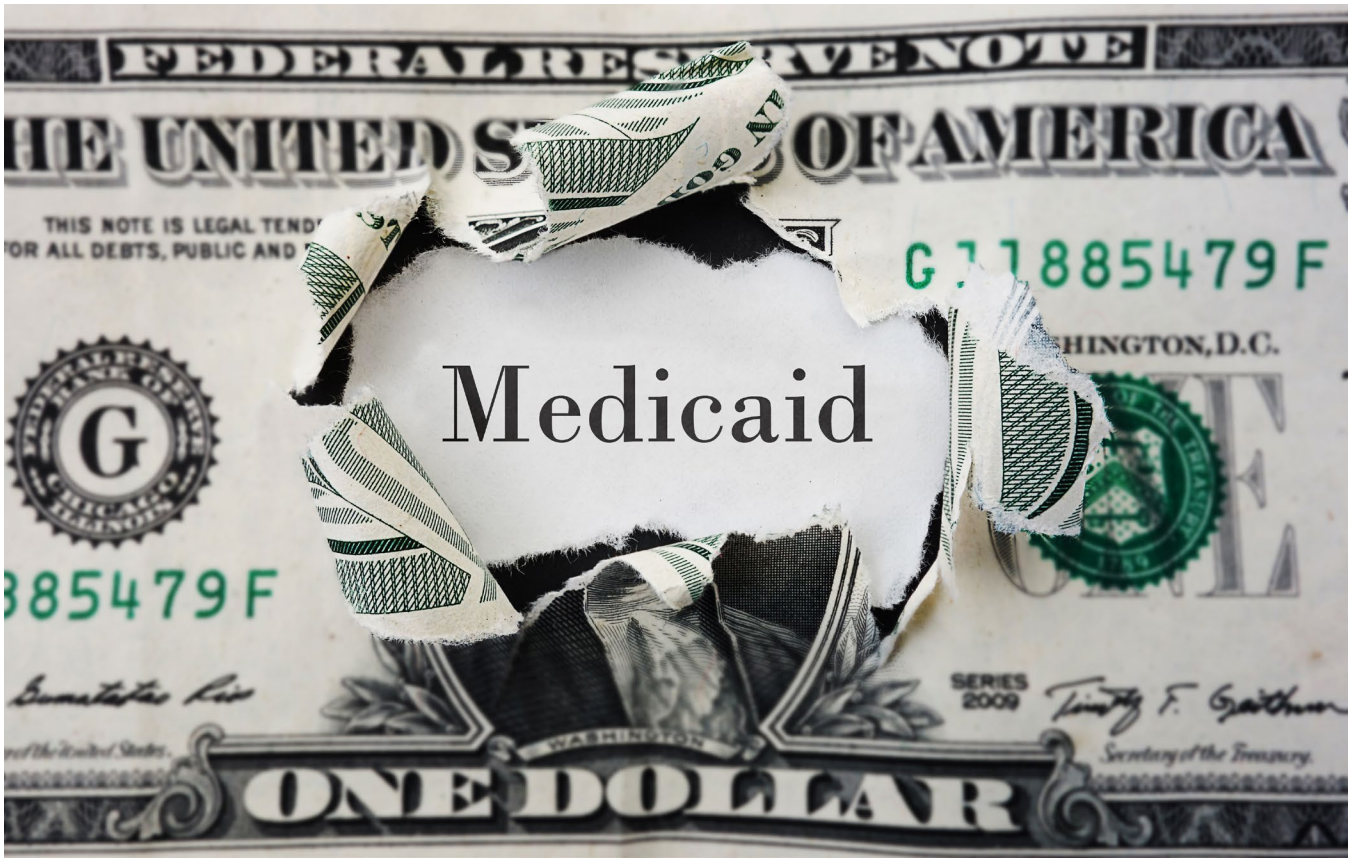
States, Medicaid, and COVID

Funneling Coronavirus Relief to the States through Medicaid Will Aggravate Problems with the Program and Delay the Economic Recovery

Brian Blase, Phd.

May 6, 2020



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Introduction

Governments, at the federal, state, and local levels, as well as the private sector have responded in an unprecedented fashion to slow the spread of the coronavirus with large scale shutdowns of businesses, schools, and social gatherings. As a result of these closures, economic activity has plummeted,[1] more than 30 million people have lost jobs, and the country is in a severe recession.[2]

Congress has provided massive funding for shuttered businesses and unemployed workers. In total, Congress has enacted four pieces of legislation to support businesses and workers as well as to direct money to support hospitals and health care providers. These actions, combined with automatic spending increases that would have occurred even without congressional action, will add about $2.7 trillion to the national debt, according to the Congressional Budget Office (CBO).[3]

Congress also has provided substantial assistance to states. The Families First Coronavirus Response Act increased the federal Medicaid matching rate by 6.2 percentage points. This provides greater assistance to wealthier states as they tend to have more profligate programs. It raised federal Medicaid payments by 12.4 percent in the wealthiest states, compared an 8.3 percent increase in federal payments in the poorest states.[4] Overall, this action is projected to increase federal spending by about $50 billion, according to CBO.[5]

The CARES Act included a $150 billion coronavirus relief fund that states and localities can utilize to cover coronavirus-related costs. In addition, it provides a $45 billion Federal Emergency Management Agency (FEMA) relief fund that states and localities also can tap to cover costs associated with the federally-declared emergency under the Stafford Act. CARES also included another $80 billion for state and local agencies.[6] Moreover, much of the remainder of the $2.7 trillion is for programs that will help state finances eventually—both directly through increased federal funds but also indirectly by income support for families and by helping businesses try to stay afloat. The Federal Reserve also is taking unprecedented action to provide relief, including buying short-term municipal debt for the first time.[7]

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[1] According to the Department of the Commerce's Bureau of Economic Analysis preliminary estimates, first quarter 2020 gross domestic product declined by 4.8 percent. This is a large decline, particularly since most jurisdictions did not implement social distancing until mid-March. See: https://www.bea.gov/data/gdp/gross-domestic-product.

[2] Mulligan, Casey, "U.S. daily cumulative costs of the COVID-19 pandemic, updated through April 29, 2020." See: http://pandemiccosts.com/. Accessed April 30, 2020.

[3] Swagel, Phillip, "CBO's Current Projections of Output, Employment, and Interest Rates and a Preliminary Look at Federal Deficits for 2020 and 2021," Congressional Budget Office, April 24, 2020. See: https://www.cbo.gov/publication/56335

[4] The wealthiest states have a federal Medicaid reimbursement rate of 50 percent. A 6.2 percentage point increase for these states increases the federal reimbursement by 12.4 percent. The poorest states have a federal Medicaid reimbursement of about 75 percent. A 6.2 percentage point increase for these states increases the federal reimbursement by 8.3 percent.

[5] Swagel, Phillip, "Re: Preliminary Estimate of the Effects of H.R. 6201, the Families First Coronavirus Response Act," Congressional Budget Office, April 2, 2020. See: https://www.cbo.gov/system/files/2020-04/HR6201.pdf

[6] These include $31 billion for an education stabilization fund, $25 billion for transit infrastructure grants, $10 billion for airport improvement grants, $5 billion for community development block grants, $4 billion for homeless assistance grants, $3.5 billion for child care and development block grants, and $0.4 billion for election security grants.

[7] Mejdrich, Kellie and Victoria Guida, "Fed to buy municipal debt for first time, underscoring peril facing cities," Politico, April 9, 2020. See: https://www.politico.com/news/2020/04/09/fed-to-buy-municipal-debt-178222

Despite the substantial aid already provided, many governors, members of Congress, as well as leading policy experts on the Left are calling on Congress to provide states with another enormous aid package. Congress should not rush into providing additional funds to states. First, Congress needs to understand the impact of the actions it already has taken, including those that may hinder the recovery or otherwise use taxpayer dollars unwisely. Second, it is imperative that Congress not present states with additional incentives to either spend irresponsibly or to shutter economic activity for longer than necessary. Third, Congress should ensure any aid is fairly distributed across states. Fourth, any aid provided to states should be temporary and capped. Finally, Congress should look to couple aid to states with reforms that will both incentivize states to spend judiciously but also improve the integrity of key programs.

Congress should be especially wary of funneling state aid through Medicaid. An explosion of state spending over the past three decades has been fueled primarily by Medicaid spending, with nearly 30 percent of state budgets now devoted to Medicaid.[8] Key features of Medicaid, including aspects added by the Affordable Care Act (ACA), have led to enormous low-value spending as well as inappropriate and unlawful use of federal Medicaid funds.[9] It is vital that Congress condition any additional aid on reforms that improve the Medicaid program and put it on a more sustainable trajectory, particularly given the nation's rapidly deteriorating fiscal situation. Such reforms would include equalizing the federal government's matching rates across Medicaid populations and improving the integrity of the program to ensure that spending benefits program enrollees and is not siphoned for other non-health related projects.

This paper reviews pertinent issues and then offers recommendations for Congress.

