

# Medicaid Responsiveness, Health Coverage, and Economic Resilience: A Preliminary Analysis

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## EXECUTIVE SUMMARY

With \$10 billion in Medicaid spending reductions under consideration by Congress, the issue of Medicaid has returned to the forefront of the nation's public policy debate. One recurring proposal to limit federal Medicaid spending would place firm caps on either Medicaid enrollment or federal Medicaid spending.

Such caps could dramatically restructure the program. Currently, individuals who meet their state program's eligibility requirements are guaranteed coverage. Accordingly, when changed economic conditions increase the number of people who qualify for Medicaid, enrollment automatically rises. This capacity to expand in response to need has prevented millions of Americans from losing coverage in recent years. From 2000 to 2004, enrollment in employer-sponsored insurance (ESI) fell from 63.6 percent to 59.8 percent of all U.S. residents. Many workers who lost ESI became uninsured, but others instead qualified for Medicaid. If Medicaid had not been allowed to grow, and enrollment was instead capped at 1999 levels, the number of uninsured in 2004 would have been 6 million higher—roughly 52 million, rather than the 46 million estimated by the Census Bureau several weeks ago.

If health insurance premiums continue to grow much faster than total earnings, the next few years are likely to see further declines in employer-sponsored coverage and an ongoing rise in the number of uninsured. That rise could be much steeper if national policymakers undercut Medicaid's capacity to expand.

Medicaid's responsiveness to changing conditions may also have important implications for the economy as a whole, not just for individuals in need. When recession hits, more households have incomes low enough to qualify for Medicaid. Because Medicaid guarantees coverage to eligible individuals, enrollment automatically rises, which increases state and federal spending. Such spending stimulates the economy, limiting further job loss and contributing to economic recovery.

Medicaid's role as an automatic fiscal stabilizer has been recognized by such authorities as the Federal Reserve Board and the Congressional Budget Office. Whether that role is major or minor in boosting the economy during recession, however, has been unclear in the past. Important parts of Medicaid spending are unaffected by the business cycle. For example, health care inflation (which affects Medicaid as well as other public and private purchasers of health coverage) has increased every year during recent decades, whether unemployment rates rose or fell.

Fortunately, these factors can be filtered out in assessments of the impact of unemployment on Medicaid costs. A careful analysis of state-level data from 1990 to 2003 shows that, controlling for such variables as health care costs, generosity of Medicaid coverage rules, likelihood of low income, and similar factors, each one percentage point increase in unemployment in 2003 would have:

- Reduced the number of ESI recipients by 2.5 million people
- Increased the number of uninsured by 1.5 million people
- Increased Medicaid enrollment by 900,000 people

To conclusively determine the resulting impact on the country's ability to recover from recession would require the use of sophisticated and complex macroeconomic models of the entire U.S. economy. Such modeling would be costly and time-consuming. Almost certainly, it could not be completed in time for Congressional consideration during the current federal budget discussion. Nevertheless, previous research permits a basic assessment of Medicaid's macroeconomic contribution. In 1999, the U.S. Department of Labor published an analysis of Unemployment Insurance (UI), using the Wharton Econometric Forecasting's Quarterly Model (WEFA Model). The report found that UI had become one of the country's most important automatic stabilizers. During the five recessions that occurred between 1969 and 1999, UI mitigated the loss in real GDP by 15 to 17 percent and saved more than 130,000 jobs in the average recession's peak year.

Medicaid's stimulus during economic downturns may be roughly comparable to the economic boost provided by UI. Data from the Bureau of Economic Analysis of the U.S. Commerce Department (BEA) show that, during the past two decades, changes in both Medicaid and UI spending have paralleled changes in the unemployment rate, with Medicaid and UI spending growth providing increased stimulus at the same order of magnitude (See Figure ES-1).

Medicaid's contributions to health coverage and the economy as a whole affect Americans of all races and ethnic backgrounds. The African American community, however, has a particularly large stake in this issue, for three reasons. First, Medicaid helps a high proportion of black Americans, including 36 percent of poor adults, 73 percent of poor children, and 44 percent of children at all economic levels (including 51 percent of all African American children under age six). Second, recessions typically cause unemployment

to reach higher levels for longer periods of time among blacks than among whites. Third, African Americans are disproportionately likely to suffer from health problems, such as hypertension, which are exacerbated by unemployment and are more likely to lead to grim results if patients lose health coverage and suffer reduced access to health care.

This analysis has several implications for national policy. First, caps or other structural changes to Medicaid that would prevent the program from automatically increasing enrollment during recession would disable what may be one of the nation's most effective tools for dampening and recovering from future recessions. More specific Medicaid policy changes-whether or not they are desirable on their own terms-would not necessarily have an economic impact of that magnitude.

Second, policymakers should seriously consider structural changes to Medicaid that would enhance the program's capacity to help workers and stimulate the economy during recession. Virtually every state is required by law to balance its budget. During recession, when Medicaid costs rise (along with spending for other needs-based assistance), state revenues drop. To balance their budgets during recession, state officials almost inevitably must reduce Medicaid eligibility, services, or provider payments. For example, in 2002-2003, 25 states cut Medicaid eligibility, and every state cut or froze reimbursement levels for Medicaid providers. Ironically, such cuts take place precisely when Medicaid is most needed to help individuals who lose their jobs and when increased spending could have the greatest potential to help the economy pull out of recession.

To resolve this state dilemma, federal matching payments could automatically increase whenever unemployment rises to specified levels. Lawmakers enacted a similar policy in May 2003 by increasing the Federal Medical Assistance Percentage (FMAP)-that is, the percentage of Medicaid costs paid by the federal government-by 2.95 percentage points for five calendar quarters, from April 2003 through June 2004. That policy prevented or reduced the scope of Medicaid cutbacks in 31 states. However, it took more than a year for Congress and the president to reach agreement, delaying much of the extra help until after the worst of the economic downturn was past. If the increase in FMAP was instead made automatic, whenever unemployment rates exceeded specific "triggers," economic stimulus could be much better timed, beginning promptly when necessary and expiring immediately when no longer needed.

For example, FMAP could automatically increase when the national unemployment rate for a calendar quarter reached or exceeded 6.0 percent; that threshold is one percentage point above the 5.0 percent unemployment rate that the Office of Management and Budget now forecasts as the long-term "equilibrium" level. To compensate states for the increased costs expected to result from elevated unemployment, our analysis and that of other researchers suggest that FMAP would need to increase between 1.67 and 3.49 percentage points for each percentage point by which unemployment exceeds the "baseline" rate of 5.0 percent.

That approach would limit FMAP increases to periods of major national economic difficulty. For example, in the most recent economic downturn, such a policy would have increased FMAP only during the second and third quarters of 2003, and the size of the FMAP boost would have been between 1.89 and 3.94 percentage points. While the 2.95 percentage point increase adopted by national policymakers falls squarely in the middle of this suggested range, the automatic increase in FMAP would have been briefer than the actual increase legislated by Congress. If policymakers preferred automatic increases to be more frequent, the "trigger" for enhanced FMAP could be set below 6.0 percent unemployment.

Of course, a specific state's economy can suffer serious harm even when the nation as a whole is prospering. Accordingly, policymakers could supplement a national FMAP enhancement with state-specific increases that would be triggered by state unemployment rates significantly higher than the state's long-term average.

Put simply, national policy changes that prevent Medicaid from expanding during economic downturns could both deny essential health coverage to low-income, laid-off workers and make future recessions deeper and more prolonged. On the other hand, national reforms that enhance FMAP based on objectively measured changes in the unemployment rate, rather than on the decisions of elected officials, could strengthen Medicaid's ability to help workers and boost the economy precisely when such help is most needed

## INTRODUCTION

Medicaid has returned to a prominent place on the nation's policy agenda. On April 28, 2005, Congress adopted a Budget Resolution for Fiscal Year (FY) 2006 that called for Medicaid spending to be reduced by \$10 billion over the next five years. Budget Reconciliation legislation to achieve those reductions was originally slated for Congressional action during the first half of September, but it has now been (at a minimum) postponed by Hurricane Katrina. While it is currently unclear whether such legislation will move back on this year's Congressional calendar, Medicaid has also become the focus of longer-term restructuring efforts. The Medicaid Commission appointed by Secretary Michael Leavitt of the Department of Health and Human Services plans to issue recommendations for long-term change by December 2006. Not waiting for that Commission to report, both the National Governors Association<sup>1</sup> and the National Academy for State Health Policy<sup>2</sup> have issued comprehensive proposals for major modifications to the Medicaid program.

This paper focuses on one type of Medicaid proposal that has been put forward repeatedly since the 1980s—namely, the application of binding caps. Such proposals involve either enrollment limits or spending caps. As applied to a particular state, enrollment limits would prevent the number of *people* who receive Medicaid from rising above a specific number, and spending caps would limit federal Medicaid *dollars* to a particular amount, regardless of the state's changing circumstances.<sup>3</sup> In various forms, such caps were proposed by President Reagan in 1981; included in Budget Reconciliation legislation passed by Congress and vetoed by President Clinton in 1995; and incorporated into President Bush's budget proposals for 2004 and 2005.<sup>4</sup>

Despite the persistence with which they have been advocated, caps have not been enacted as a matter of national policy, and the president's budget proposal for 2006 no longer includes explicit Medicaid caps. The federal government, however, has applied such caps on a state-by-state basis through federal waivers that allow states to disregard certain Medicaid program requirements. From January 2001 through March 2005, enrollment caps were included in more than 40 percent (seven out of 17) of such comprehensive Medicaid waivers.<sup>5</sup> Outside government, some prominent analysts continue to articulate their longstanding support for binding caps on Medicaid spending or enrollment.<sup>6</sup> In recent days, the Republican Study Committee, which includes more than 100 members of Congress, proposed that relief for Katrina victims be financed with a package of spending cuts, the largest of which would save \$225 billion over 10 years by converting Medicaid into a block grant with binding caps on federal spending.<sup>7</sup>

Either as applied to enrollment or federal funding, such caps could represent a basic, structural change to Medicaid, ending the individual guarantee of health coverage for eligible people and altering the program's operational dynamics. Currently, if economic conditions worsen and more people meet the program's eligibility requirements, enrollment and spending automatically increase (except when states change their eligibility rules). By contrast, caps would limit federal spending or enrollment to specified levels, even if changing economic conditions increased the demand for coverage above these levels.

To identify the implications of such caps, this paper begins by asking how the number of uninsured might change if Medicaid enrollment were capped. It then assesses the role that flexible, responsive Medicaid spending may play in helping the country recover from recession. Next, it explores the African American commu-

nity's stake in Medicaid. Finally, it discusses several implications of this analysis for the future direction of national Medicaid policy.

## I. Medicaid caps and the number of uninsured

In recent years, the number of uninsured has gone up significantly, rising from 40.2 million and 39.8 million in 1999 and 2000, respectively, to 45.8 million in 2004, according to the U.S. Census Bureau.<sup>8</sup> A major driving force behind this increase was a decline in employer-sponsored insurance (ESI) coverage, which dropped from 63.6 percent to 59.8 percent of the population.<sup>9</sup> At the same time, Medicaid coverage expanded, moderating the net loss in insurance coverage (Figure 1).

Without this Medicaid growth, even more Americans would have been uninsured in 2004. In estimating the impact of Medicaid caps, however, one cannot simply assume that every person unable to enroll in Medicaid would have become uninsured. In recent years, for example, several states found that between 33 and 37 percent of low-income people who were denied Medicaid because of state cutbacks obtained coverage through other means.<sup>10</sup> If Medicaid enrollment had been capped at 1999 levels, and other sources provided health coverage to 37 percent of those who were thereby denied Medicaid, 51.5 million people, rather than 45.8 million, would have lacked coverage in 2004. Put differently, from 1999 to 2004, the number of uninsured would have risen by 11 million instead of 6 million, nearly doubling the increase in those without insurance (Figure 2).

