spread of COVID-19 led to the declaration of a national PHE on January 31 and a swift economic contraction in March as many businesses closed or furloughed workers due to the public health threat. On March 19, 2020, Congress enacted the Families First Coronavirus Response Act (FFCRA, P.L. 116-127), which includes a temporary enhancement to the Medicaid FMAP and the State Children's Health Insurance Program (CHIP) enhanced FMAP.[7] This temporary increase gives states and territories an additional 6.2 percentage points of federal share for the entire quarter in which the PHE was first declared through the last day of the quarter in which the PHE ends.

There is an MOE provision in effect, so states cannot receive the enhanced FMAP if they implement more restrictive eligibility standards, methodologies, or procedures (including under a waiver) or impose higher premiums than were in effect on January 1, 2020. In addition, the FFCRA established a continuous coverage requirement; to receive the enhanced financing, 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.

A Permanent Medicaid Countercyclical Mechanism

As an alternative to one-off legislative interventions, various policymakers have suggested that Congress could create a permanent statutory mechanism to automatically increase the federal share of Medicaid expenditures. 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, GAO developed a countercyclical FMAP model that would automatically trigger an enhanced FMAP when employment trends in more than half the states are declining compared to the previous year, then reverse the additional FMAP when more than half the states have improving employment

trends (GAO 2011c, 2006). Alternatively, researchers at the Hamilton Project at the Brookings Institution have proposed a state-specific approach that would compare each state's unemployment rate to its own long-run average to evaluate the need for an increased FMAP (Fiedler et al. 2019).

A statutory formula change that makes automatic countercyclical adjustments to the FMAP formula during economic downturns could be designed to provide additional federal contributions that account for both increased enrollment in Medicaid and decreased state revenue, while also providing timely and targeted state relief. As noted above, the timing and targeting of previous congressional actions did not necessarily align well with state need.

In considering the design of an automatic financing adjustment, the Commission identified several objectives:

- It should be automatic: There should be objective, timely indicators of an economic downturn that will automatically trigger changes in federal assistance, without the need for additional congressional intervention and inherent delays in the legislative process.
- It should have a trigger that is sensitive but not too sensitive: To provide effective assistance to states, the threshold should be able to signal the beginning or end of an economic downturn quickly, but not be so sensitive that small fluctuations would trigger frequent adjustments.
- Additional federal financing for states should be targeted based on state-level factors: The formula for providing assistance to states should be efficient, varying based on state-specific indicators that reflect differences in resources and need.

In addition, because an automatic countercyclical adjustment will affect the federal share of Medicaid expenditures, the Commission considered a number of refinements that could also be considered as part of any statutory change, including:

- whether additional rules should be attached to the use of federal matching funds (e.g., MOE requirements for eligibility, reporting requirements);
- whether to have an upper bound or cap on increased FMAPs; and
- whether additional FMAP should be applied to special matching rates (e.g., 90 percent FMAP for the new adult group).

Although the GAO and Hamilton Project models mentioned above both include mechanisms to end the increased federal assistance when certain indicators show sustained improvement, they also note that ending assistance when there is a return to economic growth is not the same as ending it after the economy has returned to a prerecessionary level of unemployment, spending, and state revenue. Some economic indicators, such as unemployment, may lag behind others, such as productivity or GDP (Figure 1-2). Depending on the severity of the recession, even a strong recovery—which could trigger an end to additional federal assistance under certain models—might not result in a return to prior levels of economic output for several years. Thus, although directing federal assistance to states at the beginning of a downturn is important, it is also important to ensure that it does not end too abruptly.

GAO Prototype Countercyclical Financing Model

In 2011, GAO proposed a prototype countercyclical financial model that would provide states with timely and targeted federal financial assistance on a temporary basis during a national economic downturn (GAO 2011a). GAO simulated its model using a baseline of funding for state Medicaid program needs during a downturn. However, the model could be scaled up to address broader needs or scaled down to meet a portion of state Medicaid needs. The prototype model aligns with the objectives identified by the Commission, as summarized below.