Acknowledgements

I wish to thank my colleague Doug Badger at the Galen Institute for recommending that I undertake this project and for the valuable assistance he provided, particularly with the quantitative analysis. I also want to thank Sam Adolphsen at the Foundation for Government Accountability for his review of the paper and his helpful comments.

[8] See Table 1. Figures are from the National Association of State Budget Officers annual expenditure reports.
[9] Blase, Brian and Aaron Yelowitz, "The ACA's Medicaid Expansion: A Review of Ineligible Enrollees and Improper Payments," Mercatus Center, November 18, 2019. See: https://www.mercatus.org/system/files/blase-medicaid-expansion-mercatus-research-v2_2.pdf; Blase, Brian, "Evidence Is Mounting: The Affordable Care Act Has Worsened Medicaid's Structural Problems," Mercatus Center, September 14, 2016. See: https://www.mercatus.org/publications/healthcare/evidence-mounting-affordable-care-act-has-worsened-medicaid's-structural; Blase, Brian, "The Importance of the Medicaid Fiscal Accountability Rule," Health Affairs, April 7, 2020. See: https://www.healthaffairs.org/do/10.1377/hblog20200331.308494/full/

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Medicaid spending has exploded because of inflationary design

Medicaid is a joint federal-state program, and every dollar that states spend is matched with a federal contribution. According to the statutory intent, the federal government bears at least half the cost of financing services for individuals with disabilities and low-income elderly, children and pregnant women in the wealthiest states.[10] In the poorest states, the federal government bears about three-quarters of the cost for these traditional Medicaid recipients. On average, the federal share of Medicaid spending is 60 percent, meaning that when the state spends $1 of its own money, Washington adds $1.50.[11] The ACA expanded Medicaid to a new population of able-bodied, working-age adults, and it also dramatically enhanced the federal matching percentage, providing nine federal dollars for every one dollar the state spends on them.[12]

Over the past few decades, overall state spending has exploded. The table below shows total state expenditures in inflation-adjusted dollars from 1988 to 2018 by major categories. States spent $2 trillion in 2018, a $1.1 trillion real increase from 1988. This 120 percent increase was three-and-a-half times greater than population growth in the United States during this period (34 percent). The increase was driven primarily by Medicaid spending, with the program accounting for 45 percent of total growth in state spending. For example, Medicaid spending grew by nearly five-and-a-half times more than spending on education during the past three decades. This increase has been driven by mountains of additional federal Medicaid funds.

Table 1: State Expenditure Spending and Growth (millions of 2018 dollars)

	2018	1988	Increase
Total Spending	**$2,004,219**	**$911,283**	**120%**
Medicaid	$585,285	$98,708	493%
Corrections	$60,939	$29,432	107%
Higher Educ	$206,520	$107,474	92%
Elem & Sec Educ	$395,032	$209,744	88%
Other Items	$573,876	$323,588	77%
Transportation	$157,816	$94,202	68%
Cash Welfare	$24,755	$48,138	-49%

Source: National Association of State Budget Officers reports

[10] The federal government matches state Medicaid spending at a rate determined in part by state per capita income, although the federal floor matching rate of 50 percent treats states with high per capita incomes more favorably than those with low per capita incomes.

[11] There are two ways of thinking about this. On average, if a state spends $2.50 on Medicaid, then $1.50 of that spending—or 60 percent—is reimbursed by the federal government. An equivalent way of looking at it is if a state spends $1.00 of its own money, the federal government matches that state expenditure with $1.50 of federal funding.

[12] The ACA's enhanced funding began in 2014 and states received a 100% reimbursement for the expansion population from 2014-2016, 95% in 2017, 94% in 2018, 93% in 2019, and 90% in 2020 and beyond.

States have become increasingly reliant on federal Medicaid funds with roughly two-thirds of all federal money received by states flowing through Medicaid.[13] State dependency on Medicaid will deepen if the federal government picks up more of the program costs now and in the future. This will lead state governments, even conservative ones, to increase reliance on Medicaid to fill budget holes and will reduce fiscal discipline in state capitols.

Medicaid spending has surged because its matching grant structure is inherently inflationary. This structure incentivizes states to spend freely on Medicaid in order to maximize federal funds and reduces the incentives for states to spend the money wisely, minimizing waste, fraud, abuse, and misspending. The inflationary effect is most profound for the ACA expansion population, since state spending on these enrollees reaps the largest federal remuneration.

A second problem is that the open-ended federal match of state Medicaid spending creates an incentive for states to develop illusory expenditures they can use to boost the amount of federal matching funds they receive.[14] One such technique involves provider taxes, which are taxes imposed on health care providers with payments circling back to the provider after the state uses the tax revenue to obtain additional federal matching funds. Oregon state representative Mitch Greenlick referred to provider taxes as a "dream tax" for states. "We collect the tax from the hospitals. We put it up as a match for federal money, and then we give it back to the hospitals." Greenlick explained.[15]

Another common scheme involves states drastically overpaying providers, obtaining large federal matching funds and then requiring these providers to return the overpayment to the state. This scheme is also perpetrated using government institutions as the pass through. For example, New York set daily Medicaid payment rates per patient at more than $5,000 for individuals with developmental disabilities in state institutions.[16] This scheme produced a $15 billion windfall for the state over 20 years because the actual costs were well below the government's payment rate.[17]

It turns out that richer states, which have greater fiscal capacity and often employ more numerous and sophisticated financing gimmicks, receive a disproportionate share of federal Medicaid spending. This is counter to the statutory intent underlying the Medicaid program to provide greater federal financial support to lesser wealthy states.

[13] PEW Charitable Trusts, "Medicaid Drives Growth in Federal Grants to States," February 5, 2020. See: https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2020/02/medicaid-drives-growth-in-federal-grants-to-states
[14] I discussed these schemes in depth in "The Importance of the Medicaid Fiscal Accountability Rule." See: https://www.healthaffairs.org/do/10.1377/hblog20200331.308494/full/
[15] Wong, Peter, "Oregon House extends hospital tax," Portland Tribune, March 11, 2015. See: https://portlandtribune.com/pt/9-news/253422-123198-oregon-house-extends-hospital-tax
[16] Ibid.
[17] Committee on Oversight and Government Reform, "Billions of Federal Tax Dollars Misspent on New York's Medicaid Program," March 5, 2013. See: https://republicans-oversight.house.gov/report/billions-of-federal-tax-dollars-misspent-on-new-yorks-medicaid-program/

Table 2 shows that the federal government pays wealthier states much more in Medicaid funding per person in poverty than it pays less-wealthy states. In fact, the correlation between federal spending per person in poverty and state per capita income is 0.540, a remarkably high and positive correlation that shows the underlying Medicaid formula is failing to provide greater aid to states with less fiscal capacity. Under the original intent of Medicaid's financing design, the federal government should be providing more support to poorer states so this correlation should be negative.

Table 2: Federal Medicaid Spending Per Person in Poverty (2018)

	Spend per person in poverty	Per capita income	Fed Medicaid spend	People below the poverty line
United States	**$7,275**	**$54,526**	**$302,965,566,300**	**41,644,300**
New York	$14,926	$68,710	$39,032,126,500	2,615,100
District of Columbia	$14,727	$82,111	$1,634,749,600	111,000
Alaska	$14,302	$59,605	$1,088,386,100	76,100
Maine	$12,339	$48,881	$1,787,971,900	144,900
Wisconsin	$11,636	$51,647	$7,095,802,600	609,800
Massachusetts	$11,477	$71,886	$7,648,074,800	666,400
Vermont	$11,017	$54,342	$737,040,700	66,900
Minnesota	$10,492	$57,566	$5,602,849,400	534,000
Connecticut	$9,121	$76,481	$3,270,834,800	358,600
New Hampshire	$9,062	$61,429	$859,950,400	94,900
Delaware	$8,927	$52,599	$987,366,600	110,600
Rhode Island	$8,724	$54,800	$1,110,545,900	127,300
Missouri	$8,700	$47,784	$6,799,087,300	781,500
Oregon	$8,620	$50,951	$4,315,998,200	500,700
Pennsylvania	$8,608	$56,252	$12,987,200,700	1,508,700
Maryland	$8,560	$63,426	$4,436,728,700	518,300
California	$7,387	$63,711	$36,497,606,700	4,940,800
New Jersey	$7,314	$68,409	$5,999,339,800	820,300
Ohio	$7,181	$48,793	$11,343,081,300	1,579,700
Indiana	$7,171	$47,124	$6,101,336,100	850,800
Colorado	$7,037	$58,500	$3,812,195,000	541,700
Kentucky	$7,007	$42,527	$5,067,931,400	723,300
Mississippi	$6,966	$37,904	$4,011,296,400	575,800
Hawaii	$6,947	$55,414	$890,604,900	128,200
Idaho	$6,847	$43,994	$1,414,507,000	206,600
Iowa	$6,757	$50,243	$2,318,971,200	343,200
North Dakota	$6,658	$55,598	$494,032,100	74,200
West Virginia	$6,575	$40,907	$2,042,181,600	310,600
Arizona	$6,542	$44,414	$6,371,629,300	973,900
New Mexico	$6,542	$41,663	$2,684,197,500	410,300
Tennessee	$6,423	$46,889	$6,529,389,900	1,016,600
Utah	$6,409	$46,431	$1,744,439,700	272,200
Arkansas	$6,353	$43,292	$3,228,811,200	508,200
North Carolina	$6,324	$46,126	$8,944,059,000	1,414,300
Montana	$6,220	$47,611	$778,706,500	125,200
Louisiana	$6,019	$46,245	$5,087,538,500	845,200
South Carolina	$5,996	$43,702	$4,465,172,700	744,700
Washington	$5,990	$62,122	$4,610,569,600	769,700
Michigan	$5,941	$48,480	$8,119,737,900	1,366,700
Illinois	$5,785	$56,919	$8,592,722,500	1,485,400
Kansas	$5,538	$51,474	$1,905,097,100	344,000
Virginia	$5,309	$57,910	$4,637,762,600	873,500
Texas	$5,283	$50,483	$21,932,283,600	4,151,100
Florida	$5,185	$50,199	$14,473,538,300	2,791,200
Nebraska	$5,183	$53,364	$1,113,354,300	214,800
Wyoming	$5,089	$60,375	$317,569,300	62,400
Alabama	$5,033	$42,240	$4,014,987,200	797,800
Oklahoma	$5,000	$46,267	$2,944,575,400	588,900
Georgia	$4,996	$46,519	$7,329,941,100	1,467,200
South Dakota	$4,724	$52,426	$534,232,200	113,100
Nevada	$4,596	$49,290	$1,783,583,900	388,100

