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Lessons from the Great Recession: New York Medicaid Enrollment During the COVID-19 Crisis

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As the COVID-19 pandemic unfolds, the United States confronts a public health crisis surpassing anything experienced in the last century. Beyond the immediate challenges of caring for those afflicted with the virus, the extraordinary social distancing required to fight the pandemic has also triggered a dramatic economic slowdown, with the unemployment rate at its highest level since the Great Depression and tens of millions filing for unemployment benefits.^{1,2}

Many unemployed New Yorkers are turning to Medicaid, which provides a health coverage safety net for low-income individuals. Medicaid enrollment is “countercyclical”: it rises during periods of increased unemployment, with individuals enrolling after they have lost employer-sponsored insurance and their incomes have fallen below Medicaid’s eligibility thresholds. To help policymakers and stakeholders understand what to anticipate in the current downturn, this brief examines the timing and magnitude of New York’s Medicaid enrollment growth during the “Great Recession” of 2007–2009 and describes how state and federal policies facilitated that growth. The brief also compares those historical policy changes to state and federal actions taken during the current crisis—while acknowledging the unprecedented ways in which COVID-19 is shaping Medicaid’s response to rising unemployment and New Yorkers’ need for coverage.

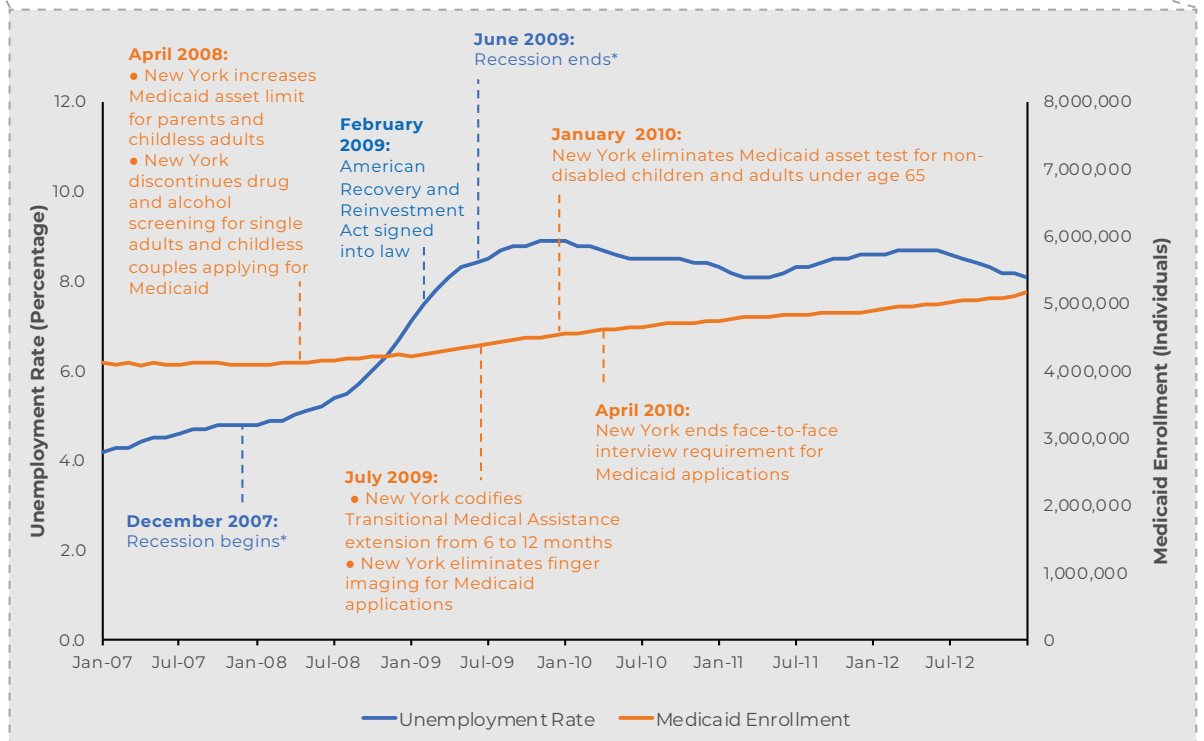
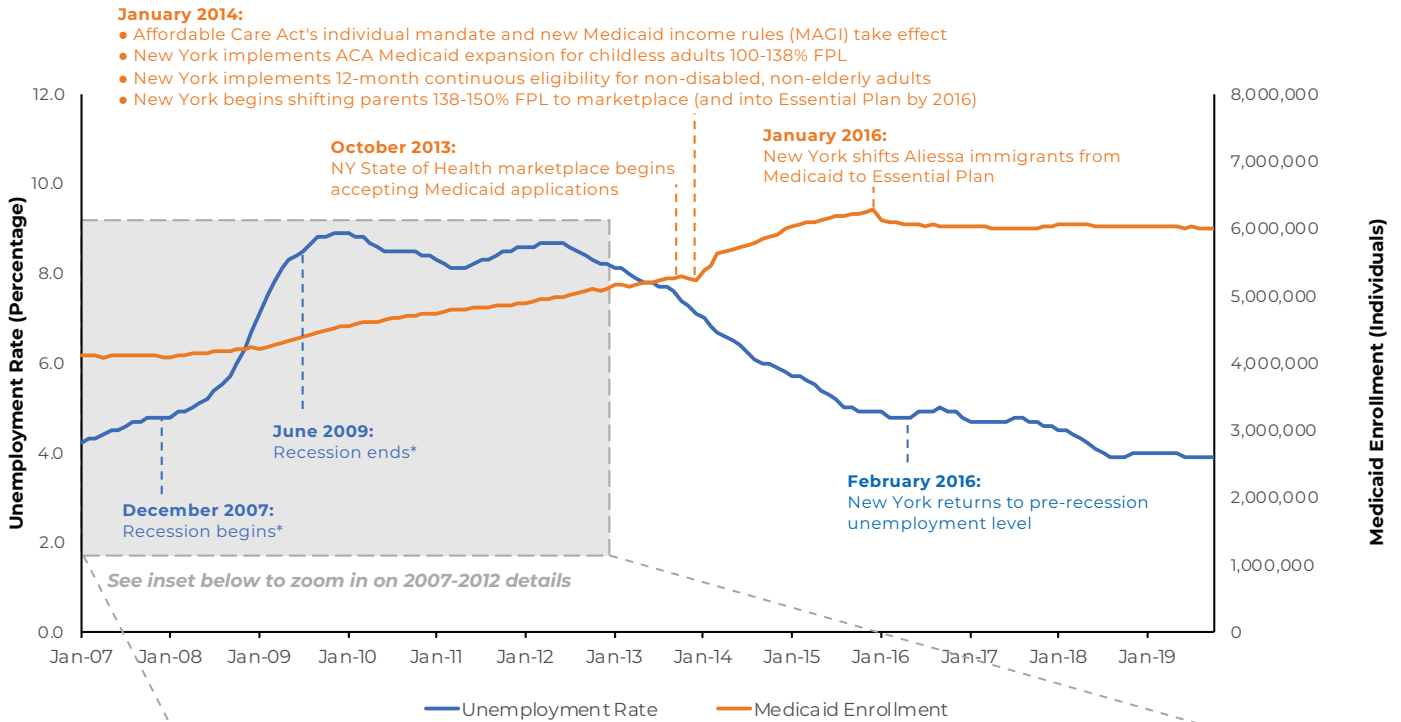
Medicaid Enrollment During the Great Recession

The 2007–2009 recession marked the largest economic downturn in the United States in decades. As unemployment in New York grew, so did Medicaid enrollment. The state’s estimated unemployment rate nearly doubled between 2007 and 2009, growing from 4.8% in December 2007 to a peak of 8.9% in November 2009.^{3,4} Medicaid enrollment grew by over 400,000 individuals during the same period, representing a 10 percent increase.⁵ However, the fastest increase in New York’s Medicaid enrollment lagged the fastest growth in the unemployment rate: between 2007 and 2012, the fastest average increases in enrollment occurred approximately seven months after the fastest average increases in unemployment.⁶ Figure 1 displays these trends, along with key economic events and federal and state policy changes affecting Medicaid eligibility and enrollment since 2007.

Many factors contributed to Medicaid’s delayed growth during the last recession. For instance, unemployed individuals may have received short-term health coverage from severance packages or from other sources such as COBRA plans, which were subsidized for up to 15 months under the American Recovery and Reinvestment Act of 2009 (ARRA).^{7,8} Some of these individuals became

more likely to enroll in Medicaid as those temporary sources of coverage expired or became unaffordable, and as their household incomes fell beneath Medicaid eligibility thresholds, such as when unemployment insurance (UI) benefits were exhausted.⁹ Others may have enrolled in Medicaid after spending down resources (prior to New York’s removal of asset tests) or losing access to family coverage, if a spouse also became unemployed.¹⁰ As the economy recovered and unemployment rates returned to pre-recession levels, growth in Medicaid enrollment continued and plateaued at a level higher than before the recession. As of October 2019, New York State Medicaid covered nearly 6.0 million individuals, or roughly one-third of the state’s residents—about 2 million more than Medicaid covered in December 2007.¹¹ Some of these gains can be attributed to implementation of the Affordable Care Act (ACA), which streamlined pathways and rules for obtaining Medicaid coverage, encouraged individuals to enroll through enhanced outreach and the individual mandate, and expanded Medicaid eligibility to new categories of adults. Other policies that originated during the Great Recession, prior to the ACA, also laid the groundwork for this growth.

FIGURE 1. NEW YORK STATE UNEMPLOYMENT, MEDICAID ENROLLMENT, AND KEY EVENTS: JANUARY 2007 TO OCTOBER 2019 (ZOOM DETAIL: 2007 TO 2012)



* Beginning and ending months of the 2007-09 recession as defined by the National Bureau of Economic Research.

Sources: New York State Department of Health. Medicaid Enrollees and Expenditures by County: Monthly Medicaid Eligibility Reports (2007-08)

New York State Department of Health. Medicaid Program Enrollment by Month: Beginning 2009 (2009-19)

U.S. Bureau of Labor Statistics. Local Area Unemployment Statistics. (2007-2019)

Policy Changes Supporting Access to Medicaid During the Great Recession

Federal and state policies contributed to New York's Medicaid growth during and after the 2007–2009 recession by preserving and expanding access to the program. Under ARRA, the federal government provided fiscal relief to states as they faced increasing demand for Medicaid coverage and decreasing revenues. ARRA increased federal Medicaid matching funds delivered through the Federal Medical Assistance Percentage (FMAP) by 6.2 percentage points for every state.^{12,13} ARRA also encouraged states to maintain or expand Medicaid eligibility: to receive the enhanced FMAP, states had to maintain the Medicaid eligibility standards, methodologies, and procedures in place as of July 2008. ARRA also created new state options to extend and modify eligibility for Transitional Medical Assistance (TMA), which extended Medicaid coverage for families with dependent children who would have otherwise lost coverage due to employment-related income increases.¹⁴ Accordingly, effective in July 2009, New York extended TMA coverage from 6 to 12 months for families with dependent children under age 21.¹⁵ Finally, ARRA increased weekly UI payments by \$25 and excluded this increase from Medicaid and CHIP income eligibility determinations.¹⁶

Beyond implementing these federal provisions, New York took several other steps to expand Medicaid eligibility and facilitate enrollment during the Great Recession.¹⁷ Most notably, New York increased the asset limit for parents

and childless adults in 2008 and eliminated its asset test altogether for children and non-disabled adults in 2010.^{18,19} Other key changes eliminated drug and alcohol screening for certain adults, finger-imaging requirements, and face-to-face interviews at initial application and renewal.^{20,21,22} These changes helped more New Yorkers access Medicaid and were preserved even when the economic environment improved, contributing to the new plateau of higher enrollment.

These steps complemented ACA provisions that fostered further Medicaid enrollment growth, such as streamlined Medicaid income rules, New York's Medicaid expansion to a new group of childless adults, and implementation of the New York State of Health (NYSOH) marketplace and related consumer outreach and assistance.²³ In particular, the NYSOH marketplace greatly facilitated Medicaid enrollment by creating an online “one-stop shop” for New Yorkers to apply for Medicaid, Child Health Plus, the Essential Plan, and qualified health plans with affordability subsidies. Other policies coinciding with ACA implementation, such as New York's shift to 12-month continuous eligibility for adults in January 2014, also stabilized and increased enrollment.²⁴

Somewhat offsetting these sources of growth were shifts of certain subpopulations of lawfully present immigrants and higher-income parents from Medicaid to the new Essential Plan between 2014 and 2016.

State and Federal Medicaid Responses to the Novel Coronavirus

In the first quarter of 2020, the novel coronavirus (COVID-19) began to spread across the United States, threatening the country's health and economic stability. As in the Great Recession, the federal government provided states with fiscal relief that also protected access to Medicaid coverage. Like ARRA, the Families First Coronavirus Response Act (FFCRA, enacted on March 18, 2020) included a 6.2 percentage point increase in each state's FMAP and required states to maintain the Medicaid eligibility standards, methodologies, and procedures in place as of January 1, 2020 in order to receive the increase. Moreover, the Coronavirus Aid, Relief, and Economic Security (CARES) Act, passed on March 27, 2020, increased weekly UI payments by \$600 per person and required states to disregard that increase when determining Medicaid income eligibility—mirroring the UI disregard in ARRA.²⁵

Unlike ARRA, these provisions reflect the daunting challenges of facilitating Medicaid enrollment during a major public health crisis. FFCRA's enhanced FMAP is available during the national emergency period declared by the U.S. Secretary of Health and Human Services.²⁶ States that receive the enhanced FMAP cannot disenroll anyone who was enrolled in Medicaid as of March 18, 2020, or who enrolls during the emergency period. Consistent with this continuous coverage requirement, New York is systematically extending all Medicaid enrollments on a rolling basis for additional 12-month periods during the emergency period.²⁷ To receive the enhanced FMAP, states are also prohibited from imposing new or increased premiums on Medicaid enrollees and cannot require

any Medicaid cost-sharing on testing or treatment related to COVID-19.²⁸ In addition, the FFCRA gives state Medicaid programs the option to cover COVID-19 testing services for uninsured individuals without regard to their income or assets, with 100 percent federal matching funds available for these services during the emergency period.²⁹

As these new federal measures protected and expanded access to Medicaid coverage, New York also leveraged existing authorities to facilitate Medicaid enrollment. The president's national emergency declaration on March 13, 2020, allowed states to submit section 1135 waivers and other requests to quickly amend a range of Medicaid policies, including provisions related to eligibility and enrollment.³⁰ New York's approved 1135 waiver removed certain Medicaid eligibility rules that required applying for other benefits, such as Medicare and Social Security, and documenting third-party health insurance. The waiver also expanded hospital presumptive eligibility (described in more detail below) to include individuals over age 65 or with a disability.^{31,32} These provisions facilitate swifter Medicaid enrollment, which is critical when many New Yorkers need health coverage for immediate access to care during the pandemic.

New York has taken several other administrative actions to streamline and expedite access to Medicaid. For example, Medicaid applicants can self-attest about their eligibility criteria, except for immigration/identity status, when applying for new coverage, increased coverage, and redeterminations.³³ Similarly,

if an application is missing any required information, the applicant can provide that information verbally (i.e., by phone) to enrollment staff. Both provisions expedite application processing and accommodate applicants' potentially limited access to documentation during the COVID-19 crisis. Finally, to further extend its safety net, New York expanded its Emergency Medicaid program for undocumented immigrants to cover COVID-19 lab testing, evaluation, and treatment as Medicaid-reimbursable emergency services.³⁴

Beyond these provisions, New York has taken other steps that indirectly support access to Medicaid. One key example is that the NYSOH marketplace opened a special enrollment period from March 16, 2020, until June 15, 2020 (as of this writing), for individuals to enroll in qualified health plans through the marketplace. This may help connect individuals to Medicaid who are unaware of their eligibility and who initially seek out other coverage via NYSOH.³⁵

Implications for New York Medicaid and Additional Strategies

New York is facing an economic downturn that may rival the Great Depression, and sustained growth in Medicaid enrollment is likely imminent. With this severe recession at hand and with the New York City metropolitan area at the epicenter of the nation's COVID-19 pandemic, the need for Medicaid coverage will likely exceed what New York experienced during the last recession. Recent estimates predict that several months of high unemployment could increase New York's Medicaid enrollment by at least several hundred thousand individuals, with specific growth depending on the magnitude of unemployment and other assumptions.³⁶ The New York State Department of Health reported a net gain of about 136,000 Medicaid enrollees between February and April 2020, indicating that such growth may be well underway.³⁷ These early data suggest that, as the pandemic accelerated, Medicaid's average monthly growth rate was four times as large as the average monthly growth rate during the Great Recession's first twelve months.

If New York follows the pattern observed during the Great Recession, the largest growth in Medicaid enrollment could follow the steepest increases in unemployment by two or more quarters, as unemployed individuals exhaust various sources of temporary coverage and as their monthly incomes fall into the Medicaid range. Further, this growth may not subside for months, if not years, after the economy begins recovering. Nevertheless, certain factors may accelerate Medicaid enrollment growth compared to the previous recession. First, enrolling in Medicaid is now substantially faster and easier due to the NYSOH marketplace, which provides 24/7 access to online Medicaid applications, integrated processing for families, multiple sources of enrollment assistance, and rapid eligibility determinations.³⁸ As noted above, NYSOH also helps connect individuals to Medicaid who might be unaware of their eligibility and who initially seek out other forms of coverage on the marketplace. Second, the pandemic itself may hasten Medicaid enrollment, as some individuals losing

employer-sponsored coverage more actively seek new coverage for COVID-19 testing and treatment and related health services, even without an individual mandate requiring health insurance.³⁹

Additional factors may offset rapid growth and contribute to lagging Medicaid enrollment. For example, in the months preceding the COVID-19 crisis, more Medicaid-eligible New Yorkers were likely to be actively enrolled in Medicaid compared to 2007. Thirty-one percent of New York State residents were enrolled in Medicaid as of October 2019, compared to 21% enrolled in December 2007. However, both periods had similar portions of the population with incomes approximately low enough to qualify for Medicaid.⁴⁰ This difference reflects the policy changes that have facilitated Medicaid enrollment since 2007, such as streamlined eligibility rules, the creation of the NYSOH marketplace, and other ACA provisions. If job losses in 2020 are initially more concentrated among low-income New Yorkers, then Medicaid enrollment may grow somewhat more modestly at first, given that many of these individuals may already be enrolled in the program. However, more widespread unemployment that disrupts higher-income individuals' existing health coverage and depresses their incomes below Medicaid thresholds could drive larger delayed increases in Medicaid enrollment—for instance, in households where COBRA premiums become unaffordable and where monthly incomes fall below the ranges for enrollment into subsidized qualified health plans, Child Health Plus, or the Essential Plan.

Regardless of how quickly enrollment grows, streamlining and expediting access to Medicaid coverage will be critical in the current health crisis. Many people will lose health coverage when they lose their

jobs—and many of those same people face the risk of contracting COVID-19 and needing immediate medical attention. New York and the federal government have already taken several important steps to facilitate Medicaid enrollment by building on earlier efforts from the Great Recession and ACA implementation. Looking ahead, several other Medicaid features and strategies could be critical for supporting individuals seeking coverage during the COVID-19 emergency:

Leveraging Presumptive Eligibility

Presumptive eligibility (PE) allows certain “qualified entities,” such as hospitals, clinics, and local health departments, to grant temporary Medicaid coverage to income-screened children, pregnant women, and breast and cervical cancer patients while their full applications are being processed.⁴¹ The ACA expanded PE by authorizing hospitals to determine PE for all Medicaid populations, with federal guidance requiring hospital presumptive eligibility for at least non-disabled children and adults. During the COVID-19 emergency, New York’s 1135 waiver expanded hospital PE to include adults over age 65 and individuals with disabilities, as noted above. During the current crisis, New York might consider ways of further leveraging presumptive eligibility to facilitate access to Medicaid, such as expanding the number and types of PE “qualified entities” to include locations like schools, WIC agencies, and other health and social care providers.⁴² New York might also consider seeking additional waiver authority to allow all qualified entities to determine PE for groups such as non-disabled, non-elderly adults. Finally, New York could review the extent to which hospitals are exercising their PE authority and encourage broader efforts if needed.

Raising Awareness of Retroactive Eligibility

Medicaid’s provision for retroactive eligibility covers unpaid medical bills up to three months prior to an enrollee’s application month if the enrollee would have been eligible for Medicaid during those months. Informing potential enrollees about this program feature may be particularly valuable to people whose loss of previous health coverage coincides with unexpected illness during the COVID-19 emergency and who might otherwise face greater risk of medical debt and personal bankruptcy if they are unaware of their Medicaid eligibility.⁴³

Maintaining Streamlined Medicaid Eligibility and Enrollment

Over the last decade, New York expanded eligibility standards and facilitated enrollment processes to improve New Yorkers’ access to Medicaid coverage. Although the State’s section 1135 waiver and other actions further this objective during the COVID-19 emergency, New York might consider whether to maintain and supplement these policies during an extended economic downturn. Some lessons may be drawn from New York’s experiences with Disaster Relief Medicaid (DRM) after September 11, 2001, which involved similarly simplified applications and minimal documentation requirements. DRM evaluations indicated that enrollees were sometimes concerned about maintaining coverage after the four-month DRM period expired, because the transition to “regular” Medicaid involved a more complex application process.⁴⁴ To prevent gaps in coverage, the State granted DRM enrollees several additional months of transitional coverage during which they could complete the regular Medicaid application process. During the transitional period, New York

City officials and consumer advocates also conducted outreach about the steps needed to retain Medicaid coverage.⁴⁵ If the current public health crisis is followed by a long-term economic downturn, similar strategies for preventing lapses in coverage may help smooth the transition back to regular enrollment and renewal processes.

Supporting Appropriate Fiscal Relief for Medicaid

ARRA’s enhanced FMAP provided fiscal relief for state Medicaid programs during the Great Recession. However, when the enhanced FMAP expired, many states continued to struggle with high unemployment, depressed revenues, and persistently high rates of Medicaid enrollment. Similarly, states may continue to face these same challenges—as well as potentially higher Medicaid costs due to long-term health effects on people who have recovered from COVID-19—when the current emergency period ends and the FFCRA’s enhanced FMAP expires. As the National Governors Association and other nonpartisan organizations have observed, additional federal actions may be needed to help states offset the costs of recession-driven increases in Medicaid enrollment and COVID-19’s unknown effects on future demand for Medicaid services—particularly among older adults and individuals with disabilities who are more susceptible to the disease and whose care is generally more costly to Medicaid.⁴⁶

Monitoring and Mitigating Disparities in Access to Coverage

Although New York has taken steps to broadly facilitate access to health coverage during the COVID-19 crisis—such as implementing the Medicaid provisions and special NYSOH enrollment period described above—the State should continue assessing

whether any racial/ethnic subgroups or other populations are experiencing disparities in access to coverage. For example, immigrant communities may be reluctant to seek coverage due to the federal “public charge” rule, which was implemented on February 24, 2020.⁴⁷ Although U.S. Citizenship and Immigration Services announced that any COVID-19 testing or treatment will not negatively affect immigrants as part of a future public charge review, New York might consider whether further outreach is necessary to help immigrants understand how accessing Medicaid or other public programs during the current crisis could affect their future immigration status.⁴⁸

Learning from Other States’ Innovations

As the entire nation combats COVID-19, New York might draw lessons from other states’ developing responses to expand access to Medicaid coverage. For example, Illinois requested an 1115 waiver allowing Medicaid

to cover cost-sharing as a secondary payer for insured individuals receiving COVID-19 treatment. Eligibility would be based on the need for COVID-19 treatment alone, regardless of income level or other existing Medicaid eligibility requirements, with the intent of dissuading anyone from forgoing COVID-19 treatment due to cost.⁴⁹ Sharing best practices and learning from other states’ innovative approaches to Medicaid enrollment could be beneficial to augmenting New York’s response to COVID-19.

While the long-term impacts of COVID-19 on the economy and public health are unknown, Medicaid will remain a vital source of health coverage in the coming months, particularly for those New Yorkers facing challenges to their health and livelihoods worse than those of the Great Recession. Sustaining and building upon New York’s progress in improving access to Medicaid will be crucial for serving those in need during these uncertain times.

If you or your family are seeking affordable health coverage through Medicaid or other sources:

In April 2020, United Hospital Fund released a free consumer guide with practical advice about obtaining or maintaining health coverage during the current crisis. The guide, *Grim Times and Health Insurance: Maintaining Coverage During the Pandemic*, provides more details about Medicaid eligibility rules and enrollment processes. The guide also includes a comprehensive overview of affordable coverage options for higher-income individuals, many of which did not exist during the previous recession—such as the Essential Plan and qualified health plans available through the New York State of Health marketplace. Finally, the guide provides answers to common consumer questions and links to additional resources.

The guide may be downloaded from UHF’s website, <https://uhfnyc.org/>. It is available in English, Spanish, Simplified Chinese, Russian, Bengali, and Creole.

Endnotes

- 1 International Monetary Fund. April 14, 2020. *The Great Lockdown*. <https://www.imf.org/en/Publications/WEO/Issues/2020/04/14/weo-april-2020>.
- 2 Rugaber C and Kirka D. May 21, 2020. Nearly 39 million have lost jobs in US since virus took hold. *Associated Press*. <https://apnews.com/900aa1955a82b7bbe2e028a8bc1a4be7>.
- 3 National Bureau of Economic Research. September 20, 2010. *US Business Cycle Expansions and Contractions*. <https://www.nber.org/cycles.html>.

Note: The National Bureau of Economic Research (NBER) defines a recession as “a significant decline in economic activity spread across the economy, lasting more than a few months, normally visible in real GDP, real income, employment, industrial production, and wholesale-retail sales.”

- 4 U.S. Bureau of Labor Statistics. *Local Area Unemployment Statistics*. <https://www.bls.gov/lau/rdscnp16.htm>.

Note: the unemployment rates reported throughout this brief are based on monthly, seasonally adjusted estimates of New York State unemployment rates drawn from the Bureau of Labor Statistics (BLS) Local Area Unemployment Statistics (LAUS) program. The LAUS estimates labor force participation among the state’s civilian noninstitutional population ages 16 and older, primarily based upon employment measures within the Current Population Survey’s monthly survey of households. LAUS estimates of the unemployment rate may differ from other measures of employment in various ways. For instance, the LAUS excludes from the “unemployed” category individuals reporting that they are not actively looking for work (i.e., individuals outside of the labor force). Conversely, the LAUS captures reported unemployment regardless of whether individuals’ current or previous employment was covered by federal-state unemployment insurance.

- 5 Medicaid enrollment data are derived from:
 - New York State Department of Health. *Medicaid Enrollees and Expenditures by County: Monthly Medicaid Eligibility Reports (2007-2008)* https://www.health.ny.gov/statistics/health_care/medicaid/eligible_expenditures/.
 - New York State Department of Health. *Medicaid Program Enrollment by Month: Beginning 2009 (2009-2019)* <https://health.data.ny.gov/Health/Medicaid-Program-Enrollment-by-Month-Beginning-200/m4hz-kzn3/data>.

Note: the Medicaid enrollment data include adults enrolled in Family Health Plus (FHP) for all months when FHP was operational.

- 6 For both unemployment and Medicaid enrollment, the “fastest average increases” were determined by identifying, respectively, the midpoint month of the three-month periods with the highest average growth between 2007 and 2012. Calculated by UHF from the following sources:
 - New York State Department of Health. *Medicaid Enrollees and Expenditures by County: Monthly Medicaid Eligibility Reports (2007-2008)* https://www.health.ny.gov/statistics/health_care/medicaid/eligible_expenditures/.
 - New York State Department of Health. April 2014. *Medicaid Program Enrollment by Month: Beginning 2009 (2009-2019)* <https://health.data.ny.gov/Health/Medicaid-Program-Enrollment-by-Month-Beginning-200/m4hz-kzn3/data>.
 - U.S. Bureau of Labor Statistics. March 20, 2020. *Local Area Unemployment Statistics*. <https://www.bls.gov/lau/rdscnp16.htm>.

- 7 Under ARRA, COBRA premium subsidies were available for up to 15 months for individuals who were involuntarily terminated from employment between September 1, 2008, and May 31, 2010.
- See: Congressional Research Service. June 3, 2010. *Health Insurance Premium Assistance for the Unemployed: The American Recovery and Reinvestment Act of 2009*. https://www.everycrsreport.com/files/20100603_R40420_857b2cc603d50b43aef5f949524b3dfd28108ffd.pdf.
- 8 Certain individuals who were ineligible for Medicaid may have received short-term health coverage through other narrowly targeted public programs, such as health coverage tax credits available to individuals eligible for Trade Adjustment Assistance.
- See: Congressional Research Service. April 2, 2015. *Health Coverage Tax Credit*. https://www.everycrsreport.com/files/20150402_RL32620_76aa54f013c4a1b3a256b7f13570097a62e99503.pdf.
- 9 Rothstein J and Velletta RG. National Bureau of Economic Research. June 2017. *Scraping By: Income and Program Participation After the Loss of Extended Unemployment Benefits*. <https://www.nber.org/papers/w23528.pdf>.
- 10 Lin E. October 2005. Health Insurance Coverage and Reemployment Outcomes Among Older Displaced Workers. *Contemporary Economic Policy*. 23(4), pp.529-544. <https://doi.org/10.1093/cep/byi039>.
- 11 Calculated by UHF from the following sources:
- New York State Department of Health. *Medicaid Program Enrollment by Month: Beginning 2009* (October 2019 data). <https://health.data.ny.gov/Health/Medicaid-Program-Enrollment-by-Month-Beginning-200/m4hz-kzn3/data>.
 - New York State Department of Health. *Medicaid Enrollees and Expenditures by County* (December 2007 data). https://www.health.ny.gov/statistics/health_care/medicaid/eligible_expenditures/.
 - U.S. Census Bureau. *Intercensal Estimates of the Resident Population for the United States, Regions, States, and Puerto Rico: April 1, 2000 to July 1, 2010* (average of July 1, 2007 and July 1, 2008 estimates). <https://www.census.gov/data/tables/time-series/demo/popest/intercensal-2000-2010-state.html>.
 - U.S. Census Bureau. *Annual Estimates of the Resident Population for the United States, Regions, States, and Puerto Rico*. (July 1, 2019 estimate). <https://www.census.gov/data/tables/time-series/demo/popest/2010s-state-total.html>.
- 12 The federal government's share of Medicaid costs is known as the Federal Medical Assistance Percentage (FMAP), which is computed based on the state's average per capita income relative to the national average. New York's FMAP is 50 percent for most populations and services, which is the lowest the FMAP can be.
- See: Kaiser Family Foundation. May 2020. *Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier*. <http://kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/>.
- 13 Through ARRA, states received an additional multiplier to their FMAP based on the state's unemployment rate, providing greater support to states with larger increases to their unemployment rates.
- See: Congressional Research Service. March 17, 2009. *American Recovery and Reinvestment Act of 2009 (ARRA, P.L. 111-5): Title V, Medicaid Provisions*. <https://fas.org/sgp/crs/misc/R40223.pdf>.
- 14 Congressional Research Service. March 17, 2009. *American Recovery and Reinvestment Act of 2009 (ARRA, P.L. 111-5): Title V, Medicaid Provisions*. <https://fas.org/sgp/crs/misc/R40223.pdf>.

- 15 New York State Department of Health. July 1, 2009. *General Information System Message: Transitional Medical Assistance*. https://www.health.ny.gov/health_care/medicaid/publications/docs/gis/09ma023.pdf.
- 16 Because Medicaid eligibility is determined by household income, which normally includes the value of unemployment insurance (UI) benefits, slight increases in income can push enrollees above the income eligibility threshold. This ARRA provision protected enrollees against losing coverage due to these additional UI payments.
- See: Ross DC and Parrott S. Center on Budget and Policy Priorities. March 20, 2009. *Medicaid and CHIP Eligibility Is Protected for Jobless Families That Receive Boost in Unemployment Benefits*. <https://www.cbpp.org/research/medicaid-and-chip-eligibility-is-protected-for-jobless-families-that-receive-boost-in>.
- 17 For a contemporaneous overview, see: New York State Department of Health. July 2009. *Transforming New York's Public Health Insurance Programs: 2007-2009 Health Care Transformation Report*. https://www.health.ny.gov/health_care/docs/2007-2009_health_care_transformation_report.pdf
- 18 New York State Department of Health. May 22, 2008. *General Information System Message: Increase in Medicaid Eligibility Resource Standards; Elimination of Drug/Alcohol Requirement for Medicaid*. https://www.health.ny.gov/health_care/medicaid/publications/docs/gis/08ma013.pdf.
- 19 New York State Department of Health. November 20, 2009. *General Information System Message: Elimination of the Resource Test for Non-SSI-Related Medicaid Applicants/Recipients*. https://www.health.ny.gov/health_care/medicaid/publications/docs/gis/09ma027.pdf.
- 20 New York State Department of Health. May 22, 2008. *General Information System Message: Increase in Medicaid Eligibility Resource Standards; Elimination of Drug/Alcohol Requirement for Medicaid*. https://www.health.ny.gov/health_care/medicaid/publications/docs/gis/08ma013.pdf.
- 21 New York State Department of Health. July 1, 2009. *General Information System Message: Elimination of Automated Finger Imaging System (AFIS) Requirement for Medicaid Eligibility*. https://www.health.ny.gov/health_care/medicaid/publications/docs/gis/09ma021.pdf.
- 22 New York State Department of Health. April 2, 2010. *Administrative Directive: Elimination of the Personal Interview Requirement for Medicaid and Family Health Plus Applicants*. https://www.health.ny.gov/health_care/medicaid/publications/docs/adm/10adm-4.pdf.
- 23 Other ACA provisions directly or indirectly fostered Medicaid enrollment growth. For instance, in November 2011, New York began shifting children age 6–18 with family incomes between 100% and 138% FPL from CHIP to Medicaid upon renewal, pursuant to an ACA provision simplifying children's coverage. Over time, this effectively increased Medicaid enrollment by more than 100,000 children.
- See: Mathematica Policy Research. November 28, 2016. *The Impact of Transitioning Stairstep Children from Separate CHIP to Medicaid on Use of Health Services: Evidence from Colorado and New York*. <https://www.mathematica.org/our-publications-and-findings/publications/the-impact-of-transitioning-stairstep-children-from-separate-chip-to-medicaid-on-use-of-health>.

- 24 New York also implemented “12-month continuous eligibility” for non-disabled, non-elderly adults in January 2014, under the State’s 1115 waiver (building on an existing policy of 12-month continuous eligibility for children). This new policy was intended to reduce the frequency of adults’ Medicaid renewals and effectively extended coverage following a change in income that would otherwise cause loss of eligibility, thereby reducing “churn” and stabilizing Medicaid enrollment.

See: State Health Access Data Assistance Center, University of Minnesota. September 2014. *ACA Coverage Expansions: Measuring and Monitoring Churn at the State Level*. https://www.shadac.org/sites/default/files/publications/ACADDataAnalytics_Paper_%234_Measuring_and_Monitoring_Churn_for_web.pdf.

- 25 As noted above, Medicaid normally considers the value of UI benefits when calculating income for program eligibility. The CARES Act specifically states that any Pandemic Unemployment Compensation should be excluded from applicants’ income when calculating Medicaid eligibility. This provision protects Medicaid applicants from losing eligibility if these additional payments push them above Medicaid’s income eligibility threshold.

See: Centers for Medicare & Medicaid Services. April 13, 2020. *Families First Coronavirus Response Act (FFCRA), Public Law No. 116-127 Coronavirus Aid, Relief, and Economic Security (CARES) Act, Public Law No. 116-136 Frequently Asked Questions (FAQs)*. <https://www.medicaid.gov/state-resource-center/downloads/covid-19-section-6008-CARES-faqs.pdf>.

- 26 The “emergency period” refers to the period of the public health emergency first declared by the U.S. Secretary of Health and Human Services on January 27, 2020 pursuant to section 1135(g)(1)(B) of the Social Security Act.

See: Centers for Medicare & Medicaid Services. April 13, 2020. *Law No. 116-127 Coronavirus Aid, Relief, and Economic Security (CARES) Act, Public Law No. 116-136 Frequently Asked Questions (FAQs)*. <https://www.medicaid.gov/state-resource-center/downloads/covid-19-section-6008-CARES-faqs.pdf>.

- 27 This is consistent with language that New York included in its section 1135 waiver.