Automatic indicators to signal the beginning and end of an assistance period

In MACPAC's view, the mechanism should be based, to the extent possible, on objective, readily available economic data that correlate with changes in Medicaid enrollment and state revenues. The GAO model uses employment data to prompt automatic adjustments in FMAP. GAO found that previous recessions in 2001 and 2008 coincided with more than half the states experiencing declining job participation over two consecutive months and simulated its analysis to trigger an automatic increase when 26 or more states show increased unemployment (defined as a decrease in the three-month average employment-to-population ratio over the prior year) for two consecutive months. The GAO model ends the temporary assistance once fewer than half of states show a decline in their year-over-year employment-to-population ratio over two consecutive months (GAO 2011a).

Unemployment and employment data are calculated and published monthly, so they are timely and comparable measures across states. In addition, the unemployment rate may be considered a proxy for changes in demand for Medicaid, because persons losing employment are more likely to meet the income eligibility requirements and seek public coverage (Frenier et al. 2020). State-level employment and unemployment data are available from the U.S. Bureau of Labor Statistics (BLS) Local Area Unemployment Statistics program (BLS 2020). The data for a particular month are typically released during the third week of the following month.

The FMAP increase triggered by the GAO model would go into effect in the first fiscal quarter after the trigger month (the month in which 26 or more states show increased unemployment for the second consecutive month) so an FMAP increase could begin if the threshold were reached in the last month of the prior quarter, although this would not be known until the data were available in the third week of the following month.

Sensitivity to changes in the economy

To provide effective fiscal stimulus to states, an automatic formula would need to be able to respond to an economic downturn quickly but not be so sensitive that small fluctuations would trigger frequent adjustments. In the Commission's view, the GAO approach balances the need for a responsive measure against the creation of an overly sensitive trigger. This is accomplished by comparing each state's three-month average employment-to-population ratio to the prior year and looking for a decline over two consecutive months in at least 26 states. Use of the three-month average allows timely measurement while smoothing out some seasonal changes; looking at a year-over-year trend across two consecutive months allows some trend analysis and controls for seasonal employment differences.

Going back to 1990, GAO found that its model would have triggered assistance three times, corresponding to the recessions of July 1990–March 1991, March 2001–November 2001, and December 2007–June 2009.[8] In the 2001 and 2007—2009 recessions, the GAO prototype would have automatically adjusted the FMAP several quarters earlier than legislative action. Specifically, in response to the 2001 recession, Congress enacted the JGTRRA in May 2003, with a 2.95 percent FMAP increase that went into effect in June 2003. The GAO model would have provided assistance for 13 quarters beginning in July 2001 and ending in September 2004. Similarly, in response to the 2008 downturn, Congress enacted ARRA in February 2009, providing enhanced FMAPs for a 27-month period retroactive to October 1, 2008. The GAO model would have provided increased Medicaid funding beginning in January 2008, three quarters earlier than the retroactive legislative intervention, and would have ended in September 2011, one quarter later than the end of ARRA funding. (Congress did not provide any special Medicaid relief during the 1990–1991 recession so the sensitivity of the GAO model to congressional action cannot be compared.)

Based on state-level employment data from the BLS, we estimate that the GAO model would not have triggered another assistance period until 2020. Although individual states and regions of the country have experienced periodic economic downturns, particularly relating to natural disasters, since the last nationwide recession in 2007—2009, the fact that the GAO model would not have been triggered demonstrates its value as a national approach.

The GAO model would have triggered an assistance period in 2020, because a majority of states experienced a decrease in the average employment-to-population ratio in March and April. Because the trigger was met in April, the assistance period under the GAO model would have gone into effect for the quarter beginning on July 1, 2020. The data also show that all states continued to experience a decrease in the average employment-to-population ratio through September 2020, meaning that the assistance period would have extended through at least December 2020. All states received greater fiscal relief under the FFCRA in the two quarters prior to the first assistance period than they would have had GAO's model been in effect. This is because the legislative intervention was retroactive to January 1, and the first assistance period under the GAO model would have begun on July 1.[9]

Ability to target assistance to state-level economic conditions

Finally, the Commission supports an approach that is economically efficient by providing varying levels of assistance to states based on state-level factors that account for differences in resources and need. In 2003, Congress provided all states with the same increase in the federal share, which offered the benefit of quick implementation but led to uneven effects across states. In 2009, Congress provided all states with an across-the-board federal share increase and then made an additional adjustment based upon state unemployment levels. This approach was more targeted but did not fully take into account differences among states.