Sources: Author's calculations use data from Kaiser Family Foundation State Health Care Facts for Medicaid expenditures and poverty rates by state. State GDP numbers are from the Bureau of Economic Analysis at the Commerce Department.

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Table 3 includes federal Medicaid spending on the ACA's non-traditional Medicaid recipients—able-bodied, working-age, childless adults. When that expansion population is included, wealthier states get an even larger share of federal money per person in poverty (r=0.579). Although not the subject of this paper, the fact that the federal government provides much greater welfare to finance health and long-term care expenses for lower-income people in wealthier states suggests that the entire financial structure underpinning Medicaid needs fundamental reform.

Table 3: Federal Medicaid Spending Per Person in Poverty, Including ACA Expansion (2018)

	Spend per person in poverty	Per capita income	Fed Medicaid spend	People below the poverty line
United States	**$9,051**	**$54,526**	**$376,902,723,000**	**41,644,300**
Alaska	$19,535	$59,605	$1,486,590,500	76,100
District of Columbia	$18,487	$82,111	$2,052,028,100	111,000
New York	$15,091	$68,710	$39,463,535,000	2,615,100
Massachusetts	$14,323	$71,886	$9,545,001,800	666,400
Connecticut	$14,204	$76,481	$5,093,679,900	358,600
New Hampshire	$14,107	$61,429	$1,338,725,300	94,900
Vermont	$13,958	$54,342	$933,773,700	66,900
Minnesota	$13,691	$57,566	$7,310,939,200	534,000
Delaware	$13,581	$52,599	$1,502,082,400	110,600
Maryland	$13,470	$63,426	$6,981,307,500	518,300
Oregon	$13,340	$50,951	$6,679,582,000	500,700
Maine	$12,339	$48,881	$1,787,971,900	144,900
Rhode Island	$12,060	$54,800	$1,535,215,900	127,300
Hawaii	$11,716	$55,414	$1,501,949,600	128,200
Wisconsin	$11,636	$51,647	$7,095,802,600	609,800
Pennsylvania	$11,593	$56,252	$17,490,842,100	1,508,700
Montana	$11,396	$47,611	$1,426,732,900	125,200
Kentucky	$11,018	$42,527	$7,968,983,400	723,300
New Jersey	$10,953	$68,409	$8,984,940,300	820,300
California	$10,879	$63,711	$53,748,997,200	4,940,800
Indiana	$10,748	$47,124	$9,144,369,500	850,800
North Dakota	$10,354	$55,598	$768,263,500	74,200
Colorado	$9,853	$58,500	$5,337,331,400	541,700
New Mexico	$9,818	$41,663	$4,028,527,200	410,300
Arkansas	$9,777	$43,292	$4,968,781,400	508,200
Washington	$9,761	$62,122	$7,512,957,500	769,700
Ohio	$9,642	$48,793	$15,230,879,700	1,579,700
Iowa	$9,557	$50,243	$3,280,055,100	343,200
West Virginia	$9,499	$40,907	$2,950,454,300	310,600
Arizona	$9,267	$44,414	$9,025,538,500	973,900
Louisiana	$9,009	$46,245	$7,614,721,900	845,200
Illinois	$8,749	$56,919	$12,995,974,100	1,485,400
Missouri	$8,700	$47,784	$6,799,087,300	781,500
Michigan	$8,556	$48,480	$11,693,486,100	1,366,700
Nevada	$7,640	$49,290	$2,965,228,400	388,100
Mississippi	$6,966	$37,904	$4,011,296,400	575,800
Idaho	$6,847	$43,994	$1,414,507,000	206,600
Tennessee	$6,423	$46,889	$6,529,389,900	1,016,600
Utah	$6,409	$46,431	$1,744,439,700	272,200
North Carolina	$6,324	$46,126	$8,944,059,000	1,414,300
South Carolina	$5,996	$43,702	$4,465,172,700	744,700
Kansas	$5,538	$51,474	$1,905,097,100	344,000
Virginia	$5,309	$57,910	$4,637,762,600	873,500
Texas	$5,283	$50,483	$21,932,283,600	4,151,100
Florida	$5,185	$50,199	$14,473,538,300	2,791,200
Nebraska	$5,183	$53,364	$1,113,354,300	214,800
Wyoming	$5,089	$60,375	$317,569,300	62,400
Alabama	$5,033	$42,240	$4,014,987,200	797,800
Oklahoma	$5,000	$46,267	$2,944,575,400	588,900
Georgia	$4,996	$46,519	$7,329,941,100	1,467,200
South Dakota	$4,724	$52,426	$534,232,200	$113,100

Sources: Author's calculations use data from Kaiser Family Foundation State Health Care Facts for Medicaid expenditures and poverty rates by state. State GDP numbers are from the Bureau of Economic Analysis at the Commerce Department.

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The Abundance of Improper and Wasteful Medicaid Expenditures

In addition to the lack of equity in federal Medicaid expenditures across states, the massive increase in Medicaid spending is problematic for several reasons. First, much of the spending provides low value, meaning that the recipients receive less benefit than the cost of the services. A study by economists Amy Finkelstein, Nathaniel Hendren, and Erzo Luttmer found that Medicaid enrollees placed relatively low value on the program—only receiving 20 to 40 cents of value for each dollar of spending on their behalf.[18] Numerous studies suggest that large Medicaid expansions are less cost-effective than targeted health initiatives focused on individuals who are most likely to benefit from care and through investments in child health.[19] Since ACA expansion enrollees tend to receive far less benefit than the cost of the program, overall welfare can be improved through program redesign. The insurance and hospital industries would be expected to resist such reforms. Medicaid expansion has produced substantial profits for insurance companies, as the White House Council of Economic Advisers found,[20] while also benefitting hospitals and providers who gain additional payments for services they previously provided for free or at low cost.[21]

Second, a sizeable share of Medicaid expenditures, particularly as a result of the ACA's expansion, is inappropriate and even unlawful.[22] States have a large financial incentive to misclassify enrollees as eligible under the ACA expansion rules, and many federal audits show that a large percentage of Medicaid enrollees have been improperly enrolled.[23] One such audit found eligibility problems with more than half of sampled enrollees in California's Medicaid program.[24] Largely as a result of eligibility problems, Medicaid's improper payments now almost certainly exceed $75 billion, or more than 20 percent of federal Medicaid expenditures.[25] Before the ACA, the Medicaid improper payment rate was 6 percent.[26]

[18] Finkelstein, Amy, Nathaniel Hendren, and Erzo F.P. Luttmer, "The Value of Medicaid: Interpreting Results from the Oregon Health Insurance Experiment," NBER, June 2015. See: https://www.nber.org/papers/w21308
[19] Oh, Soo and Janet Adamy, "When the Safety Net Pays for Itself," Wall Street Journal, July 22, 2019. See: https://www.wsj.com/articles/when-the-safety-net-pays-for-itself-11563800405
[20] Council of Economic Advisers, "The Profitability of Health Insurance Companies," White House, March 2018. See: https://www.whitehouse.gov/wp-content/uploads/2018/03/The-Profitability-of-Health-Insurance-Companies.pdf
[21] Finkelstein, Amy et al., "The Value of Medicaid: Interpreting Results from the Oregon Health Insurance Experiment."
[22] Blase, Brian and Aaron Yelowitz, "The ACA's Medicaid Expansion: A Review of Ineligible Enrollees and Improper Payments."
[23] Blase, Brian and Aaron Yelowitz, "Why Obama Stopped Auditing Medicaid," Wall Street Journal, November 18, 2019. See:https://www.wsj.com/articles/why-obama-stopped-auditing-medicaid-11574121931
[24] Office of Inspector General, "California Made Medicaid Payments on Behalf of Non-Newly Eligible Beneficiaries Who Did Not Meet Federal and State Requirements," Department of Health and Human Services, December 2018. See: https://oig.hhs.gov/oas/reports/region9/91702002.pdf?mod=article_inline
[25] Yelowitz, Aaron and Brian Blase, "Medicaid Improper Payments are Much Worse Than Reported," Cato Institute, November 20, 2019. See: https://www.cato.org/blog/medicaid-improper-payments-are-much-worse-reported
[26] Ibid.

