Medicaid and the 2020 Economic Downturn: Lessons Learned from the Great Recession

June 2020

The COVID-19 public health emergency is impacting the health of millions of Americans. It is also having a short- and long-term impact on the U.S. economy, ushering us into a recession and squeezing state budgets, including Medicaid budgets. This brief reflects on the 2008 Great Recession to help policymakers respond to this new economic downturn and ensure Medicaid can continue to deliver care to more than 70 million Americans. This brief was informed through a literature review and insights from former Medicaid leaders.

BACKGROUND: THE GREAT RECESSION & MEDICAID
The Great Recession decimated the United States’ economy, leaving 8.6 million Americans unemployed and more than 5 million uninsured.\(^1\)\(^2\) From December 2007 through June 2009, employment fell by 6.3 percentage points, and the uninsured rate rose by about 1.9 percent.\(^3\)\(^4\) This led to unprecedented spikes in eligibility and enrollment in public welfare programs, including Medicaid, which is designed to serve more people when the economy contracts (see sidebar). For every one percent drop in national employment, Medicaid grew by one million enrollees.\(^5\) Monthly Medicaid

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enrollment rose nearly 6 million individuals or 14 percent during the first two years of the recession.6

Plummeting tax revenues created budget gaps in nearly every state. Total state tax revenues declined by 10.2 percent from the fourth quarter of 2007 to the fourth quarter of 2009.7 In order to balance state budgets, Medicaid programs had to make budget cuts, while responding to increased enrollment in their programs. While states relied on raising taxes, cutting spending, and rainy-day funds to fill budget holes, federal assistance was essential to alleviating pressure on state budgets and allowing states to continue delivering high quality health care through Medicaid.8

In 2009, Congress passed, and President Obama signed into law, the American Recovery and Reinvestment Act (ARRA) to boost the nation’s struggling economy. It included $149 billion in health care spending, including $87 billion for a temporary increase in the federal matching percentage (FMAP) for Medicaid for two and half years. Parameters for the FMAP increase included:

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<th>Enhanced FMAP Under Families First Coronavirus Response Act</th>
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<td>In March 2020, Congress passed the Families First Coronavirus Response Act, which includes a temporary 6.2 percentage point FMAP increase. It provides this increase to all states effective January 1, 2020 and through the last day of the calendar quarter in which the public health emergency ends. To receive it, states must:</td>
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<td>• Maintain eligibility standards, methodologies, or procedures that are no more restrictive than what the state had in place as of January 1, 2020.</td>
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<td>• Not charge premiums for any Medicaid beneficiaries that exceed those in place as of January 1, 2020.</td>
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<td>• Cover testing, services, and treatments related to COVID-19.</td>
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<td>• Not terminate any individuals from Medicaid if they were enrolled as of March 18, 2020 or become enrolled during the emergency period.</td>
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<td>• 6.2 percentage points on top of states’ current FMAP with additional FMAP increases available based on state unemployment levels for a period of 9 calendar quarters.</td>
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<td>• A hold-harmless provision, which prevented reductions in a state’s base FMAP.</td>
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<td>• A maintenance of effort (MOE) for the enhanced FMAP, which required eligibility standards be no more restrictive than what was in place July 1, 2008.</td>
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<td>• Disproportionate share hospital (DSH) or eligibility expansions on or after July 1, 2008 were not included in the increased FMAP.</td>
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<td>• A requirement to report on how the increased FMAP funds were used.</td>
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LESSONS LEARNED FROM THE GREAT RECESSION

Today, Medicaid is on the frontlines of the COVID-19 pandemic, providing access to care for those the Centers for Disease Control has identified as most at risk of death from the virus, including older Americans and individuals with chronic conditions. Medicaid is also preparing to provide access to health care for many of the 40 million Americans who lost their jobs due to COVID-19. At the same time, the downturn is wreaking havoc on state budgets. As of May 14, 2020, at least 36 states have implemented, or are currently considering, cuts to the state budget. At least five governors have identified the need for Medicaid cuts.

Although there are differences in this COVID-related economic downturn from 2008, there are seven lessons learned from the Great Recession that can inform how policymakers respond now.

1. **The amount of federal fiscal relief for Medicaid needs to reflect the magnitude of the downturn.** Today, states are looking for ways to fill budget gaps that are more severe than gaps in the Great Recession. Some forecasts project state budget shortfalls will total $650 billion over the next three years, which is $140 billion more than any three year period during the great recession. Although Congress provided an enhanced 6.2 percentage point FMAP to respond to the COVID-19 public health emergency (see sidebar above), this is much lower than the increase many states received under ARRA, which included additional increase(s) above the base 6.2 percentage points based on state unemployment growth. Congress should increase the FMAP enhancement to reflect the severity of the current economic crisis.

2. **It is important to give states budget certainty.** ARRA’s base 6.2 percentage point enhanced FMAP began phasing down after December 31, 2010. It decreased to 3.2 percentage points in the first quarter of calendar year 2011 and then to 1.2 percentage points in the second quarter. The clear end date for the enhanced FMAP provided budget certainty for states. It allowed them to prepare for the reduction of federal funding and to make the necessary policy changes to balance their budgets.

   Unfortunately, the current 6.2 percentage point enhanced match is set to end with the public health emergency, and it is unclear when the Administration will declare the end of the emergency. This means the end date for the enhanced FMAP is unknown. This leaves states without the information they need to make policy decisions and balance budgets.

3. **Enhanced FMAP should be phased out over the period of state economic recovery.** The phase-out of ARRA’s enhanced FMAP recognized that economic recovery does not happen immediately; it takes time for state revenues to rebound and for Medicaid enrollment to decline. While ARRA’s phase out was a step in the right direction, it was not long enough. When the enhanced FMAP ended on June 30, 2011, Medicaid enrollment remained high and state revenues low. As a result, Medicaid programs experienced an FMAP “cliff” and had to

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10 NAMD COVID-19 State Budget Cuts Tracker: NAMD is tracking statements from governors and other state officials regarding anticipated budget cuts in light of COVID-19.

make significant cuts when the enhanced FMAP ended. As noted above, the current 6.2 percentage point enhanced match is set to end with the public health emergency. Because it is not phased out over a period of economic recovery, this will leave states with a budget cliff, likely in the middle of a recession.

4. **It may be more effective for all states to receive the same FMAP increase rather than an increase that varies by state.** The 2008 downturn had a variable impact across the country, impacting some states much worse than others. ARRA attempted to account for the differential impact of the recession on states, but ultimately the formula was not successful in responding to the variation in state need.\(^{12}\) It included additional increases in FMAP on top of the base 6.2 percentage points for states with increases in unemployment. This did not reflect overall unemployment in a state, nor did it account for state revenue loss, which dictates states’ capacity to allocate funds toward Medicaid.

This economic downturn, unlike the Great Recession, is impacting all states and their economies. Given that, it may be more effective to implement the same FMAP percentage increase across states. However, if Congress does vary an FMAP increase by state, the formula needs to reflect states’ true economic condition and capacity to allocate funds to Medicaid.

5. **It is important for Congress to consider how much fiscal relief is available to states after the costs of the maintenance of effort (MOE) are accounted for.** Under ARRA, Congress attached an MOE requirement to the enhanced FMAP, which meant states had to maintain eligibility at current levels. Congress attached an MOE to the current FMAP increase that is more restrictive. As currently implemented, it prevents states from making eligibility redeterminations or reducing the service array. This has increased enrollment and costs in Medicaid. As a result, states are using a significant portion of the enhanced FMAP to support cost growth resulting from the MOE, rather than COVID- or recession-related costs.

6. **The Centers for Medicare and Medicaid Services needs to effectively partner with states.** During the Great Recession, Medicaid Directors and their teams were forced to make difficult decisions about how to manage their budgets while maintaining access to quality care. Now, Medicaid Directors find themselves in the same position with the added challenge of responding to a major public health crisis.

For state Medicaid programs to navigate these dual crises, they will need the partnership of the federal government, including:

- Giving states regulatory flexibility to make the policy changes needed to manage budgets;
- Ensuring its processes allow states to be nimble in effectuating changes and responding to the shifting budgetary and care delivery landscape; and

• Partnering with states to ensure funding from the Coronavirus Aid, Relief, and Economy Security (CARES) Act is appropriately targeted to Medicaid providers impacted COVID-19.

7. **Collaboration between Medicaid agencies, legislatures, and stakeholders on budget decisions is more important than ever.** In the Great Recession, Medicaid Directors had to make difficult decisions to ensure the sustainability of the program. Since the last recession, the state budget dynamics have gotten more complex. In particular, Medicaid expansion shifted the Medicaid fund mix. Because 90 percent of expansion costs are paid for by the federal government, the federal government is responsible for a larger portion of overall Medicaid costs than in 2008. This means that Medicaid cuts must be deeper to generate state general fund savings. Deep cuts do not just impact the program, they also pull tens or hundreds of millions of federal dollars out of a state’s economy.

   Because of this, it more important than ever for Medicaid leaders, legislatures, providers, members, plans, and other stakeholders to think creatively, and most importantly, work collaboratively to balance state budgets.

**CONCLUSION**

In the 2008 Great Recession, state and federal policymakers grappled with many of the challenges that we are faced with today. Federal legislation in 2009, specifically the increase in FMAP, helped state Medicaid programs respond to budget constraints and increased enrollment. But today, we are facing a deeper and broader economic downturn. It is essential that we learn the lessons of the past, including from the Great Recession, to ensure Medicaid programs can weather this recession and continue delivering care to over 70 million people.