A number of analysts have linked the recent drop in employer-sponsored insurance to several factors. First, with health insurance premiums rising much faster than earnings, more lower-income workers declined employer coverage, and fewer small firms offered coverage to their employees.<sup>13</sup> According to that analysis, this basic trend is likely to continue for the near future, with the probable result that the number and percentage of uninsured Americans will continue to climb in the years ahead.<sup>14</sup> That climb will be steeper if Medicaid cannot absorb the low-income families who are unable to maintain employer-sponsored coverage or who move to jobs that lack insurance as employment shifts into categories where ESI is less prevalent. Second, the economic downturn during the first part of this decade deepened the erosion in ESI by increasing unemployment and reducing employers' collective need to recruit workers by offering health coverage.

Whatever the reasons for declining ESI, Medicaid currently has the capacity to cushion the blow by covering many of the most vulnerable workers who lose coverage. A rigid cap on Medicaid spending or enrollment could greatly reduce Medicaid's "surge capacity" and increase the rate at which American workers become uninsured in the future.

Under any circumstances, a loss in health coverage can have serious consequences. According to the Institute of Medicine, when people are uninsured their illnesses are frequently detected at later stages, they often go without essential health care, and they experience a heightened risk of serious health harm.<sup>15</sup>

These consequences can be particularly severe when uninsurance results from job loss. Unemployment increases the incidence of heart disease, hypertension, mental illness, lung cancer, domestic violence, and health problems of family members.<sup>16</sup> Without health coverage, laid-off workers can suffer reduced access to services essential to the detection and treatment of such health problems, at a time when care can be particularly important.

## II. Medicaid's responsiveness to changing economic conditions: important to recovering from future recessions?

The previous section provided one example of how Medicaid's current structure gives it the ability to respond flexibly to changing conditions: namely, when employer coverage dwindled during the early years of the 21st Century, Medicaid expanded to cover many who otherwise would have become uninsured. A second example of Medicaid's flexibility comes into play during an economic slowdown, which increases the number of Americans with incomes low enough to qualify for Medicaid. Because the program guarantees that eligible individuals can enroll, the number receiving assistance increases automatically, triggering increased spending that stimulates the economy and lessens further job loss.

There is widespread agreement that Medicaid plays this kind of automatic stabilizing role in the economy. For example, both the Federal Reserve Board<sup>17</sup> and the Congressional Budget Office<sup>18</sup> have concluded that Medicaid spending rises when unemployment increases. The question is thus not whether Medicaid responds to changes in the business cycle; rather, the important issue is whether that response is *sufficiently large* to influence the economy as a whole and provide meaningful stimulus when recession hits.

Medicaid's total spending is certainly sizable enough to have a major impact on the economy. According to the Bureau of Economic Analysis of the U.S. Commerce Department (BEA), during the second quarter of 2005, Medicaid was spending at an annual rate of \$312 billion in federal, state, and local funds, representing 18 percent of all government spending outside of national defense (Figure 3).<sup>19</sup>

Medicaid's overall size does not, by itself, determine the magnitude of the program's stabilizing effects. Many factors other than the business cycle influence Medicaid spending. One such factor is the increasing cost of health care, which affects all health care coverage (including Medicaid) and which has continued to rise in good times and bad (Figure 4).

A second factor that affects Medicaid spending independently of the business cycle is health policy change at the national level. For example, enactment of the State Children's Health Insurance Program (SCHIP) in 1997 was associated with increased outreach to encourage low-income families to enroll into health coverage, which, in turn, increased the number of children covered through Medicaid.<sup>22</sup> The Supreme Court's *Olmstead* decision in 1999<sup>23</sup> increased Medicaid's legal obligation to provide home- and community-based care, making the program more attractive to many seniors and people with disabilities, and contributing to an increase in their enrollment.

A third factor is that most Medicaid costs are generated by seniors and people with disabilities, the eligibility groups whose enrollment is least affected by economic downturns (Figure 5).

Put simply, some of Medicaid spending is countercyclical, and some is not. Fortunately, a number of researchers have disentangled these two strands, identifying the distinct impact of changing unemployment rates on Medicaid enrollment. The Appendix of this report provides such an analysis, written by one of this report's co-authors, Dr. Bowen Garrett, and published here for the first time. As far as the authors are aware, this is the most up-to-

date analysis published on the topic (although the results are generally consistent with most previously published studies, as explained in the Appendix). Examining annual data for every state from 1990 through 2003, Dr. Garrett estimated the impact of unemployment rates on enrollment into Medicaid and other types of coverage, controlling for several key factors: health care costs in each state; generosity of state Medicaid coverage rules for adults and children; the likelihood of income under 200 percent of the federal poverty level; age; race and ethnicity; education level; marital status; household size; residence within and outside Metropolitan Statistical Areas; and other potentially germane factors. After separating out the effects of these variables, Dr. Garrett was able to reach conclusions about the impact of a one percentage point increase in the unemployment rate, as expressed in Table 1.

The import of these results becomes evident when they are applied to 2003 coverage estimates from the March 2004 Current Population Survey. In 2003, the unemployment rate averaged 6.0 percent, according to the Bureau of Labor Statistics.<sup>25</sup> If the unemployment rate had instead been 7.0 percent, or one percentage point higher, the total number of individuals with various forms of coverage would have changed as follows (Table 2):

- Employer-sponsored insurance would have covered 2.5 million fewer people
- 1.5 million more people would have been uninsured
- Medicaid would have covered an additional 900,000 people

In 2003, non-elderly adults (including adults with disabilities) accounted for 55 percent of Medicaid's costs, and children accounted for another 19 percent. If individuals in each of these categories who joined the program generated the same average costs as current enrollees, each one percentage point increase in unemployment would have raised total Medicaid spending by 2.09 percent.\* Individuals who join Medicaid because of increased unemployment, however, are likely to be healthier, on average, than those already enrolled with the program, which lowers the newcomers' costs by approximately 15 to 20 percent.<sup>27</sup> Taking that factor into account, each one percentage point increase in unemployment would raise Medicaid costs by 1.67 to 1.78 percent, according to Dr. Garrett's results.

While this analysis establishes the general size of Medicaid's countercyclical component, it does not show the resulting impact on the economy as a whole. To do that definitively, researchers would need to employ a well-developed macroeconomic model of the entire U.S. economy. Several such models have been constructed; however, to engage them in a comprehensive study of Medicaid could be costly and time-consuming. By the time the final results were published, Congress most likely would have finished this year's discussion of the Medicaid program.

Although a definitive determination of Medicaid's macroeconomic role may be impossible to secure before the conclusion of the current federal budget debate, a suggestive analysis can be based on rigorous macroeconomic modeling of the Unemployment Insurance (UI) program that the U.S. Labor Department published in 1999. Using the Wharton Econometric Forecasting's Quarterly Model (WEFA Model), the Labor Department's report found that UI had become one of the country's leading automatic stabilizers. During the five recessions that occurred between 1969 and 1999, UI mitigated the loss in real GDP by 15 to 17 percent and saved more than

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\*This figure is derived as follows: Table 2 shows that a one percentage point rise in unemployment increases by 2.42 percent the 19 percent of Medicaid costs generated by children. This increases total program costs by 2.42 percent times 19 percent, or 0.46 percent. That same increase in unemployment raises by 2.97 percent the 55 percent of program costs generated by non-elderly adults, increasing total program costs by 2.97 percent times 55 percent, or 1.63 percent. Adding cost increases for the two populations yields a total estimated increase in program costs of 2.09 percent.

130,000 jobs during the average recession's peak year.<sup>28</sup>

Medicaid and UI may play roughly comparable roles in stimulating the economy during hard times. Data from BEA show that, during the past two decades, changes in both Medicaid and UI spending have paralleled changes in unemployment, and that both UI and Medicaid spending growth provided increased stimulus at the same order of magnitude when unemployment rose (Figure 6).

In analyzing this pattern, four points are important to keep in mind. First, this similarity between Medicaid and UI spending involves total dollar amounts. It does not necessarily translate into the two programs having comparable macroeconomic impacts, since different types of spending can have different economic effects. Without rigorous macroeconomic modeling of Medicaid, the analysis in this paper can show only the likelihood that Medicaid and UI may have roughly comparable stimulative effects during recession.

Second, while Figure 6 shows that changes in Medicaid spending have generally tracked changes in unemployment rates, it also shows that total Medicaid spending increased each year (as did Medicare and total health care spending during that same period).<sup>30</sup> Not expected to change in the future,<sup>31</sup> this pattern provides economic stimulus during recession-stimulus that could be limited by caps on Medicaid dollars or enrollment. By the same token, increased Medicaid spending also provides stimulus when the economy is strong. Whether or not other worthwhile goals are advanced by particular Medicaid spending increases during periods of vigorous economic growth, they are not then needed for nationwide economic stimulus.

Third, the Unemployment Insurance spending numbers in Figure 6 include special supplements to UI that Congress enacted during each recession over the past twenty years. Such supplements allowed individuals to receive UI for longer periods than under the standard UI program. When those supplements are subtracted from UI spending totals, the parallel between Medicaid and UI spending becomes even more pronounced (Figure 7).

Fourth, the pattern shown in Figures 6 and 7 may have changed in 2004.<sup>33</sup> According to BEA data published in August 2005, Medicaid spending increased by \$24.6 billion in 2004, while the average unemployment rate declined by 0.5 percent. With UI, spending on the basic program dropped by \$7.3 billion while spending on special UI supplements fell by \$9.5 billion. It is not yet clear whether these initial numbers for 2004 will eventually be revised by small amounts; whether this divergence was a one-year "blip" or the start of a new pattern that will continue in future years; or what the causes of this change may have been if indeed a meaningful shift took place last year. One contributing factor may have been legislative intervention in the ordinary operation of these programs, which had different effects for UI than for Medicaid during 2004. Supplemental UI provided by special legislation was phasing out from December 2003 through March 2004;<sup>34</sup> but two-fifths of a temporary increase in Medicaid matching funds, enacted by Congress, was for Medicaid provided in 2004, as Part IV of this report discusses in more detail.

One interesting feature of UI spending without Congressionally-enacted supplements is that the peaks in spending growth, while smaller, more closely coincided with increased unemployment. Figure 6 shows that the highest rate of UI spending increases, including legislatively-enacted special supplements, occurred *after* the unemployment rate rose. By contrast, peaks of spending increases for regular UI and for Medicaid coincided much more closely with the highest unemployment rate increases, as illustrated by Figure 7 (Figure 7). Figure

8 shows how spikes in UI spending on Congressionally-enacted special supplements have tended to lag behind unemployment rate increases (Figure 8).

This reinforces a lesson taught by macroeconomists for generations: namely, when program spending automatically responds to changed economic conditions, stimulus can begin and end at the right time, whereas if spending does not change until after policymakers have enacted national legislation, stimulus can kick in at the wrong time (after recovery is under way) and can persist after it is no longer needed for macroeconomic purposes. Poorly timed stimulus can even harm the economy as a whole if such a stimulus contributes to inflation or inflationary fears, which, in turn, can cause the Federal Reserve Board to raise interest rates and perhaps stifle an economic recovery that has gotten under way.

In sum, although both programs could be restructured to improve the timing of the increased stimulus they provide, the above analysis provides good reason to believe that Medicaid spending may be roughly comparable to UI in helping the economy during economic downturns. Medicaid could thus be an important automatic fiscal stabilizer for the economy as a whole. Without Medicaid's responsiveness to changing economic conditions, there is a risk that future recessions could be deeper and more prolonged.

### III. The African American community's stake in this issue

Medicaid now provides a remarkably broad range of services to more than 50 million Americans of all races and ethnic backgrounds. Moreover, an economic downturn harms people in many walks of life. Nevertheless, racial and ethnic minorities—and particularly the African American community—are especially vulnerable to Medicaid cutbacks and to recession.

People of color now comprise 53 percent of all Medicaid beneficiaries. African Americans alone constitute fully 24 percent of all Medicaid beneficiaries.<sup>36</sup> According to the most recent estimates from the Census Bureau,<sup>37</sup> Medicaid covers the following proportions of black Americans:

- 36 percent of poor black adults, including 33 percent of poor seniors
- 73 percent of poor children, including 80 percent of poor children under 6 years of age
- 63 percent of near-poor children
- Among African American families at every income level, 44 percent of all children, including 51 percent of all black children under age six

The African American community has a special stake in this issue for a second reason as well. If recessions deepen because Medicaid loses its capacity to act as an automatic fiscal stabilizer, blacks could suffer more than other groups, since recessions frequently hit African Americans the hardest, as illustrated by the following data:

- During the classic “double-dip” recession from the first quarter of 1980 to the fourth quarter of 1982, unemployment rates grew by four percentage points among whites and 7.4 percentage points among blacks. White unemployment rose from 5.5 to 9.5 percent, as African American unemployment increased from 13.0 to 20.4 percent.<sup>38</sup>

- During the most recent recession, white unemployment rates rose by 1.2 percentage points, while black unemployment increased by 1.7 percentage points. From the first to the fourth quarters of 2001, white unemployment grew from 3.7 to 4.9 percent, while black unemployment rose from 8.1 to 9.8 percent.<sup>39</sup>
- After the most recent recession officially ended, the African American community had disproportionate difficulty regaining lost ground. According to the National Bureau of Economic Research, the recession formally ended in the fourth quarter of 2001.<sup>40</sup> Between that time and the fourth quarter of 2004, unemployment among whites remained stable, experiencing a slight drop from 4.9 to 4.8 percent, while unemployment for blacks continued to rise, from 9.8 to 10.8 percent.<sup>41</sup>
- This disparity could sharpen still further if future recessions involve a greater “hit” to the health care industry due to Medicaid caps or cuts. African American workers are disproportionately employed by health care providers, so they are particularly vulnerable to layoffs in the health care sector. While Blacks comprised 10.7 percent of all American workers in 2003, they represented 15.2 percent of hospital employees and 15.5 percent of other health care workers.<sup>42</sup>
- Unemployment can cause particularly severe harm in the African American community because black households have fewer resources to fall back on during hard times. Median wealth for African Americans is approximately \$11,000—one-tenth that of whites.<sup>43</sup>

Finally, African Americans disproportionately suffer from such illnesses as heart disease, hypertension, lung cancer, and infant mortality<sup>44</sup>—all of which are conditions that can grow more severe when patients experience the stress of unemployment and that are significantly more likely to cause serious harm if patients lose health coverage and suffer reduced access to necessary care.<sup>45</sup> The combination of increased unemployment and reduced health coverage could thus pose particularly grave health risks for black Americans.

#### IV. Implications for policymakers

The above economic analysis has several implications about the direction of future Medicaid policy.

First, as federal policymakers struggle to control Medicaid spending, structural changes that would weaken Medicaid’s ability to respond to changing economic conditions need to be understood as posing special dangers to the country’s ability to ameliorate and recover from future recessions. Other, more specific policy changes would not have that effect.

To its credit, the administration in this year’s budget did not simply propose caps or Medicaid block grants at the federal level, while leaving to state officials the responsibility of deciding precisely where the ax should fall. Rather, the administration proposed a series of specific policy changes designed to achieve desired cost savings. These proposals included new methods of setting payment levels for prescription drugs, limits on federal matching funds provided for certain state funding sources, and reduced coverage of long-term care for seniors and people with disabilities who transfer their assets within a specified period of time before applying for Med-

icaid.<sup>46</sup> It is beyond the scope of this paper to explore the strengths and weaknesses of these and other specific changes under discussion. Rather, we make the more general point that, if policymakers aim at cost-effective improvements to help Medicaid more efficiently and effectively serve a highly vulnerable population, rather than impose rigid and inflexible caps that change the program's basic structure, they are more likely to avoid unintended but nevertheless important risks to the country's ability to bounce back from future economic shocks.\*

Second, Medicaid could be restructured to be much more effective in providing both health coverage and economic stimulus during economic downturns. In all but two states (Indiana and Vermont), balanced budgets are required by constitution or statute.<sup>47</sup> When recession hits and caseloads climb for Medicaid and other need-based programs, state revenues drop. Balancing state budgets under such circumstances can involve cuts to Medicaid eligibility, benefits, or reimbursement levels, all of which would be intended to reduce Medicaid spending below projected levels. For example, FY 2002-2003 saw the following Medicaid policy changes at the state level:

- 50 states cut or froze provider payments
- 46 states cut prescription drug payments
- 25 states cut eligibility
- 18 states cut benefits
- 17 states increased beneficiary charges<sup>48</sup>

Put simply, the *deepest Medicaid cutbacks are most likely to occur when Medicaid's contributions to health coverage and to the economy are most needed*. By contrast, the Unemployment Insurance program was originally structured to provide *increased* help during recession. Extended Benefits (EB) are automatically paid when state unemployment rates reach certain levels specified in federal law.<sup>49</sup> Since changes were made to the EB statute in the early 1980s, the revised statutory trigger has rarely been reached in more than a handful of states.<sup>50</sup> Accordingly, federal policymakers have resorted to *ad hoc* legislation that extended UI during recession. As noted above, that shift from automatic response to one mediated by the decisions of elected officials has caused what appears to be a late delivery of the stimulus furnished by UI's extended benefits.

Federal policymakers could learn from the UI experience and add an automatic countercyclical adjustment to federal matching rates under Medicaid. With such an adjustment, when unemployment rates rise to unusually high levels, federal matching percentages would likewise rise, without any need for policy intervention. That would reduce states' need to cut back Medicaid coverage when such coverage is most needed, both by uninsured individuals and the economy. Federal policymakers took a similar step when, on May 28, 2003, President Bush signed legislation that enacted a 2.95 percentage point increase in the Federal Medical Assistance Percentage (FMAP) for five quarters, from April 2003 through June 2004.<sup>51</sup> In 31 states, this either prevented Medicaid cuts or reduced the scope of such cutbacks.<sup>52</sup> However, prolonged national debate was required before this increase was adopted; legislation to provide a temporary FMAP enhancement was first introduced on April 22, 2002, more than a year before final enactment.<sup>53</sup> As a result, much of the increase in federal funding took place after the unemployment rate began to decline. An automatic fiscal adjuster would allow more timely initiation

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\*Any policy change that reduces Medicaid spending during recession will lower the amount of stimulus provided by the program. Economic risks of an entirely different order of magnitude, however, would result from legislation that prevented Medicaid from serving as an automatic fiscal stabilizer in the future. The latter risks are the focus of this paper.

and termination of economic stimulus.

To be clear, this analysis does not in any way imply that Congress erred by enacting enhanced federal matching funding for Medicaid or special UI supplements. Those national policy decisions provided UI to workers experiencing lengthy spells of unemployment and allowed states to avoid Medicaid policy changes that threatened to reduce access to health care for low-income populations. Moreover, while the stimulus may not have been *optimally* timed, it nevertheless may have played an overall *positive* role in alleviating the country's economic downturn.

Our analysis does imply, however, that automatic triggers could be more effective than legislated policy change in providing timely stimulus during economic downturns. The precise structure of such a trigger is important, as shown by the failure of automatically triggered EB to play a major role in UI since the early 1980s. Under one approach, FMAP would increase only if the national unemployment rate during a given calendar quarter exceeded a threshold level associated with a serious economic slowdown, such as 6.0 percent, or one percentage point above the 5.0 percent rate forecast as the long-term "equilibrium" level by the U.S. Office of Management and Budget (OMB).<sup>54</sup> With unemployment at levels well above the 5.0 percent baseline, national FMAP rates for the quarter would be increased by an amount sufficient to compensate for the resulting spike in Medicaid costs. According to the above analysis, that could amount to a 1.67 to 1.78 percentage point increase in federal matching rates for each one percentage point by which the unemployment rate exceeds the 5.0 percent, baseline level.<sup>55</sup> As explained in the Appendix, however, other research has found that increased unemployment has a greater impact on Medicaid enrollment than is suggested by our analysis. Based on these other studies, each one percentage point increase in unemployment could raise Medicaid costs between 1.87 and 3.49 percent.<sup>55</sup> It would be reasonable for policymakers to set the FMAP adjustment at any point in this range, from 1.67 percentage points (our lower estimate) to 3.49 percentage points (the highest estimate derived from other research).

If such a policy had been in effect during the economic slowdown of the early 2000s, FMAP would have increased only during the second and third calendar quarters of 2003, when unemployment averaged 6.13 percent,<sup>56</sup> or 1.13 percentage points above the 5.0 percent long-term OMB forecast. Under the approach described here, each state's federal matching payments would have increased between 1.89 and 3.94 percentage points during those quarters.<sup>57</sup> While the 2.95 percentage point increase adopted by Congress falls squarely in the middle of our suggested range, this precise formula would have resulted in a briefer increase in federal matching funds than Congress enacted. If national policymakers wanted an automatic countercyclical FMAP adjustment to come into effect more often, the trigger could be set at an unemployment rate below 6 percent.<sup>57</sup>

This basic approach to a national trigger would seek to reserve enhanced federal matching levels for significant and nationwide economic downturns. Before mid-2003, the last time the quarterly unemployment rate averaged 6.0 percent or higher was during the period from the fourth quarter of 1990 through the third quarter of 1994,<sup>58</sup>

<sup>54</sup>Policymakers could use other forecasts to set the "baseline" unemployment rate against which actual unemployment rates would be compared. The rationale for using the administration's forecast as the baseline, rather than a different entity's forecast, is that unadjusted FMAP rates are developed by the administration, using the same data that ultimately feed into OMB's projections. The economy's departure from such projections may thus be a reasonable touchstone for departing from those unadjusted FMAP rates.

<sup>55</sup>This number results from multiplying: (a) the 1.67 to 3.49 percent Medicaid cost increase that results from a one percentage point increase in the unemployment rate; by (b) the 1.13 percentage point increase in the unemployment rate during each of these quarters, compared with OMB's 5.0 percent baseline level.

when the economy was significantly less resilient than it seems to be at present.<sup>59</sup>

Of course, a particular state's economy can suffer serious harm, even if the national economy is doing well. The states devastated by Hurricane Katrina come readily to mind as an example from recent headlines, but other economic dislocations affecting industries located in particular states can also trigger severe but localized downturns. If policymakers wish to make enhanced federal funding available when individual states experience hard times, additional enhancements to FMAP could be triggered by state unemployment rates that significantly exceed the state's long-term average.\*\* Such long-term averages could be determined based on unemployment rates during the previous 63 months, which has been the average length of a full business cycle during peacetime since 1945, according to the National Bureau of Economic Research.<sup>60</sup>

As with the specially enacted 15-month temporary increase in federal match that ended in June 2004, access to enhanced federal matching funds under this more automatic approach could be conditioned on a state's maintenance of previous Medicaid eligibility.<sup>61</sup> Such a precondition may be needed if federal policymakers wish to ensure that increased federal resources translate into continued Medicaid coverage during hard times. Without such a precondition, states could make major Medicaid cutbacks and still receive enhanced federal Medicaid funding, which could then be funneled to purposes unrelated to health care.

In short, national policy changes that prevent Medicaid from expanding during economic downturns would create risks both to health coverage and to the economy's ability to recover quickly and fully from future recessions. By the same token, well-structured national policy changes that enhance the program's automatic responsiveness to economic slowdowns could provide state policymakers with the resources they need to safeguard coverage during hard times and revive troubled economies.

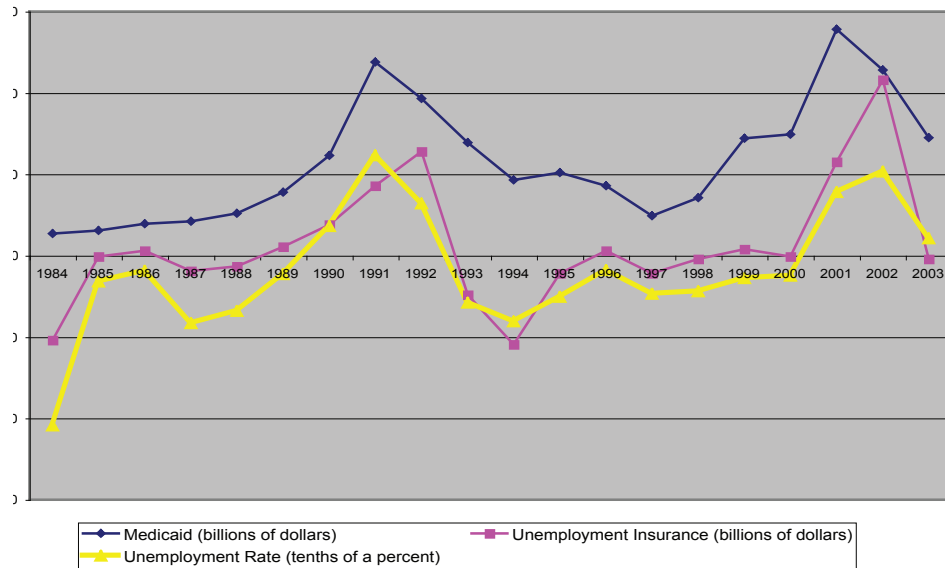
## CONCLUSION

Medicaid's capacity to adjust to changed economic circumstances has prevented millions of Americans from losing health insurance despite this decade's significant decline in employer-sponsored coverage. While definitive evidence is not currently available, there are clear indications that Medicaid's impact on the economy as a whole may be roughly comparable to that of Unemployment Insurance, which cuts the loss of real GDP during recession by 15 to 17 percent. If policymakers undermine Medicaid's capacity to grow automatically during economic downturns, future recessions could be deeper and longer. On the other hand, if policymakers establish automatic triggers that increase federal matching rates when unemployment reaches unusually high levels, Medicaid could become far more effective in helping workers and boosting the economy precisely when such help is most needed.

\*\*If future state-specific forecasts of long-term equilibrium unemployment rates acquire the same degree of reliability as current national forecasts, it may be preferable to use such state-level forecasts rather than historical averages. Past averages may not always represent the best predictors of future economic performance over the long term when, as now seems to be the case, significant structural changes are occurring in the economy.

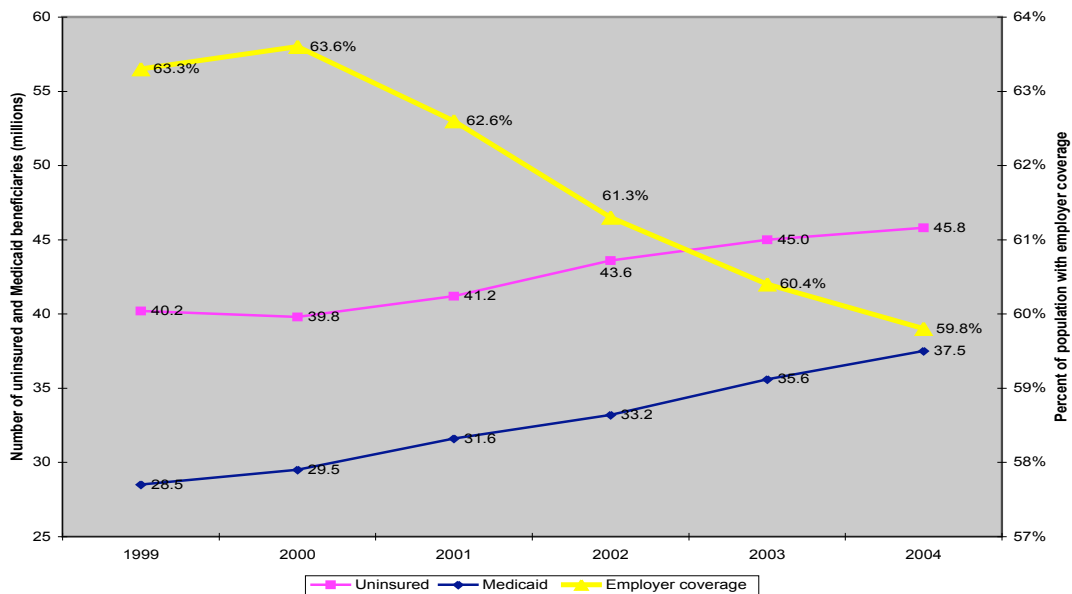
## CHARTS AND TABLES

**Figure ES-1: Changes in Medicaid Spending, Unemployment Insurance Spending, and Unemployment Rates, 1984-2003**



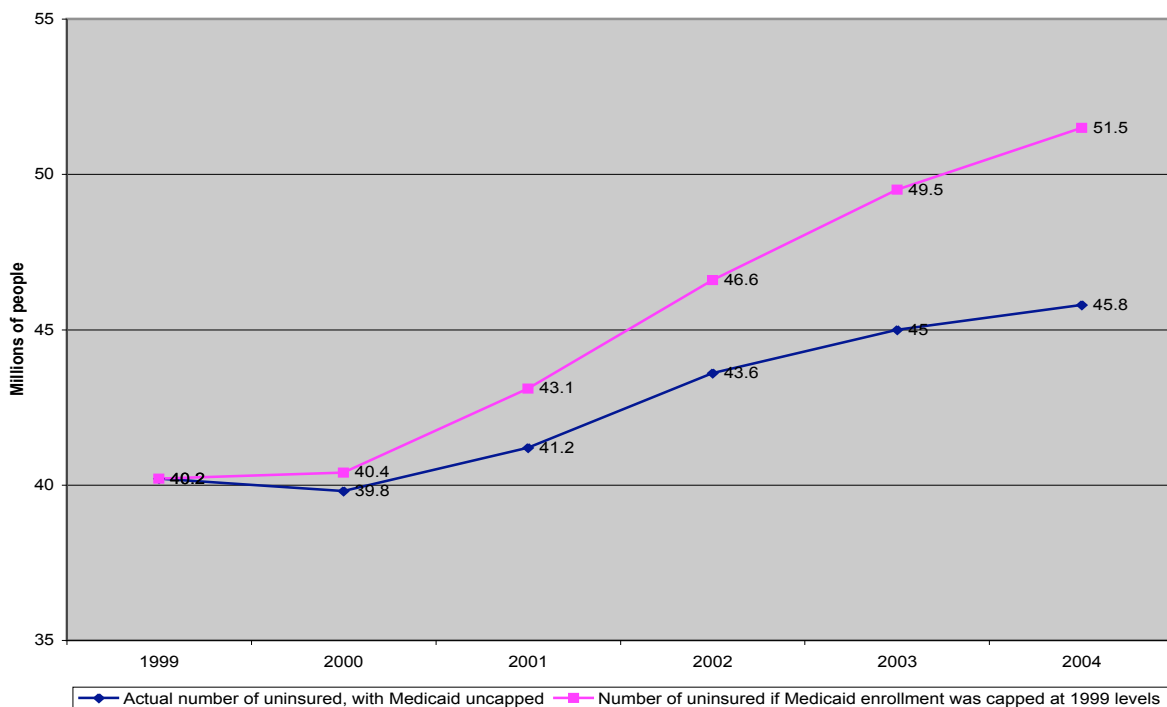
Source: BEA, August 2004. Calculation by ESRI, April 2005.

Figure 1: When employer-based coverage declined in 2000-2004, Medicaid picked up much of the slack



Source: U.S. Census Bureau, August 2005 (Current Population Survey, 2000 to 2005 Annual Social and Economic Supplements).

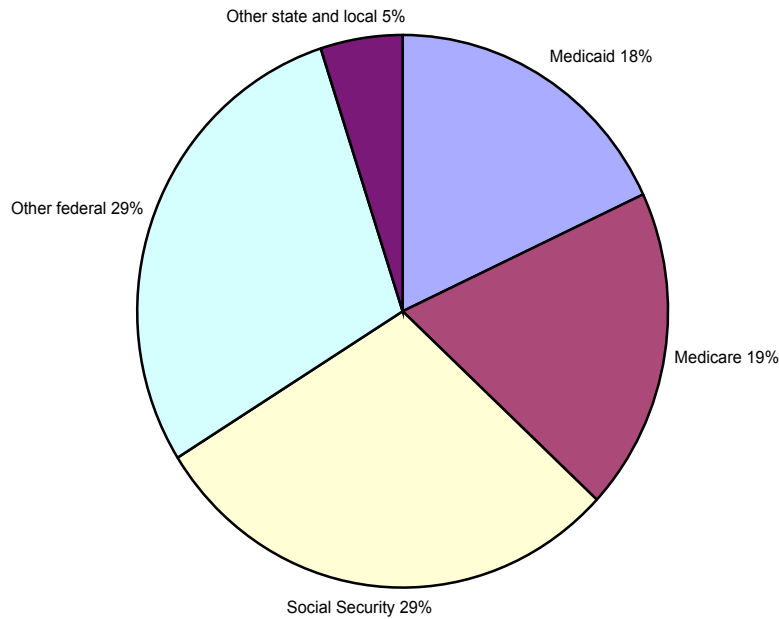
Figure 2: If Medicaid enrollment had been capped at 1999 levels, nearly six million more people would have been uninsured in 2004



Source: US Census Bureau, August 2005 (see previous figure). Calculations by ESRI, September 2005.

Notes: (1) Based on recent data about uninsurance among low-income individuals losing Medicaid, the higher uninsured numbers in the upper line reflect Medicaid enrollment capped at 1999 levels, with 37% of individuals who lost Medicaid obtaining coverage from other sources. (2) This analysis relies on data from the Census Bureau's Current Population Survey (CPS), which many analysts believe underestimates the number of Medicaid enrollees.<sup>11</sup> If administrative data from state Medicaid programs were used in place of CPS Medicaid numbers, then the increase in 2003 uninsurance levels resulting from a Medicaid enrollment cap applied in 1999 would amount to 6.7 million people, rather than the 5.7 million increase shown in this chart.<sup>12</sup>

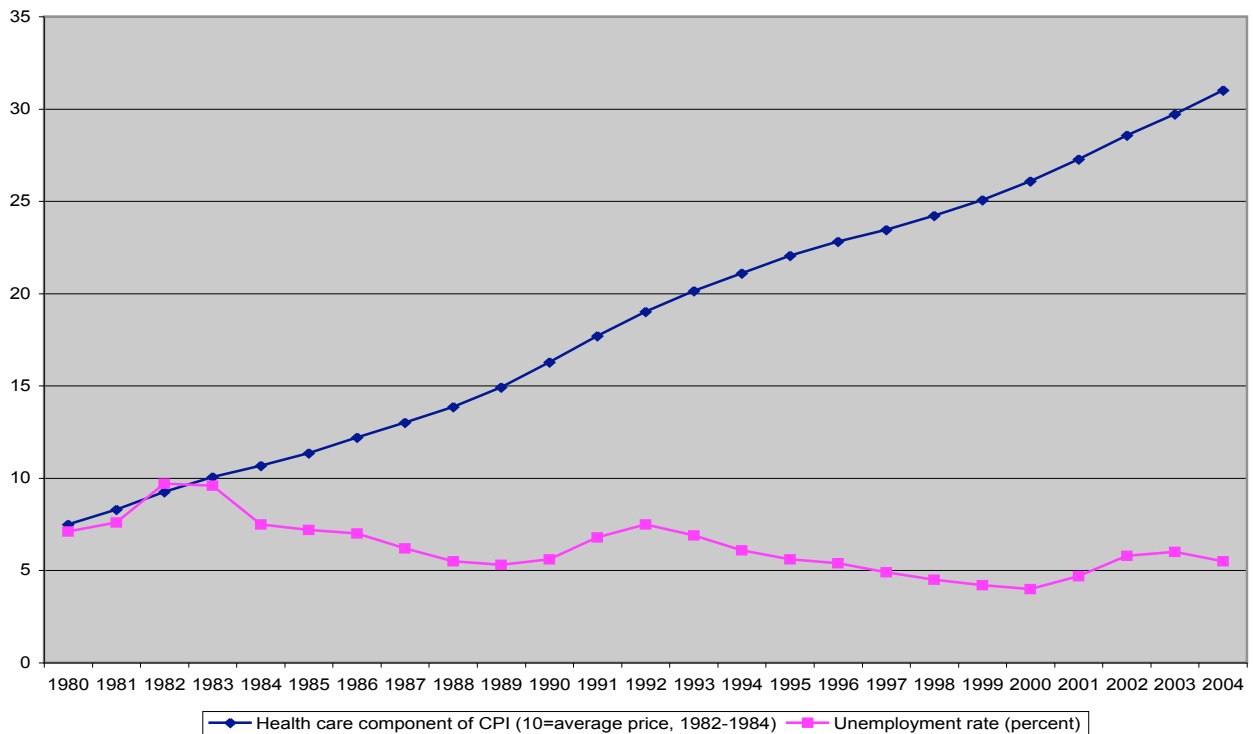
Figure 3: Estimated federal, state, and local government spending other than for national defense, 2005



Source: BEA, July and August 2005.<sup>20</sup> Calculations by ESRI, August, 2005.

Notes: This chart shows estimated annualized spending for 2005, based on spending during the second quarter of 2005.

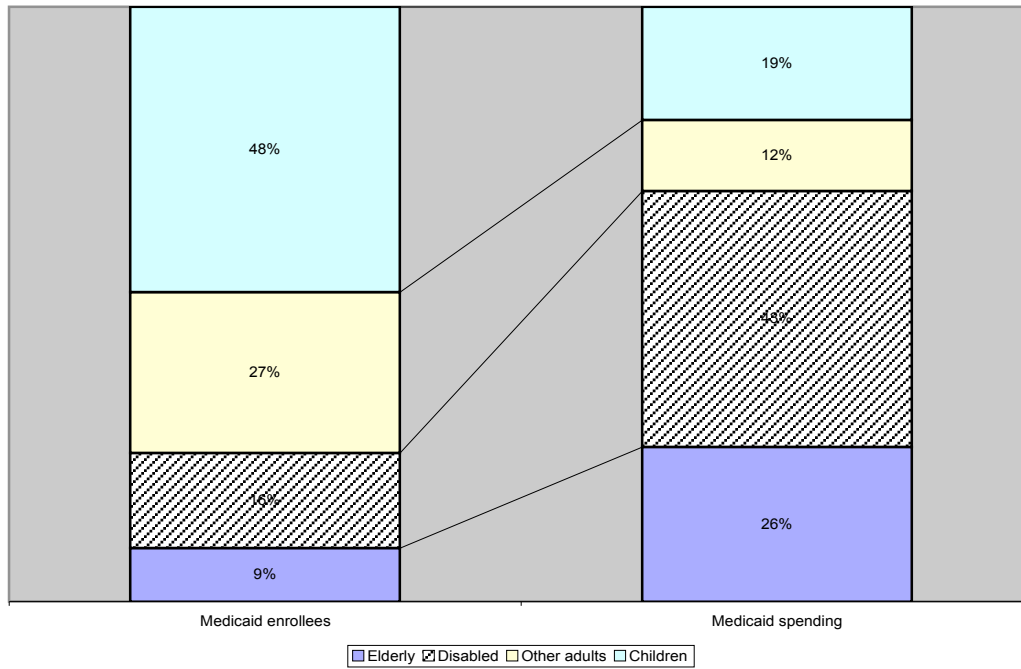
Figure 4: Health Care Inflation and Unemployment, 1980-2004



Source: Bureau of Labor Statistics, August 2005.<sup>21</sup>

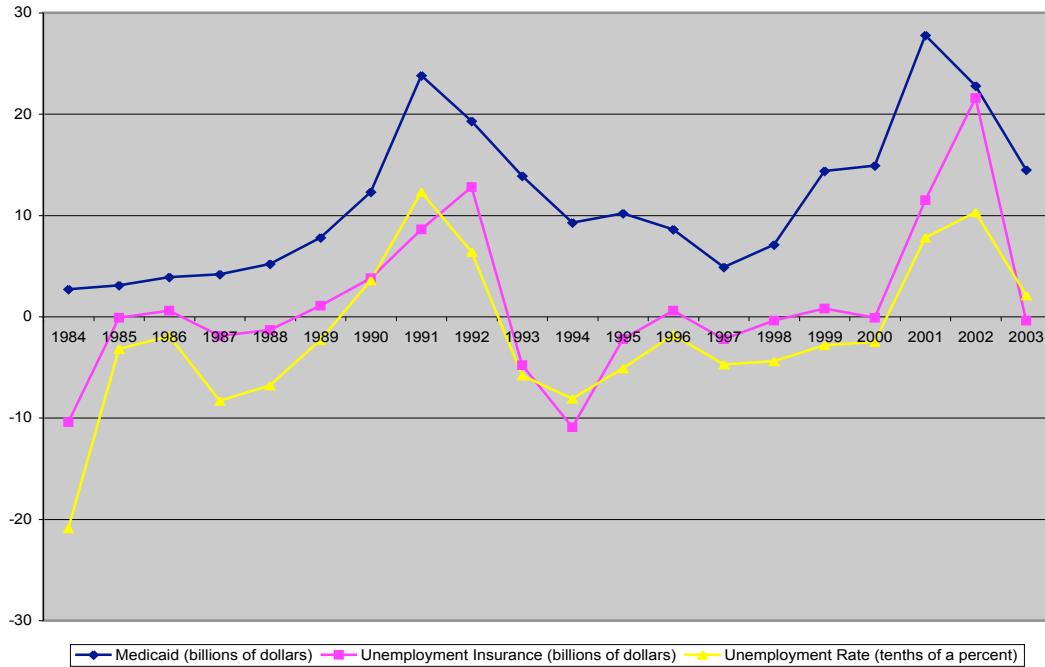
Note: CPI refers to the Consumer Price Index.

Figure 5: Medicaid Enrollment and Costs by Eligibility Group, 2003



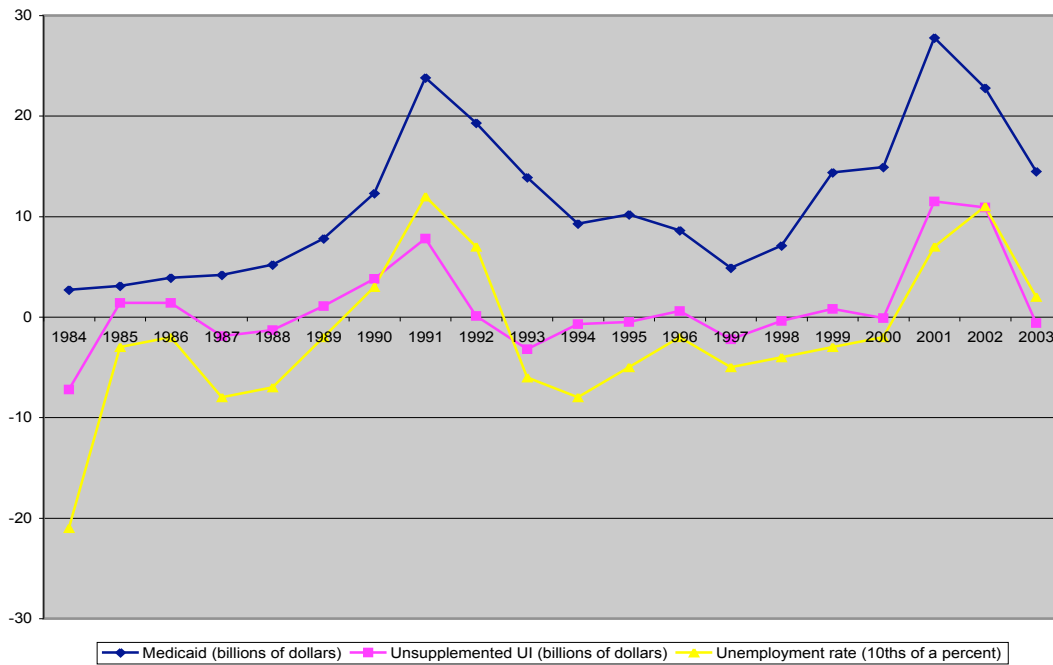
Source: Kaiser Commission on Medicaid and the Uninsured, July 2005.<sup>24</sup>

Figure 6: Changes in Medicaid Spending, Unemployment Insurance Spending, and Unemployment Rates, 1984-2003



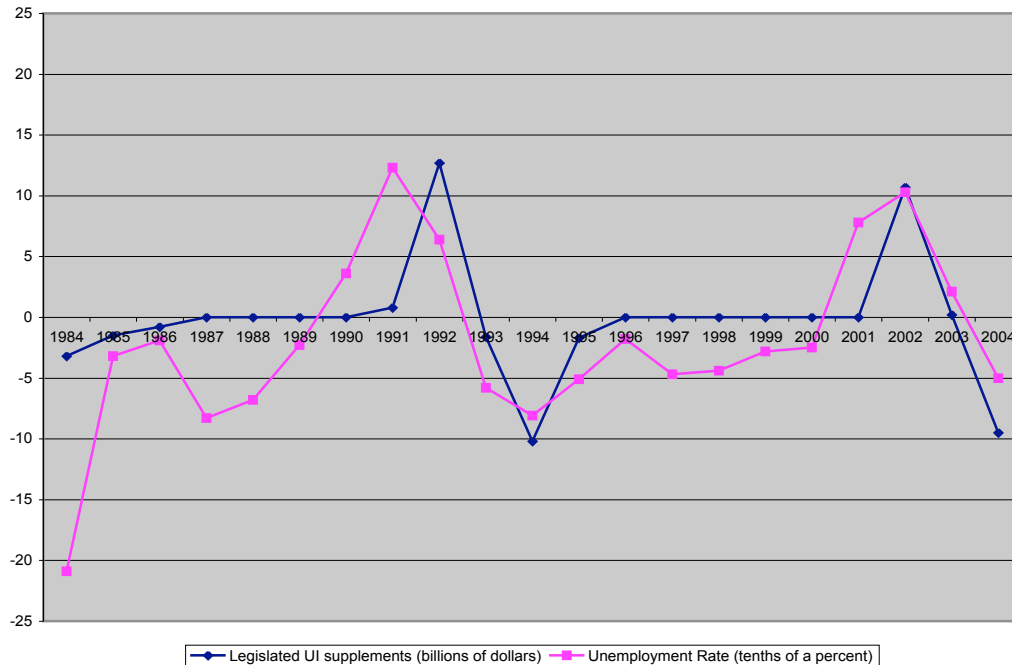
Source: BEA, August 2004.<sup>29</sup> Calculations by ESRI, April 2005.

**Figure 7: Changes in Medicaid spending, Unemployment Insurance spending not supplemented by special legislation, and unemployment rates, 1984-2003**



Source: BEA, August 2004.<sup>32</sup> Calculations by ESRI, August 2005.

**Figure 8: Changes in specially enacted supplements to Unemployment Insurance vs. changes in unemployment, 1984-2004**



Source: BEA, August 2004.<sup>35</sup> Calculations by ESRI, September 2005.

**Table 1: Estimated impact of a one percentage-point increase in the unemployment rate on the percentage of children and non-elderly adults with various forms of coverage**

	Expected change in the proportion of U.S. residents who have each listed form of coverage		
	ESI	Medicaid	No Coverage
Children	-1.048%	+0.637%	+0.427%
Non-elderly adults	-0.995%	+0.237%	+0.670%

Notes: (1) ESI refers to employer-sponsored insurance. (2) Medicaid estimates include SCHIP and other state programs that provide health coverage to low-income people. (3) The listed changes are expressed in terms of percentage points of all residents.

**Table 2: Estimated impact on health coverage of a one percentage point increase in the unemployment rate, 2003**

		Actual enrollment, with 6.0% unemployment	Estimated enrollment, with 7.0% unemployment	Change	
				Number	Percentage
Total (children and non-elderly adults)	ESI	165.1 million	162.6 million	-2.5 million	-1.52%
	Medicaid	32.4 million	33.3 million	+900,000	+2.64%
	Uninsured	44.7 million	46.2 million	+1.5 million	+3.44%
Children	ESI	45.7 million	45.0 million	-800,000	-1.66%
	Medicaid	19.4 million	19.9 million	+500,000	+2.42%
	Uninsured	8.4 million	8.7 million	+300,000	+3.68%
Non-elderly adults	ESI	119.4 million	117.6 million	-1.76 million	-1.47%
	Medicaid	13.0 million	13.4 million	+400,000	+2.97%
	Uninsured	36.3 million	37.5 million	+1.2 million	+3.39%

Notes: (1) Sums may not precisely total due to rounding. (2) The actual enrollment numbers (and the underlying percentages of children and non-elderly adults receiving various forms of coverage) are estimated from the U.S. Census Bureau's March 2004 Current Population Survey,<sup>26</sup> as explained in Appendix Table 2. (3) For other notes, see Table 1.