The GAO model addresses how much assistance to provide and how to vary it by state with a single formula that provides an increase in the federal contribution based on two state-specific factors:

- increases in state unemployment, as a proxy for increased Medicaid enrollment; and
- reductions in total wages and salaries, as a proxy for decreased revenues to support state Medicaid programs.[10]

The formula would decrease the state share by the corresponding increase in the unemployment rate and decrease in state wages and salaries. For example, if a state's FMAP formula had a 60-percent federal contribution and a 40-percent state contribution, and the unemployment rate went up 10 percentage points, the state share would go down by 10 percent of 40 percent, or 4 percentage points. If the state's total wages decreased 10 percent, the state share would go down by 10 percent of 40 percent, or 4 percentage points. Together, the state share would go down by 8 percentage points, from 40 percent to 32 percent.

Under the GAO model, the first component of the formula increase is based on the percentage point change in a state's unemployment compared to a baseline unemployment rate. The baseline is the lowest quarterly unemployment rate during the look-back period, which goes back at least eight quarters from the current quarter.[11] As noted above, state-level unemployment data for a particular month are typically released during the third week of the following month and there is generally a lag of one quarter to calculate the unemployment assistance portion of the FMAP adjustment. For example, for an assistance period in the third quarter, beginning July 1, the most recent quarterly state-level unemployment data available for analysis would be from the second quarter, April through June.

The second component of the GAO model is based on the percent change in a state's wages and salaries compared to a baseline figure.[12] The baseline is the highest quarterly wage and salary level during the look-back period, which goes back

at least eight quarters from the current quarter. State-level wages and salaries are a component of the Bureau of Economic Analysis (BEA) state quarterly personal income data. These data are typically released at the end of a quarter and have a lag of two quarters. For example, for an assistance period in the third quarter, beginning July 1, the most recent personal income data available for analysis would be from the first quarter, January through March.[13]

GAO has not applied its prototype formula to data from the current period, so MACPAC undertook its own analysis. As discussed above, based on the data available through September 2020, the GAO model would have gone into effect for the quarter beginning on July 1, 2020, and would have lasted at least through December 31, 2020. To estimate the effect of the FMAP increase under the GAO prototype for the current economic downturn, we used current unemployment and wage and salary data to estimate state-specific FMAP increases during the periods of assistance.[14]

To calculate the unemployment assistance component for each state during the first quarter of the assistance period (July–September), we used the most recent quarter of unemployment data available at the beginning of the quarter (April–June) and reviewed all quarters back to the second quarter of 2018 to identify the baseline (lowest) unemployment rate. We applied the GAO formula to calculate how much state share would decrease for each state in the first quarter of the assistance period. We then used July–September unemployment data for the second quarter of the assistance period (October–December) and adjusted the look-back period accordingly. Based on these data, all states would have received an FMAP increase from 1.32 to 8.41 percentage points through the unemployment component for the July–September period. Many states would have seen a decrease in this component for the October–December period because states' unemployment rates improved over the summer, with the FMAP increase for the unemployment component ranging from 0.46 to 5.37 percentage points for this period. If unemployment rates increase in subsequent quarters, then the FMAP change for the unemployment component will see a corresponding increase.