See: New York State Department of Health. March 23, 2020. *New York State: Medicaid 1135 Waiver Request*. https://coronavirus.health.ny.gov/system/files/documents/2020/03/1135_waiver_request.pdf.

- 28 In order to receive the FFCRA’s enhanced FMAP, states are also not permitted to increase the share of Medicaid costs paid by local governments beyond any arrangements that were in effect as of March 11, 2020.

- 29 Kaiser Family Foundation. May 2020. *Key Questions About the New Medicaid Eligibility Pathway for Uninsured Coronavirus Testing*. <https://www.kff.org/coronavirus-covid-19/issue-brief/key-questions-about-the-new-medicaid-eligibility-pathway-for-uninsured-coronavirus-testing/>

- 30 States could submit emergency section 1135, section 1115, and section 1915 Appendix K Medicaid waivers to the federal Centers for Medicare & Medicaid Services (CMS). CMS issued a blanket section 1135 waiver and a template for states to make additional requests.

See: National Academy for State Health Policy. March 24, 2020. *States Use Federal Waivers to Expand Health Care Resources to Confront COVID-19*. <https://nashp.org/states-use-federal-waivers-to-expand-health-care-resources-to-confront-covid-19/>.

- 31 “Presumptive eligibility” allows state-designated qualified entities, such as hospitals, federally qualified health centers, government agencies, and schools, to provide temporary Medicaid coverage to individuals who likely qualify for Medicaid even if the individual is not currently enrolled in Medicaid. Prior to the ACA, presumptive eligibility could only be provided to pregnant women, children, and breast or cervical cancer patients. The ACA extended presumptive eligibility in several ways, including by allowing hospitals to grant temporary Medicaid coverage to all Medicaid populations regardless of whether states

had established presumptive eligibility programs. At a minimum, states must implement hospital presumptive eligibility for most non-disabled children and adults, and states have the option of allowing hospitals to determine presumptive eligibility for adults over age 65 and individuals with disabilities. See:

- Centers for Medicare & Medicaid Services. January 2014. *Medicaid and CHIP FAQs: Implementing Hospital Presumptive Eligibility Programs*. <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>.
- Centers for Disease Control and Prevention, Office for State, Tribal, Local, and Territorial Support, Public Health Law Program. August 2014. *Hospital Presumptive Eligibility*. <https://www.cdc.gov/php/docs/hospitalpe-brief.pdf>.

32 New York State Department of Health. March 23, 2020. *New York State: Medicaid 1135 Waiver Request*. https://coronavirus.health.ny.gov/system/files/documents/2020/03/1135_waiver_request.pdf.

33 If citizenship cannot be verified though the Social Security Administration or immigration/identity status documentation needed for the application, coverage will be granted if the applicant is otherwise eligible. The applicant will be granted a 90-day period to provide supporting documentation.

See: New York State Department of Health. April 2, 2020. *General Information System Message: Coronavirus (COVID-19) –Medicaid Eligibility Processes During Emergency Period*. https://www.health.ny.gov/health_care/medicaid/publications/docs/gis/20ma04.pdf.

34 New York State Department of Health. March 2020. *New York State Medicaid Coverage and Reimbursement Policy for Services Related to Coronavirus Disease 2019 (COVID-19)*. https://www.health.ny.gov/health_care/medicaid/program/update/2020/docs/mu_no07_2020-03-27_covid-19_reimbursement.pdf.

35 For information on this special enrollment period, see:

- New York State Department of Health. March 16, 2020. *NY State of Health and New York State Department of Financial Services Announce Special Enrollment Period for Uninsured New Yorkers, as Novel Coronavirus Cases Climb*. https://www.health.ny.gov/press/releases/2020/2020-03-16_nysoh_special_enrollment_period.htm.
- Governor Andrew M. Cuomo. May 4, 2020. *Amid Ongoing COVID-19 Pandemic, Governor Cuomo Outlines Additional Guidelines for When Regions Can Re-Open*. <https://www.governor.ny.gov/news/amid-ongoing-covid-19-pandemic-governor-cuomo-outlines-additional-guidelines-when-regions-can>.

36 In the second quarter of 2020, Health Management Associates (HMA) and Urban Institute released state-level estimates of COVID-19-related Medicaid enrollment growth under various scenarios where unemployment ranged from 10% to 25% among states' working populations. Urban Institute excluded individuals over age 65 because most are eligible for Medicare, and both estimates included Medicaid and CHIP in the same projections. Accordingly, these estimates were not precise projections of total enrollment growth in Medicaid alone.

Kaiser Family Foundation (KFF) also released state-level projections of individuals gaining Medicaid and CHIP eligibility due to unemployment and loss of employer-sponsored insurance during the COVID-19 pandemic. Notably, KFF estimated changes in Medicaid/CHIP eligibility, not enrollment, so its projections are not directly comparable to HMA's and Urban Institute's estimates. For more information about these estimates' specific projections, methods, and assumptions, see:

- Health Management Associates. April 2020. *COVID-19 Impact on Medicaid, Marketplace, and the Uninsured, by State*. <https://www.healthmanagement.com/blog/hma-model-provides-forecast-of-covid-19-impact-on-medicaid-marketplace-uninsured/>.