## APPENDIX

### Estimation of the Effect of the Macroeconomy on Health Insurance Coverage

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August 31, 2005

Prepared for The Economic and Social Research Institute

The unemployment rate summarizes the state of the macroeconomy in a way that is especially relevant to health insurance coverage. Some workers who lose their jobs and their access to employer-sponsored insurance (ESI) during an economic downturn may experience a drop in income that qualifies the whole family or particular family members for Medicaid, the State Children's Health Insurance Program (SCHIP), or other means-tested state coverage. Others may become uninsured. The unemployment rate also captures the strength of the labor market. In a weak labor market, employers may have less of an incentive to offer health insurance to attract and retain workers.

To estimate the extent to which changes in the unemployment rate lead to changes in health insurance coverage, I use data from the Current Population Survey (CPS) March Annual Demographic File for survey years 1991 to 2004. Each year's March CPS collects data on individual health insurance coverage over the prior calendar year, as well as state of residence and individual-level demographic information, including age, race, years of education, and marital status. The CPS data are linked, by year, to state-level data on unemployment rates, and constructed measures of health care costs and Medicaid program generosity.

Multivariate regression models of coverage status (linear probability models) are estimated for four coverage types: ESI, Medicaid/state (including SCHIP and other state coverage), nongroup private coverage, and being uninsured. Coverage categories are not mutually exclusive, and individuals with other types of coverage (Medicare and other public coverage) are left in the estimation sample.

Regression models are estimated separately for non-elderly adults (age 18 to 64) and children (age 0 to 17), and include the following explanatory variables:

- State unemployment rate and one-year lag
- State private health care cost measure (proxy) and lag
- Percent of children under state's income threshold for child poverty-related Medicaid eligibility or SCHIP and lag
- Percent of non-elderly adults under state's income threshold for Medicaid eligibility through 1115 waiver income threshold and lag
- State Aid to Families with Dependent Children (AFDC)/Section 1931 earnings thresholds for Medicaid eligibility for a family of three to qualify and lag

- Age and age-squared
- Gender
- Race/ethnicity-Black/non-Hispanic, Hispanic, other race (reference group = White/non-Hispanic)
- Marital status-married, divorced/separated/widowed (reference group = never married)
- Educational attainment-less than high school, some college, college degree (reference group = high school graduate)\*
- Own children present\*
- Number of children\*
- Estimated probability that family income is less than 200 percent of the federal poverty level (averaged over all family members) based on factors I assume to be exogenous (e.g., age, gender, education, marital status)
- Urban residence
- Post-1993, post-1996, and post-2000 dummies (to capture changes in the CPS)
- State fixed effects

\*Excluded from children's models

Prior studies have shown that private coverage tends to decrease when private health insurance costs increase (Cutler 2002, Kronick and Gilmer 1999). Due to limited data availability and concerns about endogeneity, I use a proxy measure of state-level health care costs based on Medicare payments, as proposed by Glied and Jack (2003). An advantage of using a Medicare-based measure rather than one based on overall health spending is that Medicare spending should be relatively unaffected by the changes in unemployment and changes in health insurance coverage.

For each year, the state health care cost proxy is constructed as (state-level total Medicare spending per enrollee less home health spending)\*(national-level private health insurance expenditure per enrollee / national-level Medicare spending per beneficiary)\*(all item Consumer Price Index adjuster to 2003 dollars). The first factor is intended to capture exogenous changes in health care costs, while the second factor captures changes in the loading factor for private coverage through the divergence between private and Medicare costs over time (for data sources, see Glied and Jack, 2003). State-level Medicare spending per enrollee for 2002-2003 was imputed using state-specific linear trends, with further adjustment to conform to measured national growth rates.

The data used to construct the three Medicaid policy variables come from multiple sources, compiled by the Urban Institute. The AFDC/Section 1931 earnings threshold variable is used to summarize state Medicaid generosity for adults with children through AFDC-related family coverage categories. The variable is also relevant for child eligibility, particularly in the early 1990s. It is constructed by adding a state's countable income threshold for Medicaid eligibility through AFDC (up to and including 1996) or through Section 1931 (after 1996) to disregarded earnings. The value is computed for a family of three, consisting of one working adult and two children, with no unearned income or child support and no assets. Child care disregards are not included. In several instances in which data were missing for a particular state/year, or inconsistencies in data sources were observed, reasonable edits were made after consulting information from a variety of sources. This typically affected five to seven states in a given year.

The state Medicaid poverty-related/SCHIP and Section 1115 waiver policy variables were created by applying the age (for child expansions) and income eligibility thresholds of a particular state's expansion program to a fixed CPS sample to create an individual-level indicator for program eligibility. The indicator is then used to get a weighted estimate of the number of children or adults eligible for Medicaid through the expansions in each state and year. Because the rules are applied to a fixed sample, the measure captures pure variation in Medicaid policies.

Regressions are weighted using CPS sample weights. Standard errors are adjusted for clustering by state, thereby allowing for potentially correlated errors within a state across individuals and over time.

For each model, the reported unemployment effect is the sum of the contemporaneous and lagged unemployment regression coefficients. The estimates measure the percentage point change of a coverage type given a percentage point change in the unemployment rate (i.e., marginal effect). The total (marginal) effect of unemployment is statistically significant (different from zero) in all models, with the exception of the nongroup coverage models for adults and children.

The estimates obtained are reasonable in sign and plausible in magnitude. As would be expected, unemployment has its largest effect on ESI coverage. The effect on Medicaid is larger for children than adults, which is reasonable because Medicaid eligibility criteria are more stringent for adults. Also, the effect of unemployment on being uninsured is smaller for children than adults.

Appendix Table 1 compares the estimates used in this report to estimates reported in earlier studies. When the elasticities used in Holahan and Garrett (2001) are converted to the same units as the current estimates, the effects of unemployment on Medicaid are quite similar. The similarity is striking considering that administrative data on Medicaid enrollment were used in the earlier study in contrast to the CPS data used here. Results obtained by Cawley and Simon (2003) for Medicaid for children are higher (1.040 vs. 0.638). Their Medicaid results for adults are not directly comparable due to differences in the estimation sample (women only versus men and women combined). To check comparability, I limited the adult sample to women and estimated an effect of 0.331 (not shown in Table 1), which is closer to but still smaller than the Cawley and Simon finding of 0.680.

The ESI result for adults is very similar to the average of the Cawley and Simon (2003) results estimated for men and women separately. A weighted average of the uninsured results for children and adults (0.608-not shown in Table 1) is fairly similar to what Gruber and Levitt (2002) estimated for all non-elderly combined (0.500). The uninsured result for adults is similar to what Cawley and Simon obtained for men. But the earlier study found essentially no effect of unemployment on uninsurance for women and children. No effect seems unlikely, as it is reasonable to expect some fraction of women and children to lose ESI yet not manage to obtain other coverage as unemployment rates rise.

The Glied and Jack (2003) estimates for private coverage (which is mostly ESI) and public coverage (mostly Medicaid/state) are in the same direction but substantially smaller in magnitude than the other reported estimates. In addition to state unemployment rates, the study included state income per capita (log), industry composition controls, and a separate variable for labor force participation. The inclusion of additional measures

of economic conditions that are highly correlated with the unemployment rate likely contributes to a smaller estimated effect of the unemployment rate relative to the other studies. Although potential richness can be gained by including additional related measures of economic conditions, for present purposes that benefit is outweighed by the convenience of describing economic conditions with a single measure for policy simulations. The influence of other correlated aspects of the changing economy will be loaded onto the unemployment rate and its lag in estimation.

The estimates of unemployment effects from the present study are used in conjunction with population size estimates from the March 2004 CPS to simulate the number of children and adults affected by a one percentage point change in the unemployment rate. The components of the simulation are shown in Appendix Table 2. The simulated change in coverage is obtained by multiplying the total population size by the estimate of the effect of unemployment.

### Appendix References

Cawley, John, and Kosali I. Simon. "Health insurance coverage and the macroeconomy." National Bureau of Economic Research Working Paper 10092. Cambridge, MA: NBER, 2003. Available at: <http://www.nber.org/papers/w10092>.

Cutler, David. "Employee costs and the decline in health insurance coverage." National Bureau of Economic Research Working Paper 9036. Cambridge, MA: NBER, 2002. Available at: <http://www.nber.org/papers/w9036>.

Glied, Sherry, and Katherine Jack. "Macroeconomic conditions, health care costs, and the distribution of health insurance coverage." National Bureau of Economic Research Working Paper 10029. Cambridge, MA: NBER, 2003. Available at: <http://www.nber.org/papers/w10029>.

Gruber, John, and Larry Levitt. "Rising unemployment and the uninsured." Publication #6011. Washington, DC: The Kaiser Family Foundation, 2002. Available at: <http://www.kff.org/uninsured/6011-index.cfm>.

Holahan, John, and Bowen Garrett. "Rising unemployment and Medicaid." Health Policy Online No. 1. Washington, DC: The Urban Institute, 2001. Available at: <http://www.urban.org/url.cfm?ID=410306>.

Kronick, R., and T. Gilmer. "Explaining the decline in health insurance coverage, 1979-1995." Health Affairs. 18(2), 1999: 30-47.

<b>Appendix Table 1: Comparison of Unemployment Effect Estimate Across Studies</b>				
		<b>ESI</b>	<b>Medicaid/State</b>	<b>Uninsured</b>
<b>Children</b>				
Present Study		-1.034	0.638	0.418
Holahan and Garrett (2001) <sup>1</sup>			0.773	
Cawley and Simon (2003) <sup>2</sup>			1.040	0.000
<b>Adult (non-elderly)</b>				
Present study		-0.980	0.216	0.686
Holahan and Garrett (2001) <sup>1</sup>			0.235	
Cawley and Simon (2003) <sup>3</sup>	Men	-1.250		0.700
	Women	-0.780	0.680	0.030
Glied and Jack (2003) <sup>4</sup>		-0.147	0.035	
<b>All non-elderly</b>				
Gruber and Levitt (2002)				0.500

Notes: Blank cells indicate comparable figures were not available.

<sup>1</sup> Elasticities used in simulations were converted to marginal effects and evaluated at CPS sample means from the present study.

<sup>2</sup> Marginal effects from Table 4 of the study, multiplied by 100 for comparable scaling.

<sup>3</sup> Marginal effects from Table 2 (men) and Table 3 (women) of the study, multiplied by 100 for comparable scaling.

<sup>4</sup> First column is the overall marginal effect on private insurance (mostly ESI) from Table 3 of the study. Second column is the overall marginal effect on public coverage (mostly Medicaid/State) from Table 5 of the study.

**Appendix Table 2: Simulations of the Change in Population Coverage Due to a Percentage Point Change in the Unemployment Rate**

	ESI	Medicaid/State	Uninsured
<b>Children</b>			
Effect estimate (percentage point change in coverage due to 1.0 percentage point change in the unemployment rate).	-1.034	0.638	0.418
Total number of children	73,576,605	73,576,605	73,576,605
Baseline 2003 - Coverage rate	0.622	0.264	0.114
Baseline 2003 - Number of persons covered	45,740,942	19,392,130	8,373,349
Simulated 2003 - Coverage rate given change in unemployment rate	0.611	0.270	0.118
Simulated 2003 - Number of persons covered given change in unemployment rate	44,979,850	19,861,846	8,681,123
Simulated change in coverage (persons)	-761,092	469,716	307,774
Simulated percent change in coverage	-1.66%	2.42%	3.68%
<b>Adults</b>			
Effect estimate (percentage point change in coverage due to 1.0 percentage point change in the unemployment rate).	-0.980	0.216	0.686
Total number of non-elderly adults	179,132,544	179,132,544	179,132,544
Baseline 2003 - Coverage rate	0.667	0.073	0.203
Baseline 2003 - Number of persons covered	119,401,030	13,047,011	36,300,959
Simulated 2003 - Coverage rate given change in unemployment rate	0.657	0.075	0.210
Simulated 2003 - Number of persons covered given change in unemployment rate	117,645,199	13,433,871	37,530,369
Simulated change in coverage (persons)	-1,755,831	386,859	1,229,410
Simulated percent change in coverage	-1.47%	2.97%	3.39%

Source: Author's estimates based on March 2004 Current Population Survey and effects reported in Appendix Table 1.

Note: Figures may differ from direct computations because the quantities used in the simulations use more decimal places than displayed in the table.

## ENDNOTES

1 National Governors Association, *Medicaid Reform A Preliminary Report*, 15 June 2005 <http://www.nga.org/Files/pdf/0506medicaid.pdf>.

2 Vernon Smith, Neva Kaye, Debbie Chang, Jennie Bonney, Charles Milligan, Dann Milne, Robert Mollica, and Cynthia Shirk, *Making Medicaid Work for the Twenty-First Century: Improving Health and Long-Term Care Coverage for Low-Income Americans*, National Academy for State Health Policy (January 2005) [http://www.nashp.org/Files/Making\\_Medicaid\\_Work\\_for\\_the\\_21st\\_Century.pdf](http://www.nashp.org/Files/Making_Medicaid_Work_for_the_21st_Century.pdf).

3 A very different type of cap was proposed by President Clinton (but not enacted)-namely, a *per capita* cap that would have limited growth in Medicaid spending per individual recipient. That would not have limited the number of enrollees, modified the guarantee of coverage for individuals meeting their state's eligibility rules, or prevented program spending from growing in response to caseload growth. Accordingly, whatever other arguments could be made for and against a *per capita* cap, the factors discussed in this report would not apply.

4 Jeanne Lambrew, "Making Medicaid a Block Grant Program: An Analysis of the Implications of Past Proposals," *Milbank Quarterly*, vol. 83, no. 1 (26 January 2005) <http://www.milbank.org/quarterly/8301lambrew.pdf>. The first two proposals described in the text would have converted Medicaid into a block grant. Under budget proposals advanced by President Bush, each state accepting long-term spending caps would have received short-term funding increases.

5 Samantha Artiga and Cindy Mann, *New Directions for Medicaid Section 1115 Waivers: Policy Implications of Recent Waiver Activity*, *Kaiser Commission on Medicaid and the Uninsured*, Kaiser Commission on Medicaid and the Uninsured (KCMU) (March 2005) <http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=52128>.

6 See, for example, Newt Gingrich and James Frogue, "Revamp Medicaid to help minorities fare better," *Atlanta Journal-Constitution* (7 April 2005) <http://www.ajc.com/opinion/content/opinion/0405/07ednewt.html>; Michael F. Cannon, *Medicaid's Unseen Costs*, The Cato Institute (18 August 2005) <http://www.cato.org/pubs/pas/pa548.pdf>.

7 The second-largest cutback proposed is far smaller-namely, an \$87 billion restructuring of Medicare cost-sharing rules. Republican Study Committee, *RSC Budget Options 2005: Summary and Explanation of Offsets* (21 September 2005) <http://johnshadegg.house.gov/rsc/RSC%20Budget%20Options%202005.pdf> The RSC

describes itself as “a group of over 100 House Republicans organized for the purpose of advancing a conservative social and economic agenda in the House of Representatives.” *About the RSC*, <http://johnshadegg.house.gov/rsc/about.htm>.

8 Carmen DeNavas-Walt, Bernadette D. Proctor, Cheryl Hill Lee, *Income, Poverty, and Health Insurance Coverage in the United States: 2004*, U.S. Census Bureau, Current Population Report P60-229 (August 2004) <http://www.census.gov/prod/2005pubs/p60-229.pdf>.

9 John Holahan and Arunabh Ghosh, *The Economic Downturn and Changes in Health Insurance Coverage, 2000-2003*, The Urban Institute, for KCMU (September 2004) <http://www.kff.org/uninsured/upload/The-Economic-Downturn-and-Changes-in-Health-Insurance-Coverage-2000-2003-Report.pdf>.

10 When Oregon and Utah made Medicaid cuts affecting individuals with incomes below 100 percent and 150 percent of FPL, respectively, coverage was obtained through other sources by 33 percent and 37 percent, respectively, of individuals affected by those cuts. A higher proportion (49 percent) obtained other coverage in Rhode Island, which applied cuts exclusively to individuals above 150 percent of FPL. Samantha Artiga and Molly O’Malley, *Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experiences*, KCMU (May 2005) <http://www.kff.org/medicaid/upload/Increasing-Premiums-and-Cost-Sharing-in-Medicaid-and-SCHIP-Recent-State-Experiences-Issue-Paper.pdf>. Another analysis of Oregon disenrollment suggests that, in fact, more than 63 or 67 percent of people losing Medicaid could become uninsured if Medicaid enrollment were capped. Among the 33 percent of Oregon beneficiaries who obtained health insurance despite the state’s cutbacks, 39 percent shifted to a different category of Medicaid eligibility, which obviously would not be an option with a program-wide enrollment cap. Matthew Carlson and Bill Wright, *The Impact of Program Changes on Enrollment, Access, and Utilization in the Oregon Health Plan Standard Population*, Office for Oregon Health Policy and Research (March 2005) <http://egov.oregon.gov/DAS/OHPPR/RSCH/docs/OHREC.cohort-flwup.03.05.rpt.pdf>. See also Bill J. Wright, Matthew J. Carlson, Tina Edlund, Jennifer DeVoe, Charles Gallia, and Jeanene Smith, “The Impact Of Increased Cost Sharing On Medicaid Enrollees,” *Health Affairs* (July/August 2005) <http://content.healthaffairs.org/cgi/reprint/24/4/1106>.

11 See presentations at American Enterprise Institute, *9 Millions Fewer Uninsured?* (8 April 2005) Analyses by Michael O’Grady, U.S. Department of Health and Human Services; Cathi Callahan, Actuarial Research Corporation; Linda Giannarelli, Urban Institute; John Czajka, Mathematica Policy Research; Michael Davern, SHADAC, University of Minnesota; Charles Nelson, Census Bureau; and Chris L. Peterson, Congressional Research Service. [http://www.aei.org/events/eventID.1042,filter.all/event\\_detail.asp](http://www.aei.org/events/eventID.1042,filter.all/event_detail.asp).

12 Eileen R. Ellis, Vernon K. Smith, and David M. Rousseau, *Medicaid Enrollment in 50 States: June 2004 Data Update*, Health Management Associates and KCMU (September 2005) <http://www.kff.org/medicaid/upload/7349.pdf>. According to these data, the number of Medicaid enrollees grew from 30.6 million in June 1999

to 41.3 million in June 2004- an increase of 10.7 million enrollees, rather than the 9.0 million increase shown in the CPS data. If Medicaid enrollment had been capped so this caseload growth could not have taken place, and 63 percent of individuals displaced from Medicaid became uninsured as a result, then the estimated increase in uninsurance would have been 6.7 million, based on Medicaid administrative data.

13 See, for example, Kaiser Family Foundation and Health Research and Educational Fund, *Employer Health Benefits, 2005 Annual Survey* (14 September 2005) <http://www.kff.org/insurance/7315/index.cfm>; Todd Gillmer and Richard Kronick, "It's The Premiums, Stupid: Projections Of The Uninsured Through 2013," *Health Affairs*, Web Exclusive (5 April 2005) [http://content.healthaffairs.org/cgi/reprint/hlthaff.w5.143v1?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&author1=kronick&andorexactfulltext=and&searchid=1126545474420\\_2276&stored\\_search=&FIRSTINDEX=0&resourcetype=1&journalcode=healthaff](http://content.healthaffairs.org/cgi/reprint/hlthaff.w5.143v1?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&author1=kronick&andorexactfulltext=and&searchid=1126545474420_2276&stored_search=&FIRSTINDEX=0&resourcetype=1&journalcode=healthaff); Uwe E. Reinhardt, *Sailing Into the Perfect Storm: Who will come to the rescue?* Presentation at 12th Princeton Conference (19-20 May 2005) <http://sihp.brandeis.edu/council/pubs/Princeton%20XII/PRINCETON%20PDF%20CONFERENCE%20MAY%2019-20%202005.pdf>; Holahan and Ghosh (2004); and John Holahan, *Changes in Employer-Sponsored Health Insurance Coverage*, Snapshots of America's Families III, No. 9, Urban Institute (September 2003) [http://www.urban.org/UploadedPDF/310849\\_snapshots3\\_no9.pdf](http://www.urban.org/UploadedPDF/310849_snapshots3_no9.pdf).

14 Gillmer and Kronick (5 April 2005); Reinhardt, (19-20 May 2005).

15 Committee on the Consequences of Uninsurance, *Care Without Coverage: Too Little, Too Late*, U.S. Institute of Medicine (May 2002) <http://www.nap.edu/books/0309083435/html/>

16 See C. D. Mathers and D. J. Schofield, "The Health Consequences of Unemployment: The Evidence," *Medical Journal of Australia*, vol. 168:178-182 (1998); P. Martikainen, T. Volkonen, "Excess Mortality of Unemployed Men and Women during a Period of Rapidly Increasing Unemployment," *Lancet* 348: 909-912 (1996); K. A. Moser, P. O. Goldblatt, A. J. Fox, D. R. Jones, "Unemployment and Mortality: Comparison of the 1971 and 1981 Longitudinal Study Census Samples," *BMJ* 86-90 (1987); M. Linn, R. Sandifer, S. Stein, "Effects of Unemployment on Mental and Physical Health," *Am J Public Health*, 75:502-506 (1985); S. Shortt, "Is Unemployment Pathogenic? A Review of Current Concepts with Lessons for Policy Planners," *Int J Health Sci*, 26: 569-589 (1996); R. L. Jin, C. P. Shah, T. J. Svoboda, "The Impact of Unemployment on Health: A Review of the Evidence," *Canadian Medical Association Journal*, 153 (5): 529-540 (1995). Some of this research suggests that unemployment raises mortality rates by 37 percent among previously healthy workers. With or without employment, however, that mortality rate is quite low. See Mathers and Scofield, 1998.

17 D. Cohen and G. Follette, *The Automatic Fiscal Stabilizers: Quietly Doing Their Thing*, Federal Reserve Board (December 1999) <http://www.federalreserve.gov/pubs/feds/1999/199964/199964pap.pdf>.

18 Congressional Budget Office (CBO), *The Budget and Economic Outlook: Fiscal Years 2003-2012* (January 2002) <http://www.cbo.gov/ftpdocs/32xx/doc3277/EntireReport.pdf>; CBO, *Changes in Participation in Means-Tested Programs* (20 April 2005) <http://www.cbo.gov/ftpdoc.cfm?index=6302&type=1>.

19 Bureau of Economic Analysis, U.S. Commerce Department (BEA), National Income and Product Accounts (NIPA) Table, Underlying Detail Tables, *Table 3.12U. Government Social Benefits*, quarters seasonally adjusted at annual rates, (last revised 2 August 2005); NIPA Table, *Table 1.1.5. Gross Domestic Product*, seasonally adjusted at annual rates (last revised 29 July 2005) <http://www.economicindicators.gov/> Calculations by ESRI, August 2005.

20 BEA, 2005.

21 U.S. Bureau of Labor Statistics (BLS), Annual Average, Household Data Table 1, *Employment status of the civilian noninstitutional population, 1940 to date*, (BLS Unemployment) <ftp://ftp.bls.gov/pub/special.requests/lf/aat1.txt>; BLS, Consumer Price Index - All Urban Consumers, Medical Care, U.S. City Average, Series ID CUSR0000SAM, 1980-2005, [http://data.bls.gov/PDQ/servlet/SurveyOutputServlet;jsessionid=f0308b821e48s\\$3F\\$0CW](http://data.bls.gov/PDQ/servlet/SurveyOutputServlet;jsessionid=f0308b821e48s$3F$0CW).

22 The percentage of eligible children enrolled in Medicaid rose from 72 percent in 1996, before enactment of SCHIP, to 79 percent in 2002. Thomas M. Selden, Julie L. Hudson, and Jessica S. Banthin, "Tracking Changes in Eligibility and Coverage Among Children, 1996-2002," *Health Affairs* (September/October 2004) <http://content.healthaffairs.org/cgi/reprint/23/5/39>.

23 See, for example, Sara Rosenbaum, "The Olmstead Decision: Implications for State Health Policy," *Health Affairs*, vol. 19, no. 3 (September/October 2000) [http://content.healthaffairs.org/cgi/reprint/19/5/228?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&fulltext=olmstead&andorexactfulltext=and&searchid=1127446697933\\_4920&stored\\_search=&FIRSTINDEX=0&resourcetype=1&journalcode=healthaff](http://content.healthaffairs.org/cgi/reprint/19/5/228?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&fulltext=olmstead&andorexactfulltext=and&searchid=1127446697933_4920&stored_search=&FIRSTINDEX=0&resourcetype=1&journalcode=healthaff).

24 KCMU, *Medicaid: A Primer* (July 2005) [http://www.kff.org/medicaid/upload/7334%20Medicaid%20Primer\\_Final%20for%20posting-3.pdf](http://www.kff.org/medicaid/upload/7334%20Medicaid%20Primer_Final%20for%20posting-3.pdf).

25 BLS Unemployment.

26 DeNavas-Walt, et al., 2004.

27 John Holahan and Bowen Garrett, *Rising unemployment and Medicaid*, *Health Policy On-line No. 1*, The Urban Institute (2001), <http://www.urban.org/url.cfm?ID=410306>. See also John Holahan, "Health Status And The Cost Of Expanding Insurance Coverage," *Health Affairs* (November/December 2001) [http://content.healthaffairs.org/cgi/reprint/20/6/279?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&author1=holahan&andorexactfulltext=and&searchid=1127482089823\\_403&stored\\_search=&FIRSTINDEX=0&resourcetype=1&journalcode=healthaff](http://content.healthaffairs.org/cgi/reprint/20/6/279?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&author1=holahan&andorexactfulltext=and&searchid=1127482089823_403&stored_search=&FIRSTINDEX=0&resourcetype=1&journalcode=healthaff).

28 L. Chimerine, T. S. Black, and L. Coffey, *Unemployment Insurance as an Automatic Stabilizer: Evidence of Effectiveness Over Three Decades*, Coffey Communications, LLC, for U.S. Department of Labor (July 1999) Unemployment Insurance Occasional Paper 99-8. <http://wdr.doleta.gov/owsdrr/99-8/99-8.pdf>.

29 BEA, NIPA Table, *Table 3.12., Government Social Benefits* (last revised 5 August 2004) <http://www.bea.gov/bea/dn/nipaweb/TableView.asp?SelectedTable=108&FirstYear=2002&LastYear=2003&Freq=Year>.

30 The same is true of health insurance costs for each year in this period, with the exception of 1986 and 1987, when total health insurance expenditures declined. BEA, NIPA Table, *Table 3.12., Government Social Benefits* (last revised 4 August 2005) (hereinafter BEA Table 12) <http://www.bea.gov/bea/dn/nipaweb/TableView.asp#Mid>; BEA, NIPA Table, *Table 2.4.5. Personal Consumption Expenditures by Type of Product* (last revised 4 August 2005) <http://www.bea.gov/bea/dn/nipaweb/TableView.asp#Mid>.

31 CBO, *Baseline Projections of Mandatory Spending, Including Offsetting Receipts* (15 August 2005) <http://www.cbo.gov/showdoc.cfm?index=1944&sequence=0#table1-3>.

32 BEA, Table 3.12.

33 BEA Table 3.12; BLS Unemployment. Calculations by ESRI, September 2005.

34 See, for example, Isaac Shapiro, *More Than One Million Of The Unemployed Have Now Been Denied Aid Due To End Of Federal Program*, Center on Budget and Policy Priorities (25 March 2004) <http://www.cbpp.org/3-25-04ui.htm>.

35 BEA Table 3.12.

36 Marsha Lillie-Blanton, Osula Evadne Rushing, and Sonia Ruiz, *Key Facts: Race, Ethnicity & Medical Care*, Kaiser Family Foundation (update June 2003) <http://www.kff.org/minorityhealth/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14366>.

37 The bullets following in the text were calculated by ESRI in September 2005, based on U.S. Census Bureau, Current Population Survey, *2005 Annual Social and Economic Supplement*, formerly called the March Supplement, Tables H101, Health Insurance Coverage Status and Type of Coverage by Selected Characteristics: 2004; H103, Health Insurance Coverage Status and Type of Coverage by Selected Characteristics for Poor People in the Poverty Universe: 2004, and H104, Health Insurance Coverage Status and Type of Coverage by Selected Characteristics for Near-Poor People in the Poverty Universe: 2004. These tables are all available at <http://pubdb3.census.gov/macro/032005/health/toc.htm>. Near-poor individuals have incomes between 100 percent and 125 percent FPL. The numbers for black Americans include all Census interviewees who identified themselves as black, whether or not they also identified themselves as belonging to another racial or ethnic group.

38 BLS, Website Public Data Query, Series ids. LNS14000003Q, LNS14000006Q, *Seasonally adjusted, quarterly unemployment rates, Whites and Blacks*, (BLS race data) <http://data.bls.gov/PDQ/outside.jsp?survey=ln>.

39 BLS race data.

40 National Bureau of Economic Research, *U.S. Business Cycle Expansions and Contractions* (26 January 2005) <http://www.nber.org/cycles.html/>.

41 BLS race data.

42 U.S. Census Bureau, *Statistical Abstract of the United States: 2004-2005*, <http://www.census.gov/statab/www/sa04baa.pdf>, citing U.S. Bureau of Labor Statistics, *Employment and Earnings*, monthly, January 2004 issue.

43 Lawrence Mishel, Jared Bernstein, Sylvia Allegretto, *The State of Working America: 2004-05*, Economic Policy Institute (September 2004) [http://www.epinet.org/content.cfm/books\\_swa2004](http://www.epinet.org/content.cfm/books_swa2004). This is a particularly striking example of the broader economic disparity between African Americans and whites, with significantly higher rates of poverty and near-poverty in the black community. DeNavas-Walt, et al., 2004.

44 National Center for Health Statistics, *Health, United States, 2004* (December 2004), “Selected Trend Tables with Data for the Black or African American Population” <http://www.cdc.gov/nchs/products/pubs/pubd/hus/>

black.htm.

45 Committee on the Consequences of Uninsurance, May 2002.

46 OMB, *Budget of the United States Government, Fiscal Year 2006*, “Department Of Health and Human Services” <http://www.whitehouse.gov/omb/budget/fy2006/hhs.html>. One exception to this trend is administrative costs, which the president’s budget proposes to convert into a capped allotment for each state.

47 National Association of State Budget Officers, *Budget Processes In The States* (January 2002) <http://www.nasbo.org/Publications/PDFs/budpro2002.pdf>.

48 V. Smith, R. Ramesh, K. Gifford, E. Ellis, V. Wachino, *States Respond to Fiscal Pressure: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2003 and 2004*, Health Management Associates for KCMU (September 2003) <http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=22126>.

49 U.S. Department of Labor, Office of Workforce Security, Division of Legislation, *Unemployment Compensation: Federal-State Partnership* (April 2005) <http://www.ows.doleta.gov/unemploy/pdf/partnership2005.pdf>.

50 Rick McHugh, National Employment Law Project, *Background Paper on Extended Benefits: Restoring Our Unemployment Insurance Safety Net for Workers and Communities Impacted by Long Term Unemployment* (March 2001) <http://www.nelp.org/docUploads/pub66%2Epdf>,

51 Center for Medicare and Medicaid Services, *Increased Federal Medical Assistance Percentage Legislation: Questions & Answers* (Undated) <http://www.cms.hhs.gov/medicaid/mbes/fy03fmapleg.pdf>

52 KCMU, *State Fiscal Conditions and Medicaid* (November 2004) <http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=49527>. For a more detailed description of policy changes during the FY 2004 budget cycle in 10 states, see John Holahan, Teresa A. Coughlin, Randall R. Bovbjerg, Ian Hill, Barbara A. Ormond, and Stephen Zuckerman, *State Responses to 2004 Budget Crises: A Look at Ten States*, Urban Institute (February 2004) [http://www.urban.org/UploadedPDF/410946\\_StateBudgetCrises.pdf](http://www.urban.org/UploadedPDF/410946_StateBudgetCrises.pdf).

53S. 2221, 107th Congress, 2nd Session (22 April 2002). See also S. 2570, 107th Congress, 2nd Session (23 May 2002) <http://thomas.loc.gov/cgi-bin/thomas>.

54 While OMB has not formally determined an equilibrium level of unemployment, OMB projects that unemployment will stabilize at 5.0 percent, starting in 2008 and continuing thereafter. The Blue Chip Consensus forecast is somewhat more optimistic, projecting that long-term unemployment rates will begin averaging 5.0 percent one year earlier, in 2007. U.S. Office of Management and Budget, *Fiscal Year 2006: Mid-Session Review, Budget of the U.S. Government* (13 July 2005) <http://www.whitehouse.gov/omb/budget/fy2006/pdf/06msr.pdf>. Slightly less optimistic, the Congressional Budget Office forecasts that long-term unemployment rates will average 5.2 percent. See CBO, *The Budget and Economic Outlook: An Update* (15 August 2005) <http://www.cbo.gov/ftpdocs/66xx/doc6609/08-15-OutlookUpdate.pdf>. These forecasts were all published before Hurricane Katrina. While the Hurricane almost certainly will affect forecasted unemployment rates for the next year or two, it seems unlikely to change the long-term, equilibrium level for unemployment. Federal Reserve Board Open Market Committee, *Statement/Press Release* (20 September 2005) <http://www.federalreserve.gov/boarddocs/press/monetary/2005/20050920/>.

55 At least two sources of uncertainty affect the estimate of the impact of unemployment on Medicaid costs. The first is elasticity- that is, for each one percentage point increase in unemployment, what is the expected change in Medicaid enrollment for children and non-elderly adults? The second is cost- that is, for children or adults joining Medicaid because of increased unemployment, how do their average costs compare to children or adults already on the program? The range indicated in the text results from both factors. To derive that range, we first adjusted our projected impact on Medicaid enrollment to fit the elasticities reported by other researchers-elasticities that are described in the Appendix. Second, we projected a range of resulting costs that involve a 15 to 20 percent reduction in expected costs for new enrollees, compared with previous Medicaid enrollees. As explained earlier, a reduction in that general range is needed, given that new enrollees are likely to be healthier, on average, than prior enrollees. See Holahan and Garrett, 2001.

56 BLS Unemployment. Calculations by ESRI, September 2005.

57 For example, if enhanced FMAP were triggered by a national unemployment rate of 5.8 percent or more, enhanced federal match would have been paid during the second and fourth quarters of 2002 as well as all four quarters of 2003. During the second quarter of 2002 and the first quarter of 2003, the average unemployment rate was 5.83 percent and during the final quarters of 2002 and 2003, the average unemployment rate reached 5.87 percent. See BLS Unemployment.

58 BLS Unemployment.

59 For one perspective on how economic changes have reduced the country's vulnerability to recession, see *Remarks by Chairman Alan Greenspan, Economic Flexibility*, presentation to the HM Treasury Enterprise

Conference, London, England, via satellite (26 January 2004) <http://www.federalreserve.gov/boarddocs/speeches/2004/20040126/default.htm>.

60 National Bureau of Economic Research, 26 January 2005.

61 While states that cut back previous *eligibility* could not receive the temporary FMAP increase, enhanced FMAP was available for states that made other Medicaid cutbacks, including reductions in covered services, cost increases for beneficiaries, and increased procedural requirements to establish or maintain coverage. Center for Medicare and Medicaid Services, *Increased Federal Medical Assistance Percentage Legislation: Questions & Answers* (Undated) <http://www.cms.hhs.gov/medicaid/mbes/fy03fmapleg.pdf>.