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Third, states use Medicaid to inflate federal funding generally, diverting Medicaid money for other purposes and violating Medicaid's core financial design of shared federal and state expenses. For decades, government watchdogs have documented how state schemes raise federal costs and can harm patient care.[27]

States' use of these schemes has been criticized by many on the Left as well as the Right. For example, presumptive Democratic presidential nominee Joe Biden has called provider taxes a "scam" and has urged reform.[28] The Obama administration proposed reducing states' ability to finance the state share of Medicaid from provider taxes.[29] The National Commission on Fiscal Responsibility and Reform, established by an executive order from President Barack Obama, recommended eliminating provider taxes.[30] Numerous scholars at the left-of-center Urban Institute have encouraged reform.[31] Law professor Daniel Hatcher, who argues that welfare programs should benefit the poor and not the "poverty industry," has criticized state actions that divert Medicaid dollars. He writes: "In a time when Democrats and Republicans are seemingly unable to agree on anything, states have reached bipartisan political consensus on the practice of taking aid funds from the poor."[32]

[27] Iritani, Katherine, "Completed and Preliminary Work Indicate that Transparency around State Financing Methods and Payments to Providers Is Still Needed for Oversight," U.S. Government Accountability Office, July 29, 2014. See: https://oversight.house.gov/sites/democrats.oversight.house.gov/files/migrated/uploads/Iritani-GAO%20Final.pdf

[28] Blase, Brian, "Biden Was Right: Medicaid Provider Taxes A 'Scam' That Should Be Scrapped," Forbes, February 16, 2016. See: https://www.forbes.com/sites/theapothecary/2016/02/16/biden-was-right-medicaid-provider-taxes-a-scam-that-should-be-scrapped/#1326655e1c6c

[29] Office of Management and Budget, "Fiscal Year 2013 Budget of the U.S. Government," White House. See: https://obamawhitehouse.archives.gov/sites/default/files/omb/budget/fy2013/assets/budget.pdf

[30] National Commission of Fiscal Responsibility and Reform, "The Moment of Truth," White House, December 2010. See: https://www.washingtonpost.com/wp-srv/politics/documents/TheMomentofTruth.pdf

[31] In December 2015, Urban Institute senior research fellow John Holahan called provider taxes "egregious" and "a national disgrace." See: "Improving heath and health care: An agenda for reform," December 9, 2015. https://www.aei.org/events/improving-health-and-health-care-an-agenda-for-reform/; Urban Institute senior research fellows Teresa Coughlin and Stephen Zuckerman argued in a 2002 paper that the failure of the state to make a real financial contributions "is contrary to a basic tenet of Medicaid: That is, it is a program in which the federal government and states or localities share the financial burden." See: "States' Use of Medicaid Maximization Strategies to Tap Federal Revenues: Program Implications and Consequences," June 2002. https://www.urban.org/sites/default/files/publication/60176/310525-States-Use-of-Medicaid-Maximization-Strategies-to-Tap-Federal-Revenues.PDF. Coughlin, Teresa A., Stephen Zuckerman, and Joshua McFeeters, "Restoring Fiscal Integrity to Medicaid Financing?" Health Affairs. 2007; 26(5):1469-1480. doi.org/10.1377/hlthaff.26.5.1469

[32] Hatcher, Daniel L., "Medicaid Maximization and Diversion: Illusory State Practices that Convert Federal Aid into General State Revenue," Seattle University Law Review. 2016; 39:1225-1261. See: https://scholarworks.law.ubalt.edu/cgi/viewcontent.cgi?article=2003&context=all_fac

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Recommendations for Congress

Many policy experts have properly cautioned Congress against using the current crisis to relieve states from making necessary reforms if they have irresponsibly managed their states' finances, particularly around unfunded pension and extremely generous health benefits for public employees.[33] While Congress should avoid bailing out states for imprudence, Congress may decide to help states in the short-term in order to continue to provide important public services during the recession. However, Congress should take more care with this action than it has with past actions during this crisis and should avoid taking steps that will slow the speed of the nation's economic recovery, create inequities between states, or provide states with incentives to spend wastefully.

1) Do not further increase the federal share of state Medicaid spending.

Congress already has boosted the federal government's share of state Medicaid spending for every quarter during which the public emergency exists. The 6.2 percentage point increase in the federal Medicaid reimbursement from the Families First Coronavirus Response Act (FFCRA) raised the federal reimbursement rate by 12.4 percent for the wealthiest states but by only 8.3 percent for the poorest states.[34] Simply put, such increases in the federal Medicaid reimbursement rate disproportionately benefit wealthier states that generally have more costly Medicaid programs. Any new financial relief should be based upon criteria that are more directly related to the coronavirus crisis, not to a state's historic ability to maximize its the federal Medicaid match. For example, Congress could provide payments based on the state's population or retrospective figures like the state's poverty rate or uninsured rate.

[33] Biggs, Andrew, "A Bailout for Illinois? Not Without Strict Conditions," Wall Street Journal, April 24, 2020. See: https://www.wsj.com/articles/a-bailout-for-illinois-not-without-strict-conditions-11587765373

[34] The wealthiest states have a federal Medicaid reimbursement rate of 50 percent. A 6.2 percentage point increase for these states increases the federal reimbursement by 12.4 percent. The poorest states have a federal Medicaid reimbursement of about 75 percent. A 6.2 percentage point increase for these states increases the federal reimbursement by 8.3 percent.

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Table 4: Estimated Impact of FFCRA's Medicaid Increase in 2020

	Fed Medicaid spending	Spend per person in poverty	Per Capita Income
United States	**$35,363,058,868**	**$849**	**$54,526**
New York	$5,177,323,320	$1,980	$68,710
Massachusetts	$1,023,932,108	$1,537	$71,886
Alaska	$111,640,626	$1,467	$59,605
District of Columbia	$156,696,455	$1,412	$82,111
Minnesota	$742,689,177	$1,391	$57,566
Vermont	$92,253,690	$1,379	$54,342
Wisconsin	$806,996,120	$1,323	$51,647
Maine	$186,071,228	$1,284	$48,881
Connecticut	$437,792,795	$1,221	$76,481
New Hampshire	$115,237,601	$1,214	$61,429
Maryland	$590,855,178	$1,140	$63,426
Rhode Island	$144,483,586	$1,135	$54,800
Pennsylvania	$1,678,434,347	$1,113	$56,252
Delaware	$117,273,779	$1,060	$52,599
New Jersey	$798,677,057	$974	$68,409
California	$4,804,733,667	$972	$63,711
Colorado	$509,981,360	$941	$58,500
Missouri	$700,864,240	$897	$47,784
Oregon	$441,548,104	$882	$50,951
North Dakota	$64,933,517	$875	$55,598
Hawaii	$109,009,927	$850	$55,414
Washington	$600,877,135	$781	$62,122
Iowa	$265,531,364	$774	$50,243
Ohio	$1,210,975,976	$767	$48,793
Illinois	$1,132,058,470	$762	$56,919
Indiana	$623,555,276	$733	$47,124
Virginia	$622,551,098	$713	$57,910
Kansas	$232,718,023	$677	$51,474
Nebraska	$141,886,685	$661	$53,364
Kentucky	$477,010,511	$659	$42,527
Tennessee	$660,209,338	$649	$46,889
Wyoming	$40,465,614	$648	$60,375
Idaho	$133,164,268	$645	$43,994
Louisiana	$534,241,749	$632	$46,245
North Carolina	$885,279,380	$626	$46,126
Texas	$2,572,652,356	$620	$50,483
Mississippi	$355,120,819	$617	$37,904
Michigan	$840,585,758	$615	$48,480
Montana	$77,029,984	$615	$47,611
Arizona	$596,487,996	$612	$44,414
Utah	$166,340,292	$611	$46,431
New Mexico	$247,119,006	$602	$41,663
West Virginia	$186,968,393	$602	$40,907
Arkansas	$305,305,543	$601	$43,292
Florida	$1,567,640,169	$562	$50,199
South Carolina	$417,768,871	$561	$43,702
Oklahoma	$325,695,382	$553	$46,267
South Dakota	$60,064,731	$531	$52,426
Georgia	$715,432,536	$488	$46,519
Alabama	$375,427,323	$471	$42,240
Nevada	$181,466,943	$468	$49,290

Sources: Author's calculations use data from Kaiser Family Foundation State Health Care Facts for Medicaid expenditures and poverty rates by state. State GDP numbers are from the Bureau of Economic Analysis at the Commerce Department.