- Garrett B and Gangopadhyaya A. May 2020. *How the COVID-19 Recession Could Affect Health Insurance Coverage*. Washington, DC: Urban Institute. <https://www.urban.org/research/publication/how-covid-19-recession-could-affect-health-insurance-coverage>.
 - Garfield R, Claxton G, Damico A, Levitt L. May 2020. Kaiser Family Foundation. *Eligibility for ACA Health Coverage Following Job Loss*. <https://www.kff.org/coronavirus-covid-19/issue-brief/eligibility-for-aca-health-coverage-following-job-loss/>.
- 37 Young S. June 2, 2020. Medicaid Enrollment Increased During First 2 Months of Outbreak, DOH Reports. *Politico*.
- 38 State Health Access Data Assistance Center, University of Minnesota. October 2018. *Medicaid Eligibility, Enrollment, and Renewal Processes and Systems Study: Case Study Summary Report – New York*. <https://www.macpac.gov/wp-content/uploads/2018/11/New-York-Summary-Report.pdf>.
- 39 The federal Tax Cuts and Jobs Act of 2017 repealed the tax penalty associated with the Affordable Care Act’s individual mandate, effective January 1, 2019. Although this policy change was generally expected to reduce health insurance enrollment, some New Yorkers might be incentivized to seek or maintain health coverage as a safeguard against COVID-19 treatment costs, potentially increasing enrollment in Medicaid and other forms of coverage.
- For further discussion of the effects of eliminating the individual mandate penalty, see: Eibner C and Novak S. July 2018. *The Effect of Eliminating the Individual Mandate Penalty and the Role of Behavioral Factors*. New York, NY: The Commonwealth Fund. <https://www.commonwealthfund.org/publications/fund-reports/2018/jul/eliminating-individual-mandate-penalty-behavioral-factors>.
- 40 An estimated 32 percent of New Yorkers had household incomes below 200 percent of the FPL in 2007, while an estimated 29 percent had household incomes below 200 percent of the FPL in 2018, the most recent estimate. All figures calculated by UHF from the following sources:
- New York State Department of Health. *Medicaid Enrollees and Expenditures by County* (December 2007 data). https://www.health.ny.gov/statistics/health_care/medicaid/eligible_expenditures/.
 - New York State Department of Health. *Medicaid Program Enrollment by Month: Beginning 2009* (October 2019 data). <https://health.data.ny.gov/Health/Medicaid-Program-Enrollment-by-Month-Beginning-2009/m4hz-kzn3/data>.
 - U.S. Census Bureau. *Intercensal Estimates of the Resident Population for the United States, Regions, States, and Puerto Rico: April 1, 2000 to July 1, 2010* (average of July 1, 2007 and July 1, 2008 estimates). <https://www.census.gov/data/tables/time-series/demo/popest/intercensal-2000-2010-state.html>.
 - U.S. Census Bureau. *Annual Estimates of the Resident Population for the United States, Regions, States, and Puerto Rico*. (July 1, 2019 estimate). <https://www.census.gov/data/tables/time-series/demo/popest/2010s-state-total.html>.
 - U.S. Census Bureau. *Current Population Survey: Poverty Status by State* (2007 and 2018 data). <https://www.census.gov/data/tables/time-series/demo/income-poverty/cps-pov/pov-46.2007.html> and <https://www.census.gov/data/tables/time-series/demo/income-poverty/cps-pov/pov-46.2018.html>.
- 41 In New York, there are a variety of providers who are classified as “qualified entities” and can make presumptive eligibility determinations for pregnant women, children, and breast and cervical cancer patients. These include hospitals and other Article 28 facilities (e.g., clinics), comprehensive Prenatal Care Programs, Local Public Health Agencies, Certified Home Health Agencies, Public Health Nursing Services, and individually licensed physicians and certified nurse practitioners. Only hospitals are eligible to make PE determinations for all Medicaid eligibility categories.

See: New York State Department of Health. July 2019. *Guidelines for MCO Service Delivery Networks—Version 3.0*. https://www.health.ny.gov/health_care/managed_care/guidelines_for_mco_service_delivery_networks-v3.0.htm.

- 42 Wagner J. May 13, 2020. *Streamlining Medicaid Enrollment During COVID-19 Public Health Emergency*. Washington, DC: Center on Budget and Policy Priorities. <https://www.cbpp.org/research/health/streamlining-medicaid-enrollment-during-covid-19-public-health-emergency>.
- 43 Campbell AF. July 19, 2017. These 2 Medicaid provisions prevent medical debts from ruining people's lives. *Vox*. <https://www.vox.com/policy-and-politics/2017/7/19/15949250/medicaid-medical-bankruptcy>.
- 44 Kaiser Family Foundation. August 2002. *New York's Disaster Relief Medicaid: Insights and Implications for Covering Low-Income People*. <http://files.kff.org/attachment/new-yorks-disaster-relief-medicaid-insights-and-implications-for-covering-low-income-people>.
- 45 School of Industrial and Labor Relations, Cornell University. December 2005. *Disaster Relief Medicaid Evaluation Project*. https://www.health.ny.gov/health_care/medicaid/related/docs/drm_report.pdf.
- 46 National Governors Association. April 21, 2020. Governors' Letter Regarding COVID-19 Aid Request. <https://www.nga.org/policy-communications/letters-nga/governors-letter-regarding-covid-19-aid-request/>.

See also:

- National Association of Medicaid Directors. April 13, 2020. Letter to Congressional leadership. <https://medicaiddirectors.org/wp-content/uploads/2020/04/NAMD-Medicaid-Requests-for-COVID-19-Legislation.pdf>.
 - National Association of State Budget Officers. March 19, 2020. Letter to President Trump and Congressional leadership. https://higherlogicdownload.s3.amazonaws.com/NASBO/9d2d2db1-c943-4f1b-b750-0fca152d64c2/UploadedImages/Documents/NASBO_COVID-19_Letter_FINAL_3_19_20.pdf.
 - Whitener K. April 13, 2020. *States Should Accept all Federal Funding Already on Table to Fill as Many Health Coverage Gaps as Possible While Pressing for More*. Washington, DC: Georgetown Center for Children and Families. <https://ccf.georgetown.edu/2020/04/13/states-should-accept-all-federal-funding-already-on-table-to-fill-as-many-health-coverage-gaps-as-possible-while-pressing-for-more/>.
- 47 Rosenbaum S. August 2019. *The New "Public Charge" Rule Affecting Immigrants Has Major Implications for Medicaid and Entire Communities*. New York, NY: The Commonwealth Fund. <https://www.commonwealthfund.org/blog/2019/new-public-charge-rule-affecting-immigrants-has-major-implications-medicaid-and-entire>.
 - 48 U.S. Citizenship and Immigration Services. March 27, 2020. *Public Charge*. <https://www.uscis.gov/green-card/green-card-processes-and-procedures/public-charge>.
 - 49 Illinois Department of Health. March 26, 2020. *Illinois COVID-19 Section 1115(a) Demonstration Application*. <https://www.illinois.gov/hfs/SiteCollectionDocuments/03262020IllinoisCOVID19Section1115DemonstrationProposalFinal.pdf>.

See also: Weissfeld J. April 2020. *Five Innovative State Medicaid Approaches to Combat COVID-19*. Washington, DC: Families USA. <https://familiesusa.org/resources/five-innovative-state-medicaid-approaches-to-combat-covid-19/>.