

medicaid
and the uninsured

**Medicaid, SCHIP and Economic Downturn:
Policy Challenges and Policy Responses**

Prepared by
Stan Dorn, Bowen Garrett, John Holahan, and Aimee Williams
The Urban Institute

April 2008

kaiser commission medicaid and the uninsured

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Executive Summary

As the country heads into economic downturn, 28 states (including the District of Columbia) are forecasting budget deficits for the coming fiscal year, which collectively exceed \$39 billion. Because the current downturn is following unusually quickly on the heels of the last economic slowdown, states are less well-positioned than they were in the past to withstand the adverse effects of lost revenue and increased costs. Without federal help, many states may be required to increase taxes or cut spending for Medicaid and other services to meet balanced budget requirements. Already, Medicaid and SCHIP cuts are proposed in 13 states; K-12 education is targeted in 9 states; higher education funding is proposed for reductions in 12 states; and 7 states have either increased taxes or are considering such increases. In light of these economic conditions, this paper examines:

- The effect of an economic downturn on Medicaid and SCHIP enrollment and spending as well as the number of uninsured;
- Whether past federal fiscal relief was effective in preventing Medicaid cuts and providing economic stimulus, and
- Options for structuring federal fiscal relief in the future.

The key findings of the paper are:

Economic Downturns Increase Medicaid Enrollment and Spending - This analysis shows that a 1 percentage point rise in the national unemployment rate would increase Medicaid and SCHIP enrollment by 1 million (600,000 children and 400,000 non-elderly adults) and cause the number of uninsured to grow by 1.1 million. That would increase Medicaid and SCHIP costs by \$3.4 billion, including \$1.4 billion in state spending. This represents a 1 percent increase in total Medicaid and SCHIP expenditures.

Economic Downturns Reduce State Revenues - Medicaid and SCHIP are also affected by state revenue declines. Recent Urban Institute research shows that a 1 percentage point increase in the unemployment rate causes state General Fund revenue to drop by 3 to 4 percent below expected levels. If states must balance their budgets and all state spending is reduced proportionately, a 1 percentage point increase in unemployment would therefore entail a 3 to 4 percent reduction in Medicaid and SCHIP spending. Even if these health programs absorb somewhat less than their proportionate share of state revenue losses, revenue effects clearly exceed enrollment increases as a fiscal problem for Medicaid and SCHIP.

State Policy Responses Can Worsen Cyclical Downturns - Unlike the federal government, almost all states are legally required to balance their budgets. To meet this requirement in times of economic stress, states may take such steps as tapping reserves, borrowing from trust funds, securitizing future revenue streams, delaying spending from one fiscal year to the next, etc. Even after such efforts, states frequently need to increase taxes or cut spending on Medicaid, post-secondary education, aid to localities, or other priorities. All of the latter actions tend to worsen the economic downturn.

Moreover, the need to cut Medicaid during economic decline limits the program's ability to function as an automatic fiscal stabilizer. Such stabilizers are some of the country's most effective buffers that alleviate the harmful effects of the business cycle. They automatically stimulate the economy when it weakens and retract stimulus when it improves. This feature of unemployment insurance, an automatic fiscal stabilizer with many fewer dollars than the portion of Medicaid that responds to economic changes, saves more than 130,000 jobs in the average recession's peak year. Restructuring Medicaid to achieve similar results could improve economic security while preventing cutbacks in health coverage during economic decline.

Federal Fiscal Relief in 2003-2004 Had Positive Effects - In response to the last economic downturn, which took place earlier this decade, the federal government passed the Jobs and Growth Tax Relief Reconciliation Act (JGTRRA), which provided \$20 billion in fiscal relief to states: \$10 billion in the form of block grants and the other \$10 billion in a 2.95 percentage point increase to each state's federal medical assistance percentage, or FMAP (the percentage of Medicaid spending paid by the federal government). As a condition of receiving this enhanced FMAP, states had to agree not to reduce Medicaid eligibility standards below prior levels. The FMAP increase prevented formal Medicaid eligibility cuts and allowed restoration of some previous cutbacks. In addition, reductions of other kinds were limited in scope (though not entirely eliminated), thanks to additional federal resources.

However, delays in reaching federal agreement meant that many states made large reductions before fiscal relief was available. Because states varied in the length and depth as well as the beginning and end points of their economic downturns, a uniform FMAP increase meant that some states got assistance at the wrong time and some obtained less help than they required.

Congress May Consider Options to Better Target Federal Relief - As states enter a new economic downturn, policymakers could consider three basic options for fiscal relief. One approach would, like JGTRRA, provide a uniform increase in Medicaid matching rates to all states, for a specified time.

A second option would be partially targeted. For a Congressionally defined period, states that meet certain criteria would receive a uniform increase in their Medicaid matching rates. Such an approach is proposed in the Economic Recovery in Health Care Act of 2008.