Table 4 shows the annualized estimated impact from the 6.2 percent increase in the federal Medicaid reimbursement contained in the FFCRA. The figure demonstrates how wealthier states will receive far more funding per person in poverty, largely because they have more profligate Medicaid programs. For example, on an annualized basis, wealthy states, such as Maryland, Minnesota, and New York, will receive more than $1,000 for every person in the state under the Federal Poverty Level (FPL). Poorer states, such as Alabama, Florida, and Nevada are slated to receive less than half as much as these states per person below the FPL. These estimates are conservative because they do not account for the increase in Medicaid that will occur as a result of the recession. The primary intent is to display the inequities across states in the receipt of the aid.

In addition to exacerbating inequities between states and rewarding wealthier states, increasing the federal share of Medicaid expenditures would further reduce incentives for states to minimize waste, fraud, abuse, and low-value spending. Any increase in the federal share reduces the incentive for states to spend judiciously and maximize the value from program expenditures.

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2) Do not direct money to states in ways that would discourage economic re-openings

With 30 million newly unemployed people and huge and escalating costs of the economic shutdowns,[35] Congress should be looking for ways to restart the nation's economic engine. Basing federal payments to states on their unemployment rates creates a perverse incentive to keep their economies frozen for longer. Many proposals have been advanced for smart economic re-openings that relax restrictions in sensible ways to minimize public health concerns.[36] Any federal aid to states will create some incentive for states to maintain shutdowns, but certain designs, such as the one proposed by leading Democrats, would exacerbate this counterproductive incentive. Importantly, the proposal to ramp up federal aid based upon a state's unemployment rate creates a strong incentive for states to delay economic re-openings. Otherwise, the longer their unemployment rate remains high, the more federal money will flood state coffers. If the federal government decides to provide aid to states, it can do so in a variety of ways that minimize the incentives for the state to maintain strict lockdown requirements longer than is appropriate. For example, Congress could provide payments based on the state's population or retrospective figures like the state's poverty rate or uninsured rate.

3) Do not hurt states that have been more fiscally responsible

For both families and governments, responsible budgeting involves living within your means and saving a portion of your income in good times for leaner times. Many states have been fiscally responsible and have used past budget surpluses to create substantial rainy-day funds. This is exactly the type of state behavior that the federal government should be encouraging. In fact, a March 18, 2020, PEW Charitable Trust report found that "states collectively have amassed their largest fiscal cushion in at least two decades."[37] Altogether, states have $75 billion in rainy day funds. PEW notes that policymakers in many states used the recent economic expansion "to replenish and enlarge their rainy-day funds to prepare for the next inevitable downturn."[38]

Of course, some states have been more prudent than others. For example, Wyoming could last 398 days on its rainy-day fund, California 53, Texas 74, but a few states (Illinois, Kansas, New Jersey, Pennsylvania, and Kentucky) have virtually nothing set aside. It is unfair to the more responsible states if less responsible and short-sighted states receive a disproportionate benefit from federal assistance. While the magnitude of this crisis may necessitate an additional federal relief package to states, its construction must be carefully designed. Congress should not construct a bailout in such a way to significantly reduce incentives for states to be prudent about their finances going forward.

[35] Mulligan, Casey, "U.S. daily cumulative costs of the COVID-19 pandemic, updated through April 29, 2020."
[36] Roy, Avik, "A New Strategy for Bringing People Back to Work During COVID-19," The Foundation for Research on Equal Opportunity, April 14, 2020. See: https://freopp.org/a-new-strategy-for-bringing-people-back-to-work-during-covid-19-a912247f1ab5
[37] Rosewicz, Barb, Justin Theal, and Joe Fleming, "States' Financial Reserves Hit Record Highs," PEW Charitable Trusts, March 18, 2020. See: https://www.pewtrusts.org/en/research-and-analysis/articles/2020/03/18/states-financial-reserves-hit-record-highs
[38] Ibid.

4) Do not rush into adding more federal debt

The total debt impact of this cumulative coronavirus relief legislation, enacted by Congress over a period of just a few weeks with no hearings to assess repercussions, combined with automatic spending increases that would have occurred even without congressional action, will be roughly $2.7 trillion. Federal outlays for this fiscal year are going to be significantly more than double federal revenues. The Federal Reserve is also taking unprecedented actions.

Debt means financing present consumption with future sacrifices. Certainly, some amount of debt accumulation was necessary in order to help Americans who are facing massive income losses from the economic shutdown and to keep businesses from permanently shuttering. But, after borrowing an additional $2.7 trillion, it is appropriate for Congress to pause, better understand the ramifications of what it has already done including the unintended consequences, and carefully debate future action before enacting more relief legislation. Simply put, Congress should not rush into any further debt-fueled actions and should focus economic policies on reopening the economy.

5) Condition any state aid on structural reforms

If the federal government does find a way to equitably send additional money to states without creating perverse incentives, it should this opportunity to obtain structural reforms to the federal-state fiscal partnership. With publicly held federal government debt set to exceed 100 percent of gross domestic product this year, the need for major reforms has likely never been more urgent.[39] Two key structural reforms Congress could consider are gradually equalizing the federal Medicaid reimbursement rate across eligible populations and boosting Medicaid program integrity.

Gradually equalize the federal Medicaid reimbursement rate across populations

The enhanced reimbursement rate for the ACA expansion population provides a more generous federal match for able-bodied adults than for traditional Medicaid populations, such as individuals with disabilities and low-income children, pregnant women, and seniors. This distortion provides an incentive for states to spend less on these more vulnerable Medicaid enrollees, to inappropriately classify enrollees as eligible under the expansion, and to spend more carelessly on expansion enrollees. Starting in 2021, Congress could lower the elevated reimbursement rate for the expansion population by 5 percentage points each year until it reaches parity with the state's federal match for its traditional Medicaid populations. This represents a gradual glidepath. For poorer states, it would take about three years for parity to be reached. For richer states, it would take about eight years.

[39] According to CBO, "Federal debt held by the public would be 101 percent of GDP by the end of fiscal year 2020 and would grow to 108 percent of GDP at the end of 2021." See: https://www.cbo.gov/publication/56335

Boost Medicaid program integrity

In November 2019, the Centers for Medicare and Medicaid Services proposed the Medicaid fiscal accountability rule to shed light on Medicaid's hidden financial arrangements.[40] This rule addresses long-standing problems and better ensures the appropriateness of Medicaid spending. Its importance has increased given the surge of federal Medicaid spending that will occur from both the recession and the additional money provided by Congress. The rule would also limit states' ability to provide kickbacks to politically favored providers and would help ensure that Medicaid funds go for care for the poor. Congress should codify the requirements in this rule, having the data transparency requirements take effect in 2021 and providing states another year to conform to the broader financing reforms.

Congress could take several other actions to boost program integrity as well, including:

- Eliminating restrictions from the Families First Coronavirus Response Act (FFCRA) that prohibit states from removing ineligible enrollees. Under the FFCRA, the 6.2 percent reimbursement increase will not be available if states removed anyone, including ineligible individuals, from Medicaid for the duration of the declared emergency. This prevents states from managing their budget shortfalls by ensuring only eligible individuals are receiving Medicaid.[41]

- Permitting states to review eligibility of Medicaid enrollees more frequently than once a year.[42] Regulations promulgated during the Obama administration barred states from conducting redeterminations more than once annually. Previously, states had the option to do more frequent eligibility reviews. Given the surge of improper enrollment from the ACA and that may emerge if there is an influx of new enrollees this year, it is crucial for states to have the tools to ensure that only those who are eligible are enrolled.

- Requiring CMS to conduct annual eligibility audits of state Medicaid enrollment after the crisis ends and requiring CMS to make recoveries using a valid extrapolation method. As evidenced by recent reviews by CMS and the Office of the Inspector General at HHS as well as survey data analysis, states are increasingly failing to conduct proper eligibility reviews after the ACA Medicaid expansion took effect and millions of people are improperly enrolled.[43] CMS stopped eligibility audits from 2014 to 2017 and now only conducts them in

[40] Centers for Medicare & Medicaid Services, "Medicaid Program; Medicaid Fiscal Accountability Regulation," Federal Register, November 18, 2019. See: https://www.federalregister.gov/documents/2019/11/18/2019-24763/medicaid-program-medicaid-fiscal-accountability-regulation

[41] Ingram, Jonathan, Nicholas Horton, and Sam Adolphsen, "Extra COVID-19 Medicaid Funds Come at a High Costs to States," Foundation for Government Accountability, April 8, 2020. See: https://thefga.org/research/covid-19-medicaid-funds/

[42] Eardley, Victoria and Jonathan Ingram, "How the Trump administration can crack down on Medicaid Fraud," Foundation for Government Accountability, December 13, 2018. See: https://thefga.org/wp-content/uploads/2018/12/Eligibility-12.13.18.pdf

[43] This is all discussed in great detail here: See: Blase, Brian and Aaron Yelowitz, "The ACA's Medicaid Expansion: A Review of Ineligible Enrollees and Improper Payments."

a third of the states each year. Given the extent of the problem, CMS should conduct them in each state every year. Importantly, the audits will only be meaningful and only incentivize states to properly determine eligibility if the federal government can use the audit results and make recoveries using statistically valid extrapolation methods.

