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# Quickly Expanding Medicaid Eligibility as an Urgent Response to the Coronavirus Pandemic

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Economists believe that a global recession is unavoidable amidst the coronavirus crisis, and there are already reports of large spikes in unemployment.<sup>1</sup> Because many Americans' health insurance is tied to their employment, the US will also likely see large increases in uninsured people with newly lower incomes. In states that expanded Medicaid under the Affordable Care Act (ACA), many workers losing their jobs and health insurance will be eligible for Medicaid. Medicaid enrollment is not limited to a narrow open enrollment period (as is the case with most private insurance), so eligible people can enroll at any time during the year. But 15 states have yet to expand eligibility, and many of their newly and soon-to-be uninsured residents will not be eligible for any assistance in buying private health insurance. Subsidized Marketplace insurance is limited to those with incomes between 100 and 400 percent of the federal poverty level, meaning that losing a job and family income in a state that has not expanded Medicaid eligibility will leave many with no affordable or accessible insurance options. This situation may be sufficient impetus for at least some of the remaining states to expand Medicaid eligibility. If so, how would they do it, and how long would it take a new state to get expanded eligibility operational? What are the stumbling blocks that these states face if they want to put a program in place?

# How Long Have Other States Taken to Expand Medicaid Eligibility?

We looked at how long it took late-expanding states (those that expanded eligibility after the initial implementation of ACA reforms in January 2014) to start enrollment. Though the length of time from state authorization (legislation or executive order) to enrollment varied considerably across states, once a state secured federal approval, some states began implementation very quickly. Maine’s governor signed an executive order to implement Medicaid expansion on January 3, 2019 (her first day in office), and enrollment began just a week later.<sup>2</sup> The governor of Indiana and the federal government agreed to an alternate Medicaid expansion plan on January 27, 2015,<sup>3</sup> and enrollment began on February 1, 2015.<sup>4</sup> Alaska’s governor used executive authority to expand Medicaid eligibility, announcing it on July 16, 2015;<sup>5</sup> the expansion was implemented a month and a half later on September 1.<sup>6</sup> Though these fast turnarounds were not typical of late expansion states, they demonstrate an ability to implement these programs expeditiously.

## Potential Stumbling Blocks to Fast Implementation

Once a current nonexpansion state decides to expand, there are a number of potential barriers to getting their new programs up and running quickly.

First, each state’s plan must go through an approval process with the Centers for Medicare & Medicaid Services (CMS). At this point—after years of experience working through approvals with states—the approval process can be quick, particularly if a state expands through its “state plan” authority rather than through a waiver. If a state chooses to also rely on waiver authority to add features to the expansion that cannot be accommodated through the simpler route, those features could be added later. Several states, including New Hampshire and Virginia, have done this. Though CMS has not always approved state plan authorities quickly for newly expanding states, given the importance of coverage in this time of crisis, CMS can expedite the process as part of its extensive response to the pandemic.

Two states’ expansion paths illustrate where quick action by CMS could move the typical process to completion without delay. In Virginia, the Department of Medical Assistance Services submitted its expansion special plan amendment to CMS within 24 hours of Governor Northam signing into law the budget bill containing Medicaid expansion. CMS approved the amendment five months later, and Virginia began accepting Medicaid applications only one month after that. In contrast, CMS approved the Louisiana eligibility expansion special plan amendment just three weeks after it was submitted by the state. CMS’s ability to expedite its process, as demonstrated by the Louisiana experience, shows the agency can move at the speed called for during the current crisis. Of course, states need to keep their initial request simple to get quick CMS action.

Second, any state expanding eligibility will need to ensure system readiness to enroll larger numbers of applicants. In the short term, states can rely on Healthcare.gov to process applications

(both Louisiana and Virginia did so). In addition to modifying IT systems, given the crisis, states will want to consider simplified enrollment procedures, virtual enrollment assistance, and public service announcements and aggressive efforts to connect people receiving or seeking other benefits (e.g., the Supplemental Nutrition Assistance Program, Temporary Assistance for Needy Families, or other more limited health coverage) to Medicaid. Most hospitals are already set up to help with enrollment, and states have options to enhance that avenue to reach people in and outside the four walls of a hospital. In addition, states must develop contract amendments and payment rates for the health plans contracting with the state to provide Medicaid benefits to enrollees, and those plans may need to expand their provider networks to accommodate more enrollees. The state may also want to increase the number of managed care plans with which it contracts. However, given the current levels of sheltering in place and social distancing, many people are not going into doctors' offices, potentially reducing the pressure on provider networks in the near term. Providing Medicaid coverage to ensure financing for COVID-19 treatment and other emergency care for those needing it is the highest immediate priority.