Third, policymakers could consider fully targeted assistance that would use economic conditions to determine whether a state receives help, the amount the state obtains, and the time period when assistance is furnished. Congress could provide fully targeted assistance through a temporary measure that would appropriate a specific amount of money, available for expenditure over multiple years, but only to states that meet specified criteria showing economic distress. Alternatively, policymakers could make an ongoing change to the Medicaid and SCHIP statutes that would provide automatic, countercyclical adjustments to states that experience serious economic downturns (for both the present slowdown and in the future).

For any of these three options, Medicaid federal fiscal relief could be coupled with a broader state fiscal relief package focused on more general budget problems facing the states.

Each approach for Medicaid/SCHIP fiscal relief has its advantages. The uniform approach has been tested and was generally effective, is simple, and all states would gain. A partially targeted approach would focus assistance on states with the greatest need. A fully targeted approach would provide the most money to the states in greatest difficulty, so a given amount of federal funds would go farther to preserve health coverage and provide stimulus in the states that are experiencing the deepest economic decline. It would also prevent federal funds from being spent on states that experience economic recovery.

Fully targeted policies have been proposed by General Accountability Office (GAO) and legislation reauthorizing SCHIP that the Senate passed during the summer of 2007. There are many ways to structure such a policy option, but the key principles to consider include the following:

1. Assistance would vary with the depth and length of each state's economic distress;
2. Assistance would begin and end based on changes to state economic indicators; and
3. Funds would be sufficient to offset state costs associated with increased enrollment and the Medicaid/SCHIP share of projected state revenue losses.

Federal Fiscal Relief Can Prevent Medicaid Cuts During Economic Downturns - As a new economic downturn unfolds, many states appear headed for serious budget shortfalls. Economic hard times reduce state revenues and increase the number of people who qualify for need-based benefit programs. Because of state balanced budget requirements, these trends eventually cause many states to increase taxes and fees or cut Medicaid, SCHIP, and other services precisely when such services and the resulting economic stimulus are most needed. The federal government does not have balanced budget requirements, so it has the flexibility to target supplemental funds to states during an economic downturn, preventing harmful and ill-timed cuts in health coverage. Regardless of how federal policymakers structure assistance, state fiscal problems are emerging that warrant serious consideration as part of an ongoing national strategy to minimize the duration, severity, and consequences of economic downturn.

Medicaid, SCHIP and Economic Downturn: Policy Challenges and Policy Responses

1. Introduction

As a new economic downturn unfolds, the National Governors Association,¹ legislators in both Houses of Congress,² and key stakeholder groups³ are urging federal policymakers to provide states with federal resources that can be used to stave off Medicaid cutbacks. This paper analyzes whether such resources are needed and, if so, how they could be deployed. We begin by exploring the relationship between economic slowdowns and health coverage programs like Medicaid and the State Children's Health Insurance Program (SCHIP). We then describe what happened in 2003-2004, when states received extra federal resources to help cover increased Medicaid costs associated with economic downturn. Finally, we analyze current policy options available to Congress if it decides to provide states with new resources to prevent reductions in Medicaid and SCHIP coverage.

Of course, states are adversely affected by economic downturns in ways that extend well beyond Medicaid and SCHIP. Cuts in other programs and state tax increases can, like health coverage reductions, deepen or prolong recession while increasing the adverse impact of economic downturn on state residents. In response, Congress could follow the general example set earlier this decade, which combined state fiscal relief targeted to health coverage with a more general block grant, as explained in detail below. This paper focuses only on fiscal relief measures targeted to Medicaid and SCHIP.

2. Economic Downturns and Health Insurance Coverage

Health coverage and the business cycle affect one another in three different ways. First, when the economy slows down or goes into recession, many people lose employer-sponsored insurance. This raises the number of uninsured as well as the number of people who qualify for Medicaid and SCHIP,⁴ increasing publicly funded health care costs. Second, at the same time that unemployment drives up state costs for Medicaid and other need-based assistance, state revenues decline. Because of state balanced budget requirements, Medicaid and other assistance is most likely to be cut when state residents have the greatest need for help. Third, Medicaid's responsiveness to changed economic conditions acts as an automatic fiscal stabilizer, stimulating the economy in response to downturn and withdrawing that stimulus when beneficiaries obtain employment and leave Medicaid for employer-sponsored insurance. Such capacity to act as an automatic fiscal stabilizer could be strengthened if states received federal resources that prevented Medicaid cutbacks during economic downturns. Before we explore any of these general relationships between health programs and the economy, we briefly describe current fiscal conditions at the state level.

A. Emerging State Budget Problems

The economy is clearly in a downturn and possibly a recession.⁵ As one would expect, that has repercussions for state budgets. For the coming fiscal year, 28 states (including the District of Columbia) anticipate budget deficits, which collectively exceed \$39 billion.⁶ Three other states

anticipate deficits beginning the following year. Without federal help, state balanced budget requirements will force many states to increase taxes or cut Medicaid, SCHIP, or other services.