- Eliminating hospital presumptive eligibility (HPE). HPE was required in the ACA and allows hospitals to enroll someone in Medicaid with little information and without verification. States have reported that a significant number of people deemed eligible by hospitals were actually ineligible,[44] but HPE restricts states from recouping funds that were misspent as a result of an incorrect HPE determination.[45]

Conclusion

If Congress decides to send additional aid to states, it would be far better to estimate the amount states need and then distribute the assistance in a manner that does not lead to incentives for low-value and wasteful state spending. An increase in the federal Medicaid reimbursement should be avoided for many reasons. It would disproportionately benefit wealthy states and those with more profligate Medicaid programs, and it would significantly increase low-value spending because of the federal government's open-ended matching Medicaid reimbursement. Congress should avoid structuring any financial aid to states based on factors, like the state unemployment rate, that create incentives for states to keep their economies shut down. Moreover, Congress should certainly avoid taking action that disproportionately rewards states that have historically demonstrated less fiscal discipline. Given the need for long-term reforms, Congress should condition aid to states on longer-term structural reforms that will improve the functioning of the Medicaid program for both recipients and taxpayers.

[44] Forthcoming Foundation for Government Accountability study.
[45] According to a Centers for Medicare and Medicaid Services January 2014 FAQs document, "There is no recoupment for Medicaid services provided during a PE [presumptive eligibility] period resulting from erroneous determinations made by qualified entities. Payment for services covered under the state plan (as well as federal financial participation) is guaranteed during a PE period; without such a guarantee, providers could not rely on the PE determination." See: https://www.medicaid.gov/state-resource-center/faq-medicaid-and-chip-affordable-care-act-implementation/downloads/faqs-by-topic-hospital-pe-01-23-14.pdf.

Proposed Change Would Permanently Tie Federal Medicaid Payments to Unemployment Rate[46]

Many leading House Democrats have introduced legislation[47] that would, beginning with the January 2020 quarter, permanently increase the federal Medicaid reimbursement by 4.8 percentage points for each percentage point increase in a state's unemployment rate above about 5 percent.[48] The federal reimbursement rate could not exceed 95 percent in any quarter. This increase would be on top of the 6.2 percentage point increase in the federal reimbursement from the FFCRA that is already in place retroactive to January 1, 2020. The proposed increase would apply to able-bodied adults as well, raising the federal reimbursement from 90 to 95 percent for these enrollees.

If the formula yields a reimbursement in excess of 95 percent for a quarter, the state may elect to apply such excess to one or more previous quarters in order to receive additional federal money. The total federal reimbursement during a lookback quarter (seemingly the four quarters in the previous year) could not exceed 100 percent.[49] In other words, states would receive a refund for a part of its contribution to Medicaid in 2019, the year before the coronavirus arrived in the U.S. This is spending that has little, if any, relation to its need during the coronavirus pandemic. Once again, this formula design provides much greater benefit to wealthier states and those with more profligate Medicaid programs.

In exchange for accepting these funds, states would be prohibited from making their eligibility rules and enrollment processes more restrictive or requiring larger premium payments from enrollees than were in place prior to the downturn. Moreover, the state would be prohibited from removing anyone from the program for at least 12 months unless the individual requests a voluntary termination of eligibility or ceases to be a resident of the state. These limitations on the funding are radical proposals that damage program integrity and dramatically reduce the ability of states to manage their Medicaid programs. The legislation also would prohibit the Department of Health and Human Services from taking steps to improve transparency and fiscal accountability in the Medicaid program for a two-year period.[50]

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[46] I also critiqued this proposal in a Wall Street Journal piece on May 5, 2020. Blase, Brian "A New Recipe for Waste in Medicaid," The Wall Street Journal, May 5, 2020. See: https://www.wsj.com/articles/a-new-recipe-for-waste-in-medicaid-11588629304?mod=opinion_lead_pos10

[47] Take Responsibility for Workers and Families Act, H.R. 6379, 116th Cong., 2nd Sess. 2020. See: https://appropriations.house.gov/sites/democrats.appropriations.house.gov/files/COVIDSUPP3_xml.pdf

[48] The state-specific threshold would be set at the lower of: (a) the state's 20th percentile unemployment rate over the prior 60 quarters (15 years), plus one percentage point; and (b) the state's average unemployment rate over the prior 12 quarters (3 years), plus one percentage point. See: Take Responsibility for Workers and Families Act, H.R. 6379, 116th Cong., 2nd Sess. 2020. https://appropriations.house.gov/sites/democrats.appropriations.house.gov/files/COVIDSUPP3_xml.pdf

[49] The legislation defines a lookback period as the period of 4 fiscal quarters that ends with the fourth quarter which precedes the most recent fiscal quarters that was not an economic downturn quarter for the State.

[50] Section 70102 of the legislation, entitled "Limitation on Additional Secretarial Action with Respect to Medicaid Supplemental Payments Reporting Requirements" would prohibit the Secretary of HHS from finalizing the Medicaid Fiscal Accountability Rule, implement provisions contained in the proposed rule, or promulgate or implement any similar rule or provision for a two-year period.

The Democrats' proposal for the next spending bill would exacerbate wasteful Medicaid spending, increase state dependence on Washington, unfairly distribute federal aid to wealthier states with the most expensive Medicaid programs, and incentivize states to maintain economic lockdowns longer than necessary. Moreover, the 4.8 percentage point increase in federal payments appears to be based on a methodology in a Brookings Institution paper that assumed normal economic fluctuations, with little, if any, bearing to the current economic conditions.[51]

Given that unemployment has skyrocketed over the past several weeks, the House Democratic proposal likely would increase the federal Medicaid reimbursement rate to 95 percent in every state for both the second and third quarters of 2020 and in the fourth quarter in most states.[52] CBO projects the average national unemployment rate will be 14.0 percent in the second quarter of 2020, 16.0 percent in the third quarter of 2020, and 11.7 percent in the fourth quarter of 2020. If a state's unemployment rate goes to 14.0 percent in the 2nd quarter of 2020, this would lead to a 43.2 percentage point increase in its federal Medicaid reimbursement. This would be added to the 6.2 percentage point increase already enacted by Congress. Since every state would be above the maximum amount, it would also boost the federal share of spending in the lookback period as well. In the aggregate, this proposal would likely increase federal Medicaid spending by an amount approaching $200 billion just in 2020.[53] This proposal would also create a much bigger benefit for wealthier states with larger Medicaid programs.

Table 5 below shows the estimated amount that each state would receive in 2020 if the House Democrats' proposed formula becomes law. The second column shows the estimated increase in federal Medicaid payments that would result for the last three quarters of 2020 because of the rise in the unemployment rate. The third column provides a comparison across states by showing the additional funding per person in poverty.[54] The last two

[51] Fiedler, Matthew and Wilson Powell III, "States will need more fiscal relief. Policymakers should make that happen automatically," USC-Brookings Schaeffer Initiative for Health Policy, April 2, 2020. See: https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2020/04/02/states-will-need-more-fiscal-relief-policymakers-should-make-that-happen-automatically/ The Brookings paper assessed the correlation between yearly change in the unemployment rate and a state's fiscal capacity. The Brookings result was based on 34 data points, with three-quarters of them based on a yearly change in the unemployment rate of between 0 and 1 percent. Only twice in the previous 34 years had the unemployment rate changed by more than 2 percent in a year. In contrast, the average unemployment rate change from 2020 to 2019 will almost certainly be at least 6 percent and likely much, much higher.

[52] It's unlikely that this proposal would increase the federal reimbursement for many states in the first quarter of 2020 because the average state unemployment rate would be unlikely to exceed 5 percent given that the social distancing actions did not become frequent until the last few weeks in that quarter.

[53] In estimating the cost of the proposal, Matthew Fielder and Wilson Powell III cite the 2017 Medicaid Actuarial report that projected $658 billion in total state and federal spending on Medicaid benefits, excluding spending on Disproportionate Share Hospital Payments, which would not be affected under the proposal. They estimated that a 4.8 percentage point increase in the federal matching rate translates into a federal Medicaid spending increase of $32 billion per year. Since CBO projects the unemployment rate will average about 14 percent for the last three quarters of 2020 and using a threshold of about 5 percent, equates to $288 billion of additional federal spending in 2020. This number will be too high because many states will run into the 95 percent cap for these quarters and the ability to extend it to previous quarters does not appear to be unlimited. I estimate the projected fiscal impact in Tables 5 and 6 below. I include the lookback estimates in the 2020 amount. See: Wolfe, Christian, Kathryn Rennie, and Christopher Truffer, "2017 Actuarial Report on the Financial Outlook for Medicaid," Department of Health and Human Services. https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2017.pdf; Fiedler, Matthew and Wilson Powell III, "States will need more fiscal relief. Policymakers should make that happen automatically."

[54] The number of people below the poverty line was obtained using Kaiser Family Foundation data based on analysis of the Census Bureau's American Community Survey. See: https://www.kff.org/other/state-indicator/population-above-and-below-100-fpl/?dataView=1&currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

columns contain the same information, except they also include the benefit to the state from increasing the Medicaid reimbursement for one quarter in the lookback period.[55] Table 6 also provides estimates of the state impact of the House Democrats' proposal, but uses a 12 percent annual growth rate in spending from 2018 to 2020 (the lookback quarter calculations are unchanged). The appendix explains the methodology used to compute these tables. It is possible, if not likely, that the Table 6 estimates are more realistic, given that Medicaid enrollment in 2020 is expected to grow significantly as a result of the recession. Therefore, Table 5 should be viewed as showing conservative estimates of the projected payments to states. The lookback period estimates are also conservative for two reasons. First, states will apply the excessive reimbursement to the quarter that they had the largest expenditure in order to maximize the receipt of federal money. Second, it's unclear if the legislation allows states to apply extra excess reimbursement (which would apply in 26 states) to also obtain additional federal funds in more than a single quarter.[56]

Table 5 shows that this proposal exacerbates inequities between states and provides much greater benefit to the wealthiest states. The top four states that benefit, in terms of federal money per person in poverty, are New York ($10,236), Massachusetts ($8,027), Minnesota ($7,279), and Vermont ($7,233). The bottom four states are South Carolina ($1,803), Georgia ($1,801), Mississippi ($1,577), and Alabama ($1,509). As an illustration of how this proposal advantages rich states much more than poor states, the proposal would deliver $5,955 on average per person in poverty to states with a federal reimbursement that normally equals 50 percent for traditional Medicaid enrollees.[57] In contrast, the proposal would only deliver an average of $1,992 per person in poverty in the nine poorest states (those with a federal Medicaid reimbursement in excess of 70 percent).[58] Of note, the estimates are probably most imprecise for Maine, Utah, and Virginia, states that adopted the ACA's Medicaid expansion between 2018 and 2020.

The likely spending increase will undoubtedly exceed the projected amount because the higher federal reimbursement, particularly for the remainder of 2020, would leave states with virtually no incentive to obtain value for their Medicaid expenditures. A 95 percent federal reimbursement rate would mean that for every dollar of state spending on Medicaid, the federal government would send states $19. This means it would make economic sense for a state to obtain as little as 5 cents of value for each dollar it spent on Medicaid. States would have every incentive to pour as many state dollars as possible through Medicaid to maximize the receipt of federal money. The situation is worse than this, though, because states utilize financing gimmicks to leverage federal matching payments. In effect, states have learned how to use Medicaid to draw down federal funds that are used to fill

[55] The legislative language is complicated around the lookback period. I aggregated "excess" reimbursements, i.e., those that the formula raised above 95 percent in the second through fourth quarters of 2020, and I applied the total "excess" percentage to one quarter of state spending in 2019. (See the appendix for additional explanation.) For 26 states plus D.C., this led to them receiving a full quarter of their state's share of Medicaid returned to them. These 26 states plus D.C. had an excess reimbursement that put their adjusted federal Medicaid reimbursement above 100 percent in the lookback quarter. The House Democrat proposal caps the reimbursement in any one quarter to 100 percent of total expenditures, which essentially rebates the entire state share back to the state. For the other 24 states, this led to a large rebate, although not the complete amount, of one quarter of their spending.

[56] See footnote 53 and the appendix for additional explanation.

[57] These states are: Alaska, California, Colorado, Connecticut, Maryland, Massachusetts, Minnesota, New Hampshire, New Jersey, New York, Virginia, Washington, and Wyoming.

[58] These states are: Alabama, Arizona, Arkansas, Idaho, Kentucky, Mississippi, New Mexico, South Carolina, and West Virginia.

other state budgetary holes. As a result under such a proposal, states may be able to tap unlimited federal money without making any contribution.

This is a recipe for a massive amount of Medicaid waste, fraud, abuse, and misspending as states maximize Medicaid in order to dramatically increase the receipt of federal dollars. We know that a similar result occurred from the enhanced reimbursement rate for the ACA's Medicaid expansion population which began at 100 percent but has declined to 90 percent, where it is scheduled to remain. This economic incentive caused states to enroll large numbers of people, including many who lacked eligibility, and to set high payment rates to insurers for managing the care of these enrollees. As a result, the financial cost of the ACA's Medicaid expansion vastly exceeded projections.[59] In expansion states, enrollment and spending per enrollee generally exceeded projections by upwards of 50 percent.[60]

Already, two-thirds of all federal funding going to states flows through the Medicaid program. Given our nation's rapidly deteriorating budget situation and that huge gap between federal spending and revenue trajectories, it is irresponsible to sink the federal government more deeply into debt to further state reliance on the already problem-plagued Medicaid program.

[59] Blase, Brian and Aaron Yelowitz, "The ACA's Medicaid Expansion," Mercatus Center, November 25, 2019. See: https://www.mercatus.org/publications/healthcare/aca-medicaid-expansion
[60] Blase, Brian, "Evidence Is Mounting: The Affordable Care Act Has Worsened Medicaid's Structural Problems."

Table 5: Approximation of Federal Aid From House Democratic Unemployment Proposal (assuming 4% annual Medicaid growth from 2018 to 2020)

	2020 Federal spending boost	Boost per person in poverty	Spending boost including lookback	Boost per person in poverty
United States	**$133,388,975,503**	**$3,203**	**$171,797,546,909**	**$4,125**
New York	$22,694,862,057	$8,678	$26,768,372,241	$10,236
Massachusetts	$4,582,227,999	$6,876	$5,349,239,913	$8,027
Minnesota	$3,300,594,099	$6,181	$3,886,928,086	$7,279
Vermont	$388,810,517	$5,812	$483,857,727	$7,233
Wisconsin	$2,912,585,183	$4,776	$4,170,347,689	$6,839
Alaska	$333,088,654	$4,377	$500,120,239	$6,572
Connecticut	$1,989,481,854	$5,548	$2,317,869,794	$6,464
New Hampshire	$523,426,692	$5,516	$609,318,989	$6,421
Maryland	$2,671,110,519	$5,154	$3,126,389,266	$6,032
Rhode Island	$633,655,641	$4,978	$758,841,257	$5,961
Pennsylvania	$7,305,643,027	$4,842	$8,806,530,735	$5,837
Delaware	$480,777,788	$4,347	$628,877,081	$5,686
Maine	$548,362,318	$3,784	$815,181,924	$5,626
District of Columbia	$375,103,025	$3,379	$576,899,738	$5,197
New Jersey	$3,596,533,627	$4,384	$4,213,071,435	$5,136
California	$21,395,541,129	$4,330	$25,324,323,153	$5,126
Colorado	$2,295,747,770	$4,238	$2,679,379,641	$4,946
North Dakota	$290,087,780	$3,910	$343,608,121	$4,631
Hawaii	$463,712,871	$3,617	$586,674,178	$4,576
Iowa	$1,013,570,594	$2,953	$1,442,862,986	$4,204
Washington	$2,672,065,431	$3,472	$3,188,381,866	$4,142
Oregon	$1,343,725,582	$2,684	$2,024,970,290	$4,044
Illinois	$5,075,014,976	$3,417	$5,997,121,759	$4,037
Missouri	$2,013,218,827	$2,576	$3,000,811,103	$3,840
Ohio	$3,974,005,500	$2,516	$5,901,328,790	$3,736
Virginia	$2,757,475,334	$3,157	$3,217,183,414	$3,683
Kansas	$938,067,541	$2,727	$1,202,626,686	$3,496
Nebraska	$597,984,732	$2,784	$733,233,773	$3,414
Wyoming	$170,519,292	$2,733	$209,115,848	$3,351
Indiana	$1,890,458,481	$2,222	$2,849,440,845	$3,349
Texas	$9,843,797,171	$2,371	$13,294,803,464	$3,203
Louisiana	$1,720,548,399	$2,036	$2,571,591,409	$3,043
Michigan	$2,600,117,498	$1,902	$3,898,886,341	$2,853
Oklahoma	$1,109,959,221	$1,885	$1,627,033,866	$2,763
South Dakota	$211,842,304	$1,873	$309,582,413	$2,737
Montana	$223,767,852	$1,787	$342,479,353	$2,735
Florida	$5,098,555,288	$1,827	$7,506,040,245	$2,689
Tennessee	$1,795,285,028	$1,766	$2,691,872,427	$2,648
Kentucky	$1,137,797,134	$1,573	$1,774,115,931	$2,453
North Carolina	$2,254,193,324	$1,594	$3,405,394,690	$2,408
Arkansas	$735,300,253	$1,447	$1,143,260,077	$2,250
Arizona	$1,355,347,518	$1,392	$2,115,370,911	$2,172
Nevada	$553,300,559	$1,426	$836,632,766	$2,156
Idaho	$282,993,900	$1,370	$437,463,902	$2,117
Utah	$371,727,200	$1,366	$570,757,689	$2,097
New Mexico	$534,827,739	$1,304	$843,943,227	$2,057
West Virginia	$390,996,434	$1,259	$618,836,496	$1,992
South Carolina	$865,498,167	$1,162	$1,342,667,368	$1,803
Georgia	$1,739,081,920	$1,185	$2,641,874,458	$1,801
Mississippi	$560,721,283	$974	$908,005,521	$1,577
Alabama	$775,858,470	$972	$1,204,025,784	$1,509

This spending is in addition to an estimated $35.3 billion that states will receive in Medicaid in 2020. Author's calculations use data from Kaiser Family Foundation State Health Care Facts for Medicaid expenditures and poverty rates by state.

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Table 6: Approximation of Federal Aid From House Democratic Unemployment Proposal (assuming 12% annual Medicaid growth from 2018 to 2020)

	2020 Federal spending boost	Boost per person in poverty	Spending boost including lookback	Boost per person in poverty
United States	**$153,151,863,104**	**$3,678**	**$191,560,434,510**	**$4,600**
New York	$26,327,765,697	$10,068	$30,401,275,881	$11,625
Massachusetts	$5,331,645,571	$8,001	$6,098,657,485	$9,152
Vermont	$452,494,925	$6,764	$547,542,136	$8,184
Minnesota	$3,777,461,187	$7,074	$4,363,795,174	$8,172
Wisconsin	$3,377,909,443	$5,539	$4,635,671,949	$7,602
Connecticut	$2,322,008,699	$6,475	$2,650,396,639	$7,391
New Hampshire	$594,865,526	$6,268	$680,757,823	$7,173
Alaska	$361,364,089	$4,749	$528,395,675	$6,943
Maryland	$3,025,870,800	$5,838	$3,481,149,547	$6,716
Rhode Island	$722,957,878	$5,679	$848,143,495	$6,663
Pennsylvania	$8,293,943,778	$5,497	$9,794,831,487	$6,492
Delaware	$555,883,024	$5,026	$703,982,317	$6,365
Maine	$635,970,499	$4,389	$902,790,105	$6,230
New Jersey	$4,087,913,024	$4,983	$4,704,450,833	$5,735
California	$24,320,909,377	$4,922	$28,249,691,401	$5,718
District of Columbia	$417,982,377	$3,766	$619,779,090	$5,584
Colorado	$2,622,979,225	$4,842	$3,006,611,097	$5,550
North Dakota	$332,452,816	$4,480	$385,973,157	$5,202
Hawaii	$518,534,729	$4,045	$641,496,036	$5,004
Illinois	$6,191,488,836	$4,168	$7,113,595,618	$4,789
Iowa	$1,156,430,046	$3,370	$1,585,722,438	$4,620
Washington	$3,015,528,661	$3,918	$3,531,845,095	$4,589
Oregon	$1,459,520,182	$2,915	$2,140,764,890	$4,276
Missouri	$2,334,857,338	$2,988	$3,322,449,614	$4,251
Virginia	$3,198,018,730	$3,661	$3,657,726,811	$4,187
Ohio	$4,443,509,958	$2,813	$6,370,833,248	$4,033
Kansas	$1,087,936,319	$3,163	$1,352,495,465	$3,932
Nebraska	$693,520,755	$3,229	$828,769,796	$3,858
Indiana	$2,287,101,862	$2,688	$3,246,084,226	$3,815
Wyoming	$197,762,020	$3,169	$236,358,575	$3,788
Texas	$11,416,474,826	$2,750	$14,867,481,119	$3,582
Louisiana	$1,888,492,871	$2,234	$2,739,535,882	$3,241
Michigan	$2,937,737,602	$2,150	$4,236,506,444	$3,100
Oklahoma	$1,287,289,984	$2,186	$1,804,364,629	$3,064
South Dakota	$245,686,933	$2,172	$343,427,042	$3,036
Florida	$5,913,117,376	$2,118	$8,320,602,333	$2,981
Tennessee	$2,082,105,713	$2,048	$2,978,693,112	$2,930
Montana	$234,447,101	$1,873	$353,158,601	$2,821
North Carolina	$2,614,330,719	$1,848	$3,765,532,084	$2,662
Kentucky	$1,197,373,178	$1,655	$1,833,691,975	$2,535
Arkansas	$780,226,762	$1,535	$1,188,186,586	$2,338
Idaho	$328,205,944	$1,589	$482,675,946	$2,336
Arizona	$1,508,728,871	$1,549	$2,268,752,264	$2,330
Utah	$431,115,569	$1,584	$630,146,058	$2,315
Nevada	$591,279,549	$1,524	$874,611,756	$2,254
New Mexico	$560,315,767	$1,366	$869,431,255	$2,119
West Virginia	$417,534,374	$1,344	$645,374,437	$2,078
Georgia	$2,016,923,411	$1,375	$2,919,715,948	$1,990
South Carolina	$1,003,773,022	$1,348	$1,480,942,223	$1,989
Mississippi	$650,303,973	$1,129	$997,588,211	$1,733
Alabama	$899,812,190	$1,128	$1,327,979,504	$1,665

This spending is in addition to an estimated $41.0 billion that states will receive in Medicaid in 2020. Author's calculations use data from Kaiser Family Foundation State Health Care Facts for Medicaid expenditures and poverty rates by state.

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Appendix:

Methodology for Estimating the Medicaid Rate Tied to the State Unemployment Rate

Table 5 and Table 6 are rough approximations (a back-of-the-envelope estimate) of the state-by-state impact of the House Democratic proposal. The tables were constructed using the fiscal year 2018 Medicaid expenditures as a baseline.[61] The baseline includes five expenditure categories—total Medicaid spending, federal spending on the traditional population, state spending on the traditional population, federal spending on the expansion population, and state spending on the expansion population.

First, I inflated the 2018 numbers by 4 percent for two years to construct a 2020 baseline. I also adjusted the expansion population spending so that the federal-state share amounted to a 90 percent to 10 percent split in 2020. I calculated each state's federal medical assistance percentage (FMAP) by dividing the federal spending on the traditional population by the sum of the federal and state spending on the traditional population.

Second, I constructed five equivalent quarters—4th quarter 2019 ('19 Q4), 1st quarter 2020 ('20 Q1), 2nd quarter 2020 ('20 Q2), 3rd quarter 2020 ('20 Q3), and 4th quarter 2020 ('20 Q4)—for total spending.

Third, I calculated the federal spending that would result from the 6.2 percent FMAP increase for the traditional population contained in the Families First Coronavirus Response Act. This increase is available for every quarter of the public health emergency and I assumed that the emergency would be in effect in every quarter in 2020.

Fourth, I used Congressional Budget Office estimates of the quarterly unemployment rate for the last three quarters of 2020 to account for the FMAP increase that would result from the House Democratic proposal. According to the CBO, the unemployment rates will be 14.0 percent, 16.0 percent, and 11.7 percent respectively in the second quarter, third quarter, and fourth quarter of 2020. I assumed a 5 percent unemployment threshold in all states and that CBO's national unemployment rate is the average rate in every state for that quarter.

- For the second and third quarter of 2020, every state would reach the maximum FMAP of 95 percent. The rate applies for both traditional and expansion enrollees.

- For the fourth quarter of 2020, 30 states would have an FMAP of at least 95 percent. For those states, the 4th quarter estimated federal Medicaid payment increase is equivalent to the increase in the 2nd and 3rd quarters. For states that would have an adjusted FMAP between 90% and 95%, I applied their state-specific new FMAP to all their Medicaid spending to calculate the federal payment increase. For states that would have an adjusted FMAP of less than 90%, I applied the adjustment only to the traditional population.

[61] Kaiser Family Foundation, "Medicaid Expansion Spending," Accessed May 4, 2020. See: https://www.kff.org/medicaid/state-indicator/medicaid-expansion-spending/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

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Fifth, in order to estimate the lookback period amount, I applied the excess FMAPs (the adjusted FMAP above 95 percent in each state from the second through fourth quarters of 2020) and applied the adjustment to the fourth quarter of 2019. The FMAP in the lookback quarter could not exceed 100 percent and I only applied the lookback to a single quarter (although more than one quarter of excess reimbursements were aggregated). In other words, a state cannot receive more federal money in the lookback quarter than their total Medicaid expenditure in that quarter, so the amount was limited by the state's contribution in that quarter.

About The Author

Brian Blase, Ph.D., is a senior research fellow at the Galen Institute. He previously served as a special assistant on the president's White House Economic Council for economic policy from January 2017 through June 2019. Blase coordinated the development and execution of many of the Trump Administration's key health policy achievements, including the expansions of association health plans, short-term limited-duration insurance, and health reimbursement arrangements.

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