To calculate the wage and salary assistance component for each state during the first quarter of the assistance period (July–September), we applied the GAO formula using the most recent quarter of wage and salary data available (January–March) and looked back to the first quarter of 2018 to identify the baseline (highest) wage and salary level. We then updated these with April–June wage and salary data for the second quarter of the assistance period (October–December) and adjusted the look-back period accordingly. Based on these data, six states would not have received an FMAP increase from the wage and salary component for the July–September assistance period, because their wages and salaries in the proxy quarter were higher than the baseline. For the states that would have received an FMAP increase, the increase would have ranged from 0.002 to 1.26 percentage points. However, we note that the small FMAP increases during that quarter are primarily due to the lag in available data, because the most recent available data include months prior to the implementation of stay-at-home orders that began in March. States would have received a much larger increase in the wage and salary component during the October–December period, when data for April–June (when most states had stay-at-home orders in effect) would have been applied in the formula. All states would have received an FMAP increase under the wage and salary component during the October–December period, with the increases ranging from 0.91 to 5.23 percentage points.

Based on the application of the GAO prototype formula to data from the current recession, we estimate that states would have received a total FMAP increase ranging from 1.34 and 9.11 percentage points for the July–September 2020 assistance period. For the October–December 2020 assistance period, the FMAP increase would have ranged from 1.90 to 10.60 percentage points.

Our findings suggest that the GAO approach is effective at targeting assistance to state-level conditions. However, although the model can differentiate between state-level conditions, rapid changes in economic conditions may not be quickly reflected in an adjusted FMAP due to the lag in available data. Under the GAO model for July through September 2020, 42 states would have received an FMAP increase lower than the 6.2 percentage points received under the FFCRA and only 9 states would have received an FMAP increase greater than what they received under the FFCRA. Most states would have had a larger FMAP increase under the GAO model beginning in the October–December period than in prior quarters, because at that point data from the stay-at-home period would have been included in the wage and salary component of the formula, although most states (41) would still have experienced an increase lower than under the FFCRA.

Additional Policy Issues Related to Countercyclical Financing

An automatic countercyclical adjustment affects the federal share of Medicaid expenditures, and a number of policy issues relating to Medicaid financing should be addressed in conjunction with a permanent change to the federal financing mechanism. These policy issues include:

- whether additional rules should be attached to the use of federal matching funds (e.g., MOE requirements for eligibility);
- whether to have an upper bound or cap on increased FMAPs; and
- whether additional FMAP should be applied to special matching rates (e.g., 90 percent FMAP for the new adult group).

Maintenance of effort

During an economic downturn, states may struggle to raise the funds necessary to finance their share of Medicaid and look to reduce program spending through service or eligibility reductions. To ensure that states use additional federal funds to support the cost of increased Medicaid enrollment and replace reduced state revenues and not as a substitute for state contributions, an automatic FMAP provision could include an MOE requirement.

The MOE provision in ARRA prevented states from implementing more restrictive eligibility standards, methodologies, or procedures as long as they received the enhanced FMAP, but allowed them to continue operating their eligibility and redetermination processes. By contrast, the MOE provision in FFCRA is paired with a continuous coverage requirement that requires states to continue covering all individuals enrolled at the time the provision went into effect or determined eligible after that point, until the end of the month when the PHE expires (although the enhanced FMAP would go through the end of that quarter). An MOE does not have to be paired with a continuous coverage requirement, which arguably was particularly important in 2020 given that the economic downturn was the result of a public health crisis. During the COVID-19 pandemic, access to continuous health care coverage is important to help individuals get diagnosis and treatment.

Upper bound

Policymakers may also want to consider whether there should be an upper bound or cap for states, some of which already have high federal matching rates. The statutory maximum FMAP for Medicaid under the regular formula is 83 percent, although in FY 2020, the highest state FMAP is 76.98 percent (MACPAC 2020b). Because the GAO formula does not have a mathematical maximum, if a state near or at the statutory maximum receives 17 to 20 percentage points on top of its regular FMAP, it could potentially exceed 100 percent FMAP, in which case no state contribution would be required for

medical assistance expenditures (only for program administration and expenditures not eligible for additional FMAP). Congress could specify that the enhanced FMAP could not exceed 100 percent, or another figure between 83 percent and 100 percent. Because a state would be unlikely to require such a large increase in federal contribution unless it was experiencing large increases in state unemployment and large reductions in state revenues, Congress could also consider allowing states to receive the entire amount determined by the GAO formula but impose limitations to support program integrity (e.g., prohibit excessive provider rate increases).