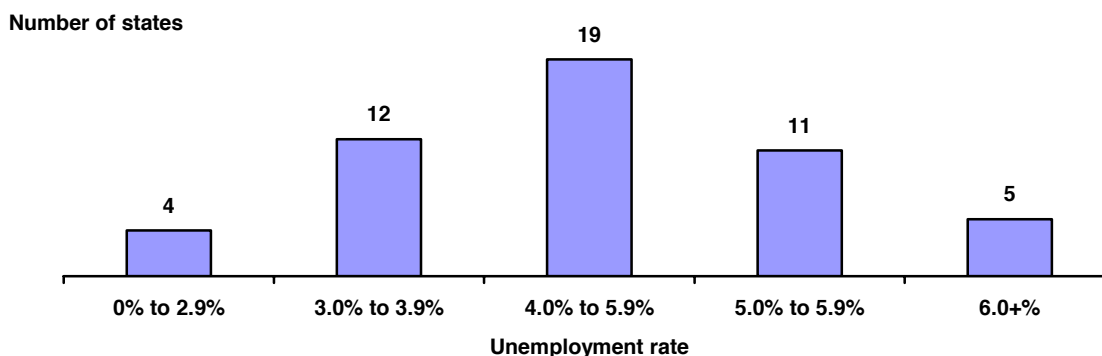
This round of state budget problems may present particular challenges to state policymakers, for several reasons. First, many states have less capacity than in the past to make relatively painless reductions. The three previous economic downturns occurred roughly once a decade – in the early 1980s, the early 1990s, and the early years of the current decade. The present downturn is beginning with approximately half that much time having elapsed since the last economic slowdown. Accordingly, compared to previous downturns, states have restored fewer prior reductions to Medicaid and other services.⁷ This new round of cutbacks will therefore be made against a lower baseline service level.

Second, many localities are experiencing significant fiscal difficulty. Most cities depend on property tax revenues, which can be disproportionately affected by the problems of the housing market that are a driving force in the current downturn. According to the National League of Cities, 62 percent of cities have seen an increase in foreclosures, and 33 percent are experiencing or projecting a drop in revenue, compared to one year ago.⁸ In prior slowdowns, by contrast, housing was an area of economic strength, helping limit fiscal damage. Compared to past downturns, states now have less capacity to address their budget challenges by shifting responsibilities to localities or cutting their aid.

Already, Governors and other state officials are proposing significant cutbacks. Medicaid and SCHIP cuts are proposed in 13 states; K-12 education is targeted in 9 states; higher education funding is proposed for reductions in 12 states; and 7 states have either increased taxes or are considering such increases.⁹

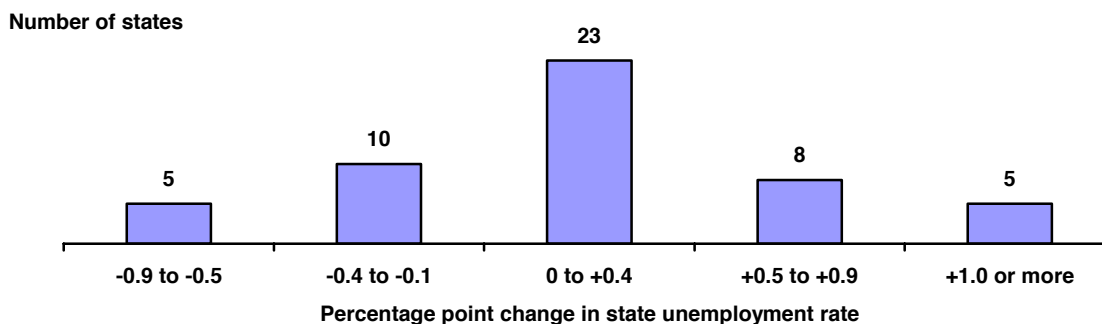
While serious budget problems loom in many places, state circumstances vary. For January 2008, when the national unemployment rate was 4.9 percent, 5 states had unemployment rates of 6.0 percent or more, while 4 states had unemployment rates under 3.0 percent (Figure 1). From January 2007 to January 2008, 15 states experienced a decline in unemployment, while 13 experienced increases of 0.5 percentage points or more (Figure 2). (As with all figures in this paper that depict the numbers of states that fit various categories, the District of Columbia is counted as a state.)

FIGURE 1. NUMBER OF STATES WITH UNEMPLOYMENT RATES AT VARIOUS LEVELS: JANUARY 2008



Source: Bureau of Labor Statistics, February 2008, reporting seasonally adjusted unemployment rates.

FIGURE 2. NUMBER OF STATES EXPERIENCING VARIOUS CHANGES IN UNEMPLOYMENT RATES: JANUARY 2007 TO JANUARY 2008



Source: Authors' calculations, BLS seasonally adjusted unemployment rates.

Note: many of these changes were not statistically significant, according to BLS. Among states experiencing statistically significant changes in unemployment rates from January 2007 to January 2008, 19 states experienced increased unemployment and 4 experienced declines.¹⁰

B. Economic Downturns, Changes in Insurance Coverage, and Medicaid Spending

Much of Medicaid spending is independent of the business cycle. Unemployment has the least effect on enrollment among the elderly and disabled, whose care comprises the bulk of Medicaid spending. Nevertheless, important portions of Medicaid and SCHIP respond to changes in the business cycle. As unemployment increases, workers and dependents may lose access to employer coverage; this can happen through unemployment, through employer reductions in subsidies paid for health coverage, through reduced eligibility for employer-sponsored insurance (ESI) because of fewer hours of employment, etc. Some who lose employer-based coverage become uninsured, potentially increasing state and local uncompensated care costs. Others enroll in a spouse's employer plan, non-group coverage, or, if eligible, Medicaid or SCHIP. The following is a brief discussion of our methods and findings as we sought to quantify those relationships. Our methods are explained in more detail in Appendix I.

We examined state-level data from multiple years (1990 through 2003) of the Current Population Survey (CPS) as well as other sources. We estimated regression models of coverage rates for four coverage types-- ESI, Medicaid/SCHIP (also including other state-funded coverage), non-group private coverage, and a lack of health coverage. The models were structured to estimate the relationship between each type of coverage and the unemployment rate. We then projected what insurance coverage would be in 2008 in the absence of an economic downturn. Using the regression models, we estimated the impact of unemployment on the number of adults and children in each coverage category, including Medicaid and SCHIP. We then used Medicaid and SCHIP spending data, adjusted for expected differences between the health status of previous and new enrollees, to estimate the impact on these programs' expenditures.

The Effects of Rising Unemployment on Coverage – For children, the results shown in Table 1 show that a 1.0 percentage point increase in the seasonally adjusted unemployment rate would cause the proportion of children receiving employer-sponsored insurance to fall by 0.95 percentage points but Medicaid/SCHIP coverage to increase by 0.79 percentage points. Changes in non-group coverage and uninsurance were not statistically significant. These results indicate that broad coverage through Medicaid and SCHIP offsets most of children’s decline in ESI during an economic downturn.

For adults under age 65, the picture is somewhat different. A 1.0 percentage point rise in the unemployment rate would reduce the proportion of adults with employer-sponsored insurance by 0.92 percentage points. The proportion of adults receiving Medicaid would rise by 0.20 percentage points, non-group coverage would increase by 0.18 percentage points, and the percentage of adults without coverage would grow by 0.59 percentage points. Because Medicaid and SCHIP provide much less coverage for adults than for children, newly unemployed adults are more likely, compared to children, to end up with non-group coverage or to become uninsured.

TABLE 1. THE ESTIMATED EFFECT OF A 1 PERCENTAGE POINT INCREASE IN THE UNEMPLOYMENT RATE ON THE PERCENTAGE OF CHILDREN AND NON-ELDERLY ADULTS WITH VARIOUS TYPES OF HEALTH COVERAGE

	Children	Non-elderly adults
ESI	-0.95 percentage points	-0.92 percentage points
Medicaid/SCHIP	+0.79 percentage points	+0.20 percentage points
Uninsured	No statistically significant change	+0.59 percentage points
Non-group coverage	No statistically significant change	+0.18 percentage points

Source: Urban Institute, February 2008.

Note: ESI is employer-sponsored insurance.

As shown in Table 2, below, we concluded that, with a 1.0 percentage point increase in unemployment, the number of children and adults with employer-sponsored-insurance in 2008 would decline by 700,000 and 1.7 million, respectively. The number of children on Medicaid and SCHIP would increase by 600,000; the number of adults would rise by 400,000. The lesser increase in adult enrollment reflects both the smaller estimated effect of increased unemployment as well as the lower number of Medicaid-covered adults, relative to children receiving Medicaid or SCHIP. The number of uninsured adults would rise by 1.1 million.

TABLE 2. THE NATIONAL IMPACT OF A 1 PERCENTAGE POINT INCREASE IN UNEMPLOYMENT ON THE NUMBER OF CHILDREN AND NON-ELDERLY ADULTS WITH VARIOUS TYPES OF HEALTH COVERAGE: 2008

	Children	Non-elderly adults	Total
ESI	-700,000	-1.7 million	-2.5 million
Medicaid/SCHIP	+600,000	+400,000	+1.0 million
Uninsured	No statistically significant change	+1.1 million	+1.1 million
Non-group coverage	No statistically significant change	+300,000	+400,000

Source: Urban Institute, February 2008.

Notes: (1) ESI is employer-sponsored insurance. (2) Totals may not add because of rounding and changes that, disaggregated, are less than statistically significant.

Impacts on Medicaid Expenditures - Based on current Medicaid/SCHIP spending on adults and children, as explained above, we concluded that the 2008 cost per new Medicaid/SCHIP enrollee would be \$2,313 for children and \$5,386 for adults. Multiplying these cost estimates by the changes in coverage shown in Table 2, we found that Medicaid/SCHIP spending would increase by \$1.4 billion for children and \$2.0 billion for non-elderly adults, for an overall increase of \$3.4 billion. This would represent a 1 percent rise in total Medicaid/SCHIP spending.

The states' share of national Medicaid spending was about 43 percent. Taking into account SCHIP's higher federal matching rate, we estimated that state Medicaid and SCHIP spending would increase by about \$1.4 billion for each 1.0 percentage point increase in the unemployment rate (Table 3).

TABLE 3. THE NATIONAL IMPACT OF A 1 PERCENTAGE POINT INCREASE IN UNEMPLOYMENT ON PROJECTED MEDICAID AND SCHIP COSTS: 2008

		Children	Non-elderly adults	Elderly adults	Total
Baseline projected costs	Total	\$70.9 billion	\$193.2 billion	\$71.6 billion	\$335.6 billion
	State share	\$29.5	\$83.1	\$30.8	\$143.3
Additional costs for each 1.0 percentage point increase in unemployment rates	Total	\$1.4	\$2.0	\$0	\$3.4
	State share	\$0.6	\$0.9	\$0	\$1.4
	Percentage increase	2.0 percent	1.0 percent	0.0 percent	1.0 percent

Sources: Urban Institute, February 2008; Congressional Budget Office, March 2007 Medicaid and SCHIP baselines.

Notes: (1) ESI is employer-sponsored insurance. (2) Totals may not add because of rounding. (3) The cost increases for children, including the state share of such costs, assume the increase is divided between Medicaid and SCHIP in proportion to each program's current aggregate spending on children. (4) This table underestimates the impact of unemployment on Medicaid costs because it does not include any change in seniors' enrollment. We expect any effects on seniors' enrollment to be smaller than for the non-elderly population.

C. The impact of State Balanced Budget Requirements on Sustaining Medicaid and SCHIP During Economic Downturns

Revenue Effects Have Serious Consequences for Medicaid - Not only do caseloads for Medicaid and other need-based programs rise during economic downturns, state revenues decline. According to recent Urban Institute research, each 1 percentage point increase in unemployment rates leads to a 3 to 4 percent average decline in state General Fund revenue, compared to projected levels.¹¹ Assuming that, because of state balanced budget requirements, state revenues generally equal state spending, Medicaid and SCHIP would experience 3 to 4 percent cutbacks if the revenue decline from a 1 percentage point increase in unemployment were distributed evenly across all state programs. Even if Medicaid and SCHIP absorb somewhat less than their proportionate share of revenue losses, revenue effects would still exceed increases in Medicaid and SCHIP costs during an economic downturn.

Because almost all states are legally required to balance their budgets, the loss of revenue and increase in expenditures resulting from economic downturn often lead to significant cuts to Medicaid and other state programs that are intended to help vulnerable populations.¹² Accordingly, it is precisely when state residents have the greatest need for help that assistance is most likely to be cut back.

In states that spare Medicaid and other need-based programs, cutbacks may affect other areas important to long-term economic growth, including higher education. Some states raise taxes or cut aid to localities. Such steps can delay economic recovery.

Medicaid Cuts Can Occur Late in an Economic Cycle - Depending on the state, the most painful measures may take place relatively late in economic downturns. Before state officials take drastic steps, they may spend from “rainy day funds;” borrow from special budget accounts (promising to repay them after the economy returns to normal); securitize future income streams; impose a hiring freeze on state employees; delay certain expenses from one fiscal year to the next; etc. Some states exhaust such steps before turning to major Medicaid cutbacks and other severe measures to bring their budgets into balance.

Medicaid and SCHIP cutbacks can also be delayed because of their effect on federal matching funds. Eliminating a dollar in Medicaid spending saves no more than 50 cents in state General Fund money and, in the poorest states with the highest federal matching rates, less than 30 cents. This means that more severe cuts are needed to save a given sum of state dollars through Medicaid reductions than for cutbacks in other services, which deters some state policymakers from turning quickly to large Medicaid savings.¹³

Of course, this sequence is not universally applicable. Some state policymakers may prefer to cut programs that serve low-income people before raising taxes or reducing services for middle-class constituents. A number of states are already considering Medicaid cutbacks, even at this early stage of the current economic downturn, as explained above.

D. Medicaid's Impact on the Economy

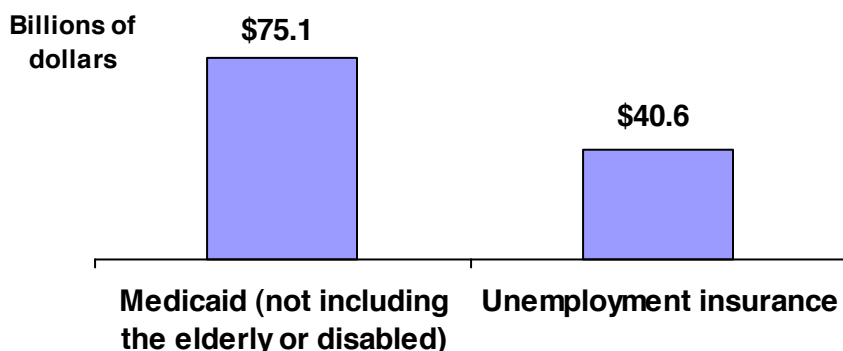
As with other state spending, Medicaid dollars stimulate local economies. This health coverage program has an especially pronounced impact, however. It brings matching federal funds into the state, generating economic activity with between \$1 and \$3 in matching federal dollars for each dollar spent by the state, depending on the state's Federal Medical Assistance Percentage (FMAP), which is the proportion of Medicaid costs paid by the federal government. In addition, a higher proportion of money spent to purchase health care remains within the state, compared to money spent on general goods and services, more of which tend to originate outside state boundaries.¹⁴

As noted above, changes in unemployment affect health spending. When the economy declines, Medicaid spending rises. When the economy improves, Medicaid continues to grow but at a slower rate. Medicaid is thus widely acknowledged to function as a countercyclical, automatic fiscal stabilizer.¹⁵ Because such stabilizers inject and withdraw stimulus in an automatic response to economic changes, without waiting for a decision by policymakers, they avoid the problem of poor timing that notoriously afflicts discretionary fiscal policy.¹⁶

No rigorous research analyzes the magnitude of Medicaid's economic contributions during recession. However, there is a good chance that it already plays a critical role ameliorating economic downturns. With another automatic fiscal stabilizer – unemployment insurance (UI) -- careful macroeconomic simulations have concluded that it mitigates the loss in real GDP by 15 to 17 percent and saves more than 130,000 jobs in the average recession's peak year.¹⁷

While no comparable simulations have quantified the countercyclical impact of Medicaid, the portion of this program that serves low-income families may play a role like UI's. UI and Medicaid are the two state programs most affected by changes in the business cycle.¹⁸ The Medicaid eligibility categories that are most responsive to unemployment – namely, children and low-income adults – involve significantly more funding than does UI (Figure 3).

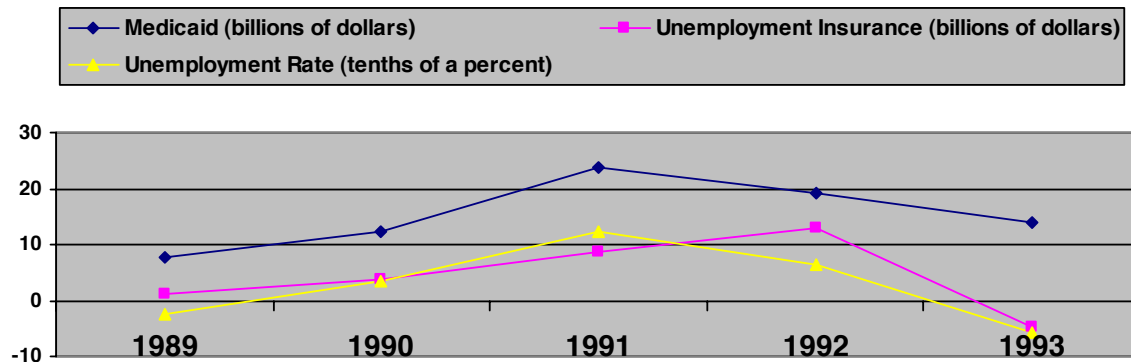
FIGURE 3. MEDICAID SPENDING ON CHILDREN AND LOW-INCOME FAMILIES VS. TOTAL SPENDING ON UNEMPLOYMENT INSURANCE: FY 2004



Sources: The Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on data from Medicaid Statistical Information System reports from the Centers for Medicare and Medicaid Services, 2007; authors' calculations, UI benefit and extended benefit totals from 4th quarter of calendar 2003 through 3rd quarter of calendar 2004, U.S. Department of Labor.

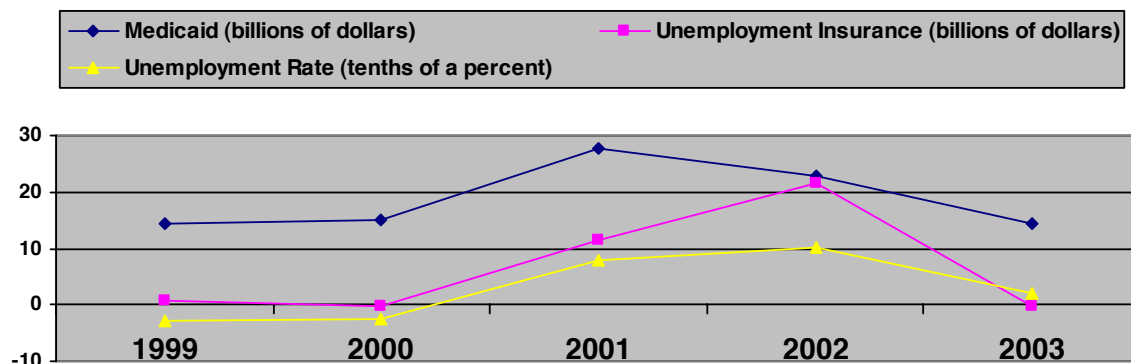
Moreover, during the last two economic downturns, the increase in Medicaid spending associated with increased unemployment was larger than the increase in UI expenditures (Figures 4 and 5).

FIGURE 4. CHANGES IN MEDICAID SPENDING, UNEMPLOYMENT INSURANCE SPENDING, AND UNEMPLOYMENT RATES: 1989–1993



Source: Authors' calculations, Bureau of Economic Analysis National Income and Product Account data (NIPA data)¹⁹ and BLS annual unemployment rates.

FIGURE 5. CHANGES IN MEDICAID SPENDING, UNEMPLOYMENT INSURANCE SPENDING, AND UNEMPLOYMENT RATES: 1999–2003



Source: Authors' calculations, NIPA data and BLS annual unemployment rates.

While this analysis has many serious limitations,²⁰ the numbers are suggestive. Medicaid's current macroeconomic effects may be comparable to UI's, in general magnitude. Moreover, Medicaid could play a more effective role as an automatic fiscal stabilizer if federal policy were changed to reduce states' need to make cutbacks during economic hard times. Such a change could enhance the country's ability to recover from economic downturns.

3. Prior Policy Response: 2003-2004 FMAP Increase

Because of the economic downturn that began in 2001, Medicaid enrollment grew and state revenues declined, continuing well into fiscal 2004. In the early years of the economic slowdown, many states responded by increasing revenues in various ways. States like Massachusetts and New York raised income taxes, other states increased user fees, and a number of states applied new provider taxes, which, when coupled with higher Medicaid reimbursement rates, had the effect of generating additional federal matching payments. Some states also tapped into “rainy day” funds, securitized tobacco settlement dollars, and borrowed from trust funds.²¹

But these measures were not sufficient to offset state revenue declines. To address budget shortfalls, states cut their Medicaid spending by scaling back benefits, freezing or trimming provider payment levels, and reducing eligibility. With state revenues continuing to decline well after the recession was declared officially over in November 2001, Congress eventually passed the Jobs and Growth Tax Relief and Reconciliation Act (JGTRRA) of 2003. The law was enacted in May 2003 and provided \$20 billion in fiscal relief to states. JGTRRA furnished half of this money, based on state population, in the form of block grants usable “to provide essential government services and to cover the costs of complying with any federal intergovernmental mandate.” The other half was spent to increase federal matching payments under Medicaid.²²

At the time, standard FMAP payments under Medicaid varied from 50 percent in the highest-income states to 77 percent in Mississippi, the lowest-income state. The FMAP represents the percentage of Medicaid costs paid by the federal government. On average, the federal government paid about 57 percent of all Medicaid spending. The JGTRRA increased each state’s FMAP by 2.95 percentage points during the last two quarters of federal fiscal year 2003 (April 1, 2003 – September 30, 2003) and the first three quarters of federal fiscal year 2004 (October 1, 2003 - June 30, 2004). On July 1, 2004, the temporary matching rate increases expired, and all states saw their FMAPs return to normal levels. JGTRRA required that, to qualify for the temporary FMAP increase, a state needed to maintain the formal Medicaid eligibility standards that were in place on September 2, 2003.

The temporary FMAP increase reduced the extent of cutbacks to Medicaid and SCHIP, preserving health coverage and providing stimulus during the time period covered by the legislation. As a result of the maintenance of effort requirement for eligibility standards, states avoided planned eligibility reductions and restored cuts that were made after September 2, 2003.²³ Surveys by the Kaiser Commission on Medicaid and the Uninsured and the National Association of State Budget Officers found that:²⁴

- 22-25 states used these resources to avoid, lessen, or postpone Medicaid cutbacks; and
- 5-7 states used these resources to restore previous Medicaid cutbacks or make other program expansions.

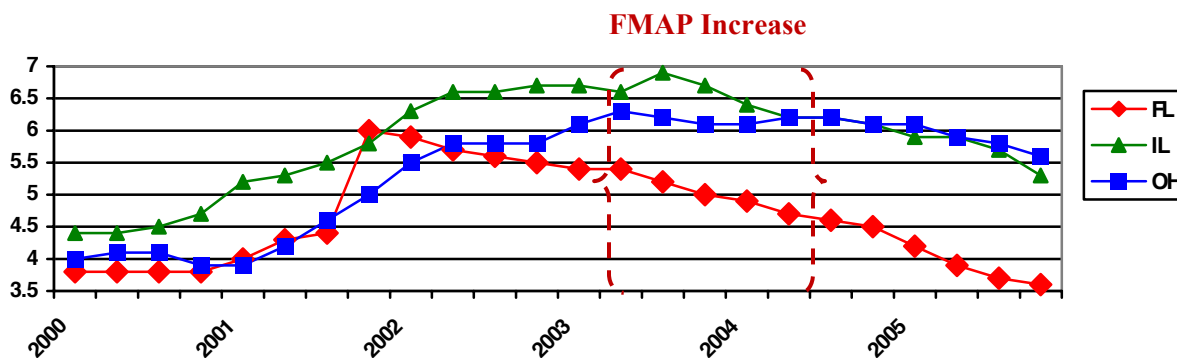
While states still made some Medicaid cuts when JGTRRA was in effect, state officials reported that the reductions would have been even greater without the federal funding.²⁵ Some of the policy changes that were made to control Medicaid spending included provider rate cuts and freezes, new co-payments, more aggressive use of inter-governmental transfers to increase

federal matching payments through supplemental reimbursement programs, and administrative policy changes to reduce the number of Medicaid beneficiaries by making it harder to enroll or remain covered. SCHIP was not affected by the FMAP legislation, and some states cut SCHIP eligibility or capped enrollment.²⁶

Most states used these funds to pay for Medicaid spending. However, because the economy in Florida had largely recovered by the time fiscal relief was provided, that state spent its enhanced FMAP for other purposes, including economic development projects and building up state reserves.²⁷

Finally, while JGTRRA greatly reduced the extent of health coverage cutbacks after it came into effect, delays in reaching federal agreement meant that the relief was not well timed for many states. It took more than year of debate for federal policymakers to reach agreement on JGTRRA.²⁸ Since the legislation was enacted relatively late during the economic downturn, most states had already made substantial Medicaid cuts.²⁹ If fiscal relief had been available sooner, many of these cuts may not have been necessary. More broadly, a uniform, Congressionally-determined period of assistance meant that aid was unavailable if states needed help at other times. Among large states, for example, the enhanced FMAP missed all five quarters in which unemployment in Florida reached 5.5 percent or more; it missed the final four out of the nine quarters in which unemployment in Ohio was above 6.0 percent; and it missed the first three out of the seven quarters in which unemployment in Illinois exceeded 6.5 percent (Figure 6).

FIGURE 6: AVERAGE QUARTERLY UNEMPLOYMENT RATES IN FLORIDA, ILLINOIS, AND OHIO AND THE TEMPORARY FMAP INCREASE: 2000-2005



Source: Authors' calculations from Bureau of Labor Statistics monthly, seasonally adjusted unemployment rates, January 2008.

4. Current Policy Options

Some federal policymakers are considering options for providing state fiscal relief during the current economic downturn.³⁰ To help states avert cutbacks to Medicaid and SCHIP, lawmakers could enact a uniform approach like that used in JGTRRA, which provides all states with the identical level of assistance for a Congressionally-defined period of time; a partially targeted approach that limits assistance to states in distress but provides each such state with the identical level of assistance for a Congressionally-defined period of time; or a fully targeted approach that uses economic conditions to determine the states that receive help, the amount of assistance, and the timing of fiscal relief.

A. Uniform Approach to Medicaid/SCHIP Fiscal Relief

If federal policymakers decide to provide states with fiscal relief to avert cuts to Medicaid and SCHIP, a uniform approach like that used in JGTRRA has several advantages. First, guaranteed federal dollars provided to every state through a uniform formula could help assure that nationwide political forces support the policy change. This is one of several factors increasing this approach's likelihood of enactment. Second, a uniform approach to distributing funds is simple, which also eases enactment. By contrast, basing fiscal relief payments on state economic conditions may involve legislative specifications with considerable complexity, as is made clear below. Third, the uniform FMAP increase during the prior economic downturn is widely viewed as having generally positive effects. Repeating a prior, successful policy has considerable appeal to policymakers since it builds on a positive track record. Finally, federal costs are relatively predictable under this approach, since the amount of federal assistance does not depend on how the economy fares in each state; federal costs are not *entirely* predictable, however, since the level of state Medicaid spending determines the amount of federal fiscal relief.

B. A Partially Targeted Approach to Medicaid/SCHIP Fiscal Relief

The JGTRRA approach could be modified to set criteria that states must satisfy to qualify for fiscