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medicaid and the uninsured

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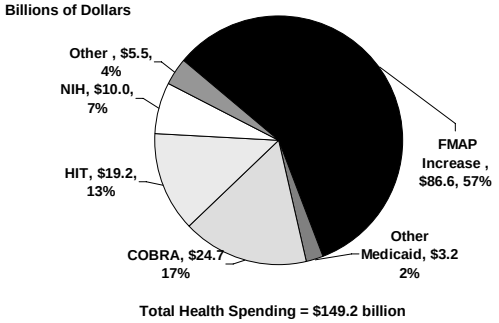
AMERICAN RECOVERY AND REINVESTMENT ACT (ARRA): MEDICAID AND HEALTH CARE PROVISIONS

In an effort to boost an ailing economy, Congress passed and President Obama signed the American Recovery and Reinvestment Act (ARRA) on February 17, 2009. The overall package, which is expected to cost $787 billion, includes significant funding for health care and state fiscal relief. More specifically, the Act includes $149 billion in health spending of which $87 billion is for a temporary increase in the federal share of Medicaid costs, $25 billion for temporary COBRA subsidies, and other spending for health information technology (HIT), the National Institutes of Health and for Community Health Centers.

Figure 1

Distribution of Health Funding in the American Recovery and Reinvestment Act (ARRA)



SOURCE: Detailed Summary of ARRA from the Appropriations Committee and Senate Finance and Ways and Means Committees. http://www.speaker.gov/blog/?p=1694 and White House Summary. Total costs of ARRA = $787 billion.

The Act is intended to provide economic stimulus and generate new jobs. This relief measure was passed at a time when unemployment rates hit 7.6% in January 2009 up from 4.9% at the start of the recession in December 2007. In addition, 46 states are facing budget deficits that could total $350 billion for the rest 2009 and through 2011. This brief will provide a summary of the Medicaid provisions in the ARRA and highlight some of the other key health provisions.

Medicaid Provisions

Temporary Increase in the FMAP ($86.6 billion). The ARRA provides a temporary increase in the federal matching percentage (FMAP) for Medicaid from October 1, 2008 through December 31, 2010. Similar to relief provided in 2003 during the last economic downturn, these funds are designed to help support state Medicaid programs, particularly at a time when there is increased demand for Medicaid coverage and when states are least able to afford to pay for their share of the program. The national unemployment rate hit 7.6% in January 2009, but some states are at substantially higher levels.

A 1 percentage point increase in unemployment is expected to result in 1 million more Medicaid and CHIP enrollees and an additional 1.1 million uninsured which puts upward pressure on state spending, while state revenues are projected to fall by 3 to 4%. Financing for Medicaid is shared by the states and the federal government based on a statutory formula that relies on a states relative per capita income and varies from a floor of 50% up to 76%. Data used to determine the FMAP is lagged and does not necessarily reflect a state's current economic conditions.

Under the Act there are three factors used to calculate a state's FMAP increase: First, the legislation would provide a "hold-harmless" to prevent states from receiving a reduction in their FMAP based on the formula. Second, all states would receive a base increase in their FMAP of 6.2%. Third, states with significant increases in quarterly unemployment over a base rate would receive a 5.5%, 8.5% or 11.5% reduction in their state share of Medicaid costs. The base rate is the lowest three month average state unemployment rate since January 2006. The unemployment increase would be applied to the state share after the hold-harmless and half of the base FMAP increase (See Table 1 for state by state estimates).

Figure 2

Example of Increased FMAP Calculation

1. Current state FMAP = 50%
2. After hold-harmless and base increase FMAP = 56.2%
3. Increases in state unemployment can result in further reductions in the state share of Medicaid.
4. If state unemployment increases by:
   - 1.5 -2.5% > Base = 5.5% Reduction in State Share
   - 2.5%-3.5 > Base = 8.5% Reduction in State Share
   - >3.5% > Base = 11.5% Reduction in State Share
5. If state unemployment is 3 percentage points above base, then:
   - 8.5% reduction in state share of Medicaid after hold-harmless + half base increase
   - FMAP = 50% + 3.1% = 53.1% / State share is 46.9%
   - 8.5% reduction = new State share of 42.9%
6. New FMAP = 57.1%

To be eligible for the enhanced federal financing, states may not have eligibility standards, methods or procedures in place that are more restrictive than those effective on July 1, 2008. States that implemented more restrictive policies after July 1, 2008 have until July 1, 2009 to reverse these restrictions to receive retroactive increased FMAP. To date, CMS has determined that South Carolina is not in compliance with maintenance of effort requirements.

The increased FMAP does not apply to payments for eligibility expansions implemented on or after July 1, 2008 or disproportional share hospital (DSH) payments. States also must report on compliance with provider prompt pay requirements. Finally, states must report on how the increased FMAP funds were used by September 30, 2011.

Extension of the Moratoria on Medicaid Regulations ($105 million). The Bush Administration had promulgated and Congress placed a moratorium on six Medicaid regulations that would limit federal Medicaid reimbursement for a number of services. The ARRA extends the existing moratorium set to expire on April on three regulations (targeted case management, provider taxes, and school-based administration and transportation services) through June 30th, 2009 and also imposes a new moratorium on the outpatient hospital regulation that became final in December 2008. The moratoria on the graduate medical education, public provider, and rehabilitation services regulations were not extended but HHS can opt to not promulgate final regulations for these three proposed rules.

Prompt Pay Requirements ($680 million). The Act temporarily applies Medicaid prompt pay requirements to nursing facilities and hospitals. Currently, states must pay 99% of clean claims for physicians and other practitioners within 90 days of receipt.

Extension of TMA ($1.3 billion) and QI1 Programs ($550 million). Transitional Medical Assistance (TMA) was extended from June 30, 2009 through December 31, 2010, providing a minimum of six months of extended Medicaid coverage for working low-income parents who become ineligible for Medicaid due to increased earning. The ARRA also gives states options to simplify TMA eligibility determinations. The Act also extends the Qualified Individual program designed to help some low-income individuals pay Medicare Part B premiums.

Temporary Increase in DSH Allotments ($460 million). DSH allotments in 2009 are increased by 2.5% and then the allotment for 2010 is increased by 2.5% over 2009 levels.

Protections for Indians Under Medicaid and CHIP ($134 million). The ARRA eliminated cost-sharing for American Indians and Alaska Natives in Medicaid, protects Indian Tribal property by ensuring that certain property does not count as assets, and maintains access to Indian health facilities by requiring states to consult with Indian Health Programs on a continual basis.

COBRA Provisions ($24.7 billion)

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) was designed to help people temporarily continue their employer-sponsored health coverage after leaving a job. However, because a beneficiary must typically pay 102% of the premium costs, many workers find that after losing their job they are not able to afford this coverage which averaged $4,704 for an individual policy and $12,680 for a family policy in 2007.

The ARRA provides a 65% subsidy for COBRA premiums for up to 9 months for workers who have been involuntarily terminated between September 1, 2008 and December 31, 2009. To be eligible for the subsidy, individuals must have been participating in their employer coverage program and they must attest that their annual income will not exceed $125,000 for an individual or $250,000 for a family.

Health Information Technology (HIT) ($19.2 billion)

To support the development of HIT the federal government is required to develop standards around the uses and exchange of electronic health data; provide Medicare and Medicaid fiscal incentives ($17 billion) to encourage doctors, hospitals and other providers to use electronic health records, and strengthen privacy laws to protect health information. Specifically, the ARRA would provide 100% federal funding (phased-down over time) to help providers that serve a high volume of Medicaid and needy patients. CBO estimates that the HIT investments would generate $12 billion in savings as a result of improved quality, care coordination and reductions in medical errors and duplicative care.

Other Health Care Provisions

Other health care priorities include: $10 billion for the National Institutes of Health; $2 billion for Community Health Centers ($1.5 billion for construction, renovation, equipment and HIT, and $500 for operations); $1.1 billion for Comparative Effectiveness Research; $500 million to expand the primary care work force ($300 million for National Health Service Corp and $200 million for primary care training programs in Public Health Services Act); $500 million to support renovation, HIT and contract health services for the Indian Health Service, and $338 million in Medicare spending to block payment reductions for teaching hospitals and hospice providers and to make technical corrections for long-term care hospital payments.

Implications

The economic recovery package provides significant funds for state fiscal relief and health care, but still falls short of closing gaps in state budgets. In addition, while the enhanced FMAP provisions and the COBRA subsidies are designed to help support coverage during the economic downturn, many will not be eligible for these programs leaving significant gaps in coverage options for recently unemployed workers. The stimulus funds were intended to provide temporary assistance and help get the economy back on track, but the ARRA was not intended to substitute for the need for broader health reform or coverage expansions.

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Additional Federal Allocations to States for Medicaid Costs under the American Recovery and Reinvestment Act of 2009 (PL 111-5)

(in millions)

	Pre-ARRA FMAP	Actual Grant Allocations (2 Quarters)	Estimated Total (9 Quarters)
	FY 2009	October 1, 2008 - March 31, 2009	October 1, 2008 - December 31, 2010
United States	**56.7%†**	**$15,246.8**	**$87,144**
Alabama	67.98%	$169.8	$850
Alaska	50.53%	$41.6	$220
Arizona	65.77%	$351.5	$1,980
Arkansas	72.81%	$109.9	$730
California	50.00%	$1,991.9	$11,230
Colorado	50.00%	$140.9	$880
Connecticut	50.00%	$274.6	$1,320
Delaware	50.00%	$60.7	$320
District of Columbia	70.00%	$58.9	$300
Florida	55.40%	$817.0	$4,390
Georgia	64.49%	$339.6	$1,730
Hawaii	55.11%	$70.6	$360
Idaho	69.77%	$53.4	$300
Illinois	50.32%	$470.9	$2,900
Indiana	64.26%	$247.2	$1,440
Iowa	62.62%	$89.1	$550
Kansas	60.08%	$71.6	$450
Kentucky	70.13%	$205.3	$1,030
Louisiana	71.31%	$230.0	$1,660
Maine	64.41%	$94.5	$470
Maryland	50.00%	$275.5	$1,630
Massachusetts	50.00%	$594.3	$3,090
Michigan	60.27%	$464.4	$2,270
Minnesota	50.00%	$356.2	$2,030
Mississippi	75.84%	$137.1	$790
Missouri	63.19%	$270.5	$1,600
Montana	68.04%	$34.2	$180
Nebraska	59.54%	$47.8	$310
Nevada	50.00%	$90.3	$450
New Hampshire	50.00%	$31.5	$250
New Jersey	50.00%	$362.2	$2,220
New Mexico	70.88%	$95.2	$630
New York	50.00%	$2,070.8	$12,650
North Carolina	64.60%	$439.6	$2,350
North Dakota	63.15%	$18.8	$110
Ohio	62.14%	$500.2	$3,010
Oklahoma	65.90%	$174.8	$960
Oregon	62.45%	$155.8	$830
Pennsylvania	54.52%	$680.3	$4,070
Rhode Island	52.59%	$93.5	$470
South Carolina*	70.07%	$173.0	$860
South Dakota	62.55%	$20.5	$120
Tennessee	64.28%	$331.3	$1,620
Texas	59.44%	$952.2	$5,450
Utah	70.71%	$53.4	$320
Vermont	59.45%	$45.5	$280
Virginia	50.00%	$252.7	$1,470
Washington	50.94%	$339.3	$2,060
West Virginia	73.73%	$76.5	$450
Wisconsin	59.38%	$163.1	$1,240
Wyoming	50.00%	$15.9	$110
Guam	50.00%	$.9	$4
Puerto Rico	50.00%	$39.1	$142
Virgin Islands	50.00%	$.6	$3

† Prior to the ARRA, the Federal share of Medicaid spending ranged from a floor of 50% to a high of 75.67% in Mississippi. The U.S. value shown here is the weighted average of all states and DC based on the federal share of Medicaid spending in FY 2006 as reported on CMS-64.

* Section 5001(f) of ARRA provides a set of special rules regarding States maintaining their eligibility requirements (MOE) in order to qualify for the increased FMAP for Medicaid and, based on preliminary analysis, Title IV-E; it also provides States which fail to satisfy the MOE an opportunity to reinstate their eligibility standards, methodologies, and procedures by July 1, 2009 and become eligible, should they wish to do so, for the increased FMAP. As of February 23, 2009, CMS had clearly determined South Carolina failed to qualify for the increased FMAP at this time.

Note: U.S. Total includes Guam, Puerto Rico, Virgin Islands, American Samoa, and Northern Mariana Islands.

Source: Allocations for First 2 Quarters are from the US Department of Health and Human Services, available at http://www.hhs.gov/recovery/statefunds.html, accessed February 23, 2009. Estimates for full 9 Quarters were prepared by the Government Accountability Office, February 11, 2009, for the U.S. Senate Committee on Finance. Territory estimates for the full 9 quarters are from the Center on Budget and Policy Priorities, "Temporary Increase in State FMAP," available at http://www.cbpp.org/1-22-09bud-fmap.pdf, Accessed February 23, 2009.