Application of additional FMAP percentage

Traditionally, temporarily enhanced FMAPs have applied only to a state's regular federal match rate, and have not been applied to services that already have higher FMAPs in statute—e.g., family planning services and services provided by the Indian Health Service. Services with higher match rates represent a small proportion of Medicaid spending. A notable exception is the 90-percent matching rate for the new adult group covered under Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act (the Act).[15] This exception applies to all services received by individuals with this basis of eligibility, apart from services that already have higher FMAPs in statute. In FY 2018, 14.8 million people were in the new adult group; expenditures for this group accounted for about 16.9 percent of total medical benefit expenditures (MACPAC 2020d, 2020e). The FFCRA FMAP increase is the first temporarily enhanced FMAP that has gone into effect since coverage began for the new adult group, and Congress excluded that group from the enhanced FMAP.

Congress has sometimes excluded temporarily enhanced FMAPs from services or programs that have designated allotments—e.g., disproportionate share hospital (DSH) payments, payments to the territories, and CHIP (MACPAC 2020c).[16] For example, when Congress applied a temporary increase to the Medicaid FMAP in 2009, it excluded DSH payments so states would not exhaust their annual allotments more quickly than planned by drawing them down at the higher rate. Congress has sometimes increased federal allotments for capped programs, such as the territories, to give them sufficient funding and allow them to benefit from the stimulative effect of the higher FMAP rate.

Commission Recommendation

In this report, the Commission recommends that Congress adopt a statutory mechanism to adjust the FMAP formula to automatically increase the federal share of Medicaid expenditures if certain economic conditions are met.

Recommendation 1.1

Congress should amend the Social Security Act to provide an automatic Medicaid countercyclical financing model, using the prototype developed by the U.S. Government Accountability Office as the basis. The Commission recommends this policy change should also include:

- an eligibility maintenance of effort requirement for the period covered by an automatic countercyclical financing adjustment;
- an upper bound of 100 percent on countercyclical adjusted matching rates; and
- an exclusion of the countercyclical adjusted federal matching rate from services and populations that receive special matching rates (e.g., for the new adult group) or are otherwise capped or have allotments (e.g., disproportionate share hospital payments, territories).

Rationale

During the last 20 years, the United States has experienced three nationwide recessions and each time, Congress has acted to provide additional

federal funds to states in the form of enhanced FMAP (among other forms of federal assistance). Although states have welcomed this assistance, during the first two of these recessions–the gradual nature of the economic downturn made it difficult for Congress to be proactive in identifying state need and taking action. In all three recessions, Congress found it hard to proactively determine how long to leave an FMAP increase in place or how to target assistance to states.

A statutory mechanism to automatically increase the federal share of Medicaid expenditures by adjusting the FMAP formula if certain conditions are met could allow federal financial stimulus to be directed to states more quickly during economic downturns. It could be designed to be automatic, using objective, timely indicators of an economic downturn; have a sensitive trigger to signal the beginning or end of an economic downturn quickly but not be so sensitive that small fluctuations would trigger frequent adjustments; and be able to target assistance to states based on state-level factors. In addition, limits can be placed on the use of enhanced federal financing to restrict their use to regular medical assistance expenditures and ensure that additional federal funds do not substitute for available state funds.

We examined the prototype countercyclical financing model developed by GAO and compared it to the legislative interventions during the current and prior two recessions. Overall, we found:

In a regular recession, the GAO prototype would automatically provide assistance to states several quarters before Congress acts. In the 2001 and 2007–2009 recessions, which were part of the regular economic cycle, Congress did not act to provide fiscal relief to states until after several quarters of economic decline. The GAO model, applied to contemporaneous data, would trigger an FMAP increase as much as two years earlier than congressional action. However, in 2020, where the economic contraction was extremely quick, Congress also acted quickly and put relief measures into place faster than economic trends could be compiled. In this case, the GAO model would have increased the FMAP six months later than the stimulus bill.

The GAO prototype appears to be sufficiently sensitive to align with major recessions, but not so sensitive that it triggers an FMAP increase due to minor economic fluctuations. The three periods over the last 20 years that the GAO prototype model triggered an FMAP increase—July 2001–September 2004, January 2008–September 2001, and 2020—also coincide with official recessions as determined by the National Bureau of Economic Research (NBER 2020). NBER uses changes in GDP to determine whether there is a recession. The GAO model uses unemployment data to signal the start and end of an FMAP increase, so although the FMAP increases aligned with the official recessionary periods they would also have continued to provide federal support after the last month of economic contraction (November 2001 and June 2009). Economists have found that unemployment, which can contribute to individuals seeking Medicaid coverage, tends to lag behind the business cycle and is highest after the economy has begun to expand (Mattoon et al. 2010). Thus, the GAO model would provide support to states that continue to see increases in Medicaid enrollment after the official end of each recession.

The GAO prototype adjusts federal relief to state-level conditions. Congress has used both flat enhanced FMAP approaches and ones that vary based on state-level factors, each of which have advantages and disadvantages. The GAO prototype, which uses both unemployment data and wage and salary data to determine the amount of additional FMAP each state will get per quarter, (1) allows the enhanced FMAP to be targeted according to state-level conditions; (2) relates the amount of enhanced FMAP to proxies for both additional demand for Medicaid (unemployment) and decreases in state revenues (wages and salaries); and (3) varies the amount of enhanced FMAP each quarter as new data are available. Together, these factors should direct more enhanced funding to states with greater

need and less enhanced FMAP to states with less need, as measured by these two indicators.

Despite the fact that the GAO prototype model meets the objectives that the Commission identified for a countercyclical financing mechanism, it does not address certain policy issues related to automatic changes in FMAP. Thus, the Commission also recommends that adoption of this model be enhanced by adoption of additional statutory changes similar to those Congress enacted with prior temporary FMAP increases. These include:

- an eligibility MOE requirement for the period covered by an automatic countercyclical financing adjustment;
- an upper bound of 100 percent on countercyclical adjusted FMAPs; and
- an exclusion of the countercyclical adjusted FMAP from services and populations that receive special matching rates (e.g., 90 percent FMAP for the new adult group) or are otherwise capped or have allotments (e.g., DSH, territories).

Adoption of an MOE will help ensure that states use additional federal funds to support the cost of increased Medicaid enrollment and replace reduced state revenues, rather than substituting for state contributions. A cap or ceiling on additional FMAP will ensure that that federal contributions to states for medical assistance are limited to 100 percent of state expenditures, regardless of the formula calculation. Finally, additional FMAP should be applied only to expenditures eligible for regular FMAP as services and populations that have already have statutory exceptions to the regular FMAP should maintain those exceptions and services. Program features with caps or allotments should not be put at risk of drawing down those funds more quickly than anticipated due to a higher than expected FMAP rate.

Implications

Federal spending. The CBO estimates that if Congress amends the Act as recommended, with a countercyclical financing adjustment going into effect for FY 2023, federal Medicaid expenditures would increase less than $1 billion in the first year and between $30 billion and $40 billion over the following 10-year period. This estimate would affect the calculation of the Medicaid baseline for purposes of determining the size of the federal budget, because expenditures authorized by Congress are included in the annual and 10-year budget estimates. The CBO uses updated economic data to reassess the potential severity and timing of a future recession as part of the annual budget process, so the estimated cost of this policy could change in later years.

It is important to note that these estimates assume that Congress will not otherwise act to increase the FMAP in future downturns. Clearly, if Congress does not adopt this recommendation, it could still decide to provide an FMAP increase in response to a future economic downturn by passing specific legislation, as it has done several times in the past, and such changes would increase federal spending. For example, in 2009, Congress authorized a 27-month increase in Medicaid FMAP that added $32 billion in federal Medicaid outlays in FY 2009 and $40 billion in FY 2010 (CBO 2009). These types of stimulus expenditures cannot be factored into routine budgeting processes and are not included in the Medicaid baseline once their authority expires.

States. Increases in federal spending would reduce spending for states, although the amounts would vary depending on state-level unemployment and wage and salary data. The availability of additional federal funding would be predictable, facilitating state decision making and prioritization, and automatic, without the delays inherent in the federal legislative process. However, if the economic indicators in the GAO model do not serve as adequate proxies for increased enrollment and decreased revenues, states may find that the additional funding is not well targeted to state need.

Enrollees. The availability of additional federal funding and the MOE will help ensure that states have the funds and the incentive to support increased Medicaid enrollment during an economic downturn.

Plans and providers. The availability of a predictable source of additional federal funding will help states more effectively determine how to allocate their budgets, and may enable them to delay or avoid provider and plan rate cuts that would otherwise be made to meet a state balanced budget requirement.

Endnotes

[1] States were not allowed to use premiums and enrollment caps in Medicaid, but were allowed to apply these types of policies in the State Children's Health Insurance Program (CHIP), which enrolls children with higher incomes than those enrolled in Medicaid.

[2] 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.

[3] The Commission reviewed a number of economic indicators in addition to those used in the GAO model (e.g., per capita income, GDP, state sales tax collections) for their usefulness in constructing an automatic countercyclical financing mechanism and found that although other indicators have merits, those chosen by GAO meet the objectives identified by the Commission. Further analysis of specific economic indicators is outside the scope of this chapter.

[4] In 2010, Congress included a provision in the ACA 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 3 percentage points or more below the previous year's FMAP. Qualifying states receive an adjustment to their annual FMAP rate based on a formula specified in statute. Since 2011, each state has been evaluated every year to see if it qualifies for a disaster-adjusted recovery FMAP as part of the process of calculating FMAPs for the following year. Louisiana has been the only state that has qualified for a disaster-recovery adjustment, which it did in fiscal years 2011 through 2014.

[5] The ARRA hold harmless provision (§ 5001(a)) 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 would be applied to the 60 percent FMAP level that was 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 would be applied to the greater of the FMAP level of the previous fiscal years.

[6] The unemployment bonus (§ 5001(c)(3)), for states that qualified, was weighted 35 percent and the FMAP increase was weighted 65 percent. ARRA increased the federal share by 5.5 percent, 8.5 percent, or 11.5 percent based upon a state's peak three-month unemployment rate compared to the lowest three-month unemployment rate of 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.

[7] The additional FMAP applies only to a state's regular federal match, not to the enhanced 90-percent match rate for the new adult group. The temporary enhanced FMAP applies to the territories, which normally would mean that they would exhaust their annual federal allotments more quickly, but the FFCRA also provided additional funding to territories to supplement the annual allotments.

[8] Note that GAO developed its prototype when the country was not in a recessionary period and could access unemployment data from the same quarter as the assistance period (i.e., retrospectively).

[9] In its discussion of design elements in the prototype formula and alternatives, GAO notes that the model could be designed to allow assistance to be applied retroactively for one or two quarters.

[10] States may still struggle to raise the state share, depending upon the depth of the recession. Although the GAO model uses economic indicators, such as changes in the employment rate and state wages and salaries, as proxies for states' ability to finance Medicaid, it does not address other aspects of states' ability to finance their programs, such as the level of their reserves. State actions will be affected by many factors, such as the amount of reserve funds available and conditions for their use, and we did not consider every factor in making our recommendations. Further, because Medicaid is not isolated from state budget pressures even if additional federal funds are made available, an automatic countercyclical Medicaid financing adjustment could be part of a package of automatic stabilizers (e.g., extended unemployment benefits). These considerations are outside of MACPAC's scope.

[11] The start of the look-back period remains fixed for the first eight quarters of assistance. In the first eight quarters of assistance, the look-back period would extend for 15 quarters. After the first eight quarters of assistance, the look-back period is limited to the prior eight quarters.

[12] The data for state wages and salaries by quarter are expressed in real dollars by dividing Bureau of Economic Analysis (BEA) quarterly wage and salary disbursements by the BEA implicit price deflator for GDP. The wages and salaries are a component of BEA State Quarterly Personal Income and the deflator is from the National Income and Product Accounts.

[13] Both the BLS and BEA may make revisions to their prior estimates. For example, the BEA releases and then revises the state personal income estimates on a regular schedule to incorporate source data that are more complete, more detailed, or otherwise more appropriate than the data that were available when the estimates were initially prepared (BEA 2020). The results presented in this chapter used the first available data to calculate the unemployment and wage and salary components and were not recalculated based on revised data. Revisions to the BLS and BEA could affect the calculation of the FMAP increase in either direction, if applied (that is, they could increase the adjusted FMAP for a state, or reduce it).

[14] Note that GAO developed its prototype after the recessionary period and could access employment and unemployment data from the same quarter as the assistance period (i.e., retrospectively). If policymakers want to calculate the FMAP increases at the beginning of a given quarter (i.e., prospectively), the calculation would need to use the most recently available data, which generally would be from a prior quarter. Our analysis took this prospective approach and used the most recent data that would have been available at the start of a quarter, which required us to use data from an earlier time period than the GAO prototype may assume (i.e., we use data from a prior quarter when GAO would use data from the same quarter).

[15] The new adult group includes both newly eligible and not newly eligible adults who are eligible under Section 1902(a)(10)(A)(i)(VIII) of the Act. Newly eligible adults include those who were not eligible for Medicaid under the rules that a state had in place on December 1, 2009. Not newly eligible adults include those who would have previously been eligible for Medicaid under the rules that a state had in place on December 1, 2009; this includes states that had already expanded to adults with incomes greater than 100 percent of the federal poverty level as of March 23, 2010, and receive the expansion state transitional matching rate.

[16] An exception is the FFCRA, which added 6.2 percentage points to the Medicaid FMAP and did not specifically state that it should not apply to other programs that derive an FMAP from the Medicaid FMAP. The CHIP program derives its enhanced FMAP using the Medicaid FMAP as a base. Therefore, as the Medicaid FMAP increases for a state, the enhanced FMAP also increases for the state.

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Commission Vote on Recommendation

In MACPAC's authorizing language in Section 1900 of the Social Security Act, Congress requires the Commission to review Medicaid and CHIP policies and make recommendations related to those policies to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states in its reports to Congress, which are due by March 15 and June 15 of each year. Each Commissioner must vote on each recommendation, and the votes for each recommendation must be published in the reports. The recommendations included in this report, and the corresponding voting record below, fulfills this mandate.

Per the Commission's policies regarding conflicts of interest, the Commission's conflict of interest committee convened prior to the vote to review and discuss whether any conflicts existed relevant to the recommendation on amending the Social Security Act to provide an automatic Medicaid countercyclical financing model. It determined that, under the particularly, directly, predictably, and significantly standard that governs its deliberations, no Commissioner has an interest that presents a potential or actual conflict of interest.

The Commission voted on Recommendation 1.1 on January 29, 2021.

An Automatic Countercyclical Financing Adjustment

1.1 Congress should amend the Social Security Act to provide an automatic Medicaid countercyclical financing model, using the prototype developed by the U.S. Government Accountability Office as the basis. The Commission recommends this policy change should also include:

- an eligibility maintenance of effort requirement for the period covered by an automatic countercyclical financing adjustment;
- an upper bound of 100 percent on countercyclical adjusted matching rates; and
- an exclusion of the countercyclical adjusted federal matching rate from services and populations that receive special matching rates (e.g., for the new adult group) or are otherwise capped or have allotments (e.g., disproportionate share hospital payments, territories).

Yes:	Bella, Barker, Brooks, Burwell, Carter, Cerise, Davis, Douglas, George, Gordon, Gorton, Lampkin, Milligan, Retchin, Scanlon, Szilagyi, Weno	17	Yes