Some states have gone to great lengths to enroll many additional people with limited staff. Louisiana is an example of this,<sup>7</sup> and the state likely has important lessons to impart to others. Additionally, CMS could allow a state to phase in eligibility with the enhanced matching rate to ease the increasing enrollment burden on a state's system. Conceivably, a state could phase in enrollment starting with geographic areas hardest hit by the virus, increased unemployment, or by income group, age, or some other categorization.

Third, states may be reluctant to expand coverage for financial reasons. Just as the need for additional coverage is peaking, state revenues are expected to plummet because of rising unemployment and depressed economic activity. Late-expanding states are required to contribute 10 percent of the costs associated with the expansion population, whereas early-expanding states had three years of full federal funding for their expansion costs. A number of analyses have shown that Medicaid expansion should result in savings for states,<sup>8</sup> but states cannot deficit spend, and the additional financial commitment to contribute 10 percent will likely be a continuing barrier for some. The federal government, recognizing the need to get funding to the states and the central role of insurance coverage in protecting the stability of the health care system amidst the current situation, has already boosted the federal matching rate for "regular" Medicaid by 6.2 percentage points during this public health emergency, but it could do more; the federal government could eliminate or lower the state contribution for expansion for at least three years, phasing up to 10 percent in subsequent years. This would provide the late-expanding states with the same financial deal the ACA provided to early-expanding states. Legislation would likely be required to make such a change, but it could be considered part of the stimulus efforts.

## Ramping Up Coverage

Detailed data on monthly enrollment through the Medicaid expansions in Louisiana and Virginia, two late-expanding states, provide clues as to the speed at which enrollment could grow in states expanding eligibility in the future. Table 1 shows that in the first month of expansion, Louisiana enrolled about 288,600 people through the Medicaid expansion. Six months later, enrollment had increased by another 40 percent, to over 404,000 people. In Virginia, enrollment was just under 200,000 people in the first month after expansion, and this figure climbed by about 50 percent (to almost 300,000 enrollees) six months later. Both states saw continued enrollment in the subsequent months. Given the public health crisis and that many people who would be newly eligible for Medicaid under an expansion have had insurance coverage recently but would lose that coverage because of a job loss or other drop in income, the ramp-up could be larger and faster in newly expanding states. This likely larger enrollment as a percentage of state population and in a shorter period suggests that full federal support for expansion, for at least a limited period, may be critical to states' ability to take on such a move.

TABLE 1

### Ramp-Up of Medicaid Expansion Enrollment over First 12 Months of Implementation

Enrollment month	Louisiana		Virginia	
	Enrollment	Percent increase since month 1	Enrollment	Percent increase since month 1
1	288,584		198,653	
2	310,936	8	220,580	11
3	324,122	12	237,165	19
4	342,075	19	255,592	29
5	360,197	25	271,023	36
6	376,668	31	284,466	43
7	404,079	40	298,277	50
8	411,341	43	312,446	57
9	417,416	45	326,961	65
10	429,511	49	341,808	72
11	435,946	51	356,972	80
12	438,048	52	372,435	87

Sources: Data for Louisiana are from "Medicaid Enrollment – New Adult Group," Data.Medicaid.gov, accessed March 24, 2020, <https://data.medicare.gov/Enrollment/Medicaid-Enrollment-New-Adult-Group/pfrr-tr7q/data>. Data for Virginia are from "Expansion Dashboard," Virginia Department of Medical Assistance Services, accessed March 24, 2020, <http://dmas.virginia.gov/#/dashboard>.

## Conclusion

The US is poised to experience an unprecedented increase in the number of people losing jobs and incomes—and with them, their health insurance coverage—as the novel coronavirus paralyzes broad swaths of the economy. The period over which this crisis will persist is unknown. States that expanded Medicaid eligibility to their residents with incomes up to 138 percent of the federal poverty level under the ACA are in a much stronger position to provide insurance coverage and access to necessary medical care than are states that have, up until this point, resisted such expansions.<sup>9</sup> More people are likely to

fall into this income group in a much shorter period than the country has experienced heretofore. For many of those losing their employment-based insurance or federally subsidized Marketplace coverage in nonexpansion states at the same time their incomes crater, there will be no affordable coverage alternative.<sup>10</sup> Simultaneously, the nation's public health depends on people being able to receive treatment for the virus, and this large, newly low-income population will be at risk for not seeking or receiving necessary care. Coverage is also the most direct way to provide payment to hospitals and other health providers already under extraordinary financial strain because of the crisis.

The pandemic facing the nation poses new considerations for states that have not expanded Medicaid. It is not costless for states to continue to resist Medicaid expansion, particularly given the current situation. Many uninsured people will go to health centers or hospitals when they are infected and need care, and states and localities will be left to pay for much of the ensuing uncompensated care. Others without insurance will not receive needed treatment, increasing the spread of the virus and imposing the economic consequences of a continuing health crisis, including lost state revenue.

CMS has demonstrated an ability to quickly approve state plan amendments to implement Medicaid expansions. They can inform the remaining nonexpansion states of their willingness to do so in an effort to stem the potentially immense implications of the pandemic for insurance coverage. Permitting states to access full federal funding for their new expansion populations for at least three years, consistent with the funding provided to early expanders, could be the assistance many of these states need to change policy and provide additional protection to their residents.

## Notes

- <sup>1</sup> Nelson D. Schwartz, "Coronavirus Recession Looms, Its Course 'Unrecognizable,'" *New York Times*, March 20, 2020, <https://www.nytimes.com/2020/03/21/business/economy/coronavirus-recession.html>; Steve Matthews, "US Jobless Rate May Soar to 30%, Fed's Bullard Says," *Bloomberg*, March 22, 2020, <https://www.bloomberg.com/news/articles/2020-03-22/fed-s-bullard-says-u-s-jobless-rate-may-soar-to-30-in-2q>; Mohamed A. El-Erian, "The Coming Coronavirus Recession and the Uncharted Territory Beyond," *Foreign Affairs*, March 17, 2020, <https://www.foreignaffairs.com/articles/2020-03-17/coming-coronavirus-recession>.
- <sup>2</sup> Joe Lawlor, "Mills' 'Executive Order 1' Makes 70,000 More Mainers Eligible for Health Insurance," *Press Herald*, January 4, 2019, <https://www.pressherald.com/2019/01/03/mills-signs-executive-order-to-implement-medicaid-expansion/>; "Status of State Action on the Medicaid Expansion Decision," Henry J. Kaiser Family Foundation, March 13, 2020, <https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.
- <sup>3</sup> Shari Rudavsky, "Gov. Pence Gets Federal OK for Medicaid Alternative," *Indy Star*, January 27, 2015, <https://www.indystar.com/story/news/politics/2015/01/27/gov-pence-gets-federal-ok-medicaid-alternative/22396503/>.
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<sup>7</sup> “Becoming Healthy Louisiana: An Overview of Planning Efforts to Implement the Medicaid Expansion,” Henry J. Kaiser Family Foundation, accessed March 24, 2020, <http://files.kff.org/attachment/fact-sheet-Becoming-Healthy-Louisiana-An-Overview-of-Planning-Efforts-to-Implement-the-Medicaid-Expansion>.

<sup>8</sup> See, for example, Ayanian and colleagues (2017), Bachrach and colleagues (2016), and Sommers and Gruber (2017).

<sup>9</sup> People not legally residing in the US are not currently eligible for Medicaid, even in expansion states. As a result, Medicaid eligibility expansion under current rules would not address the needs of undocumented residents.

<sup>10</sup> In addition, some people will lose income and become newly eligible for subsidized Marketplace coverage. We have not analyzed the implications of that change here.

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**Linda Blumberg** is an Institute fellow in the Health Policy Center at the Urban Institute. She is an expert on private health insurance (employer and nongroup), health care financing, and health system reform. Her recent work includes extensive research related to the Affordable Care Act (ACA); in particular, providing technical assistance to states, tracking policy decisionmaking and implementation at the state and federal levels, and interpreting and analyzing the implications of particular policies. Examples of her work include analyses of the implications of congressional proposals to repeal and replace the ACA, delineation of strategies to fix problems associated with the ACA, estimation of the cost and coverage potential of high-risk pools, analysis of the implications of the *King v. Burwell* case, and several studies of competition in ACA Marketplaces. In addition, Blumberg led the quantitative analysis supporting the development of a “Road Map to Universal Coverage” in Massachusetts, a project with her Urban colleagues that informed that state’s comprehensive health reforms in 2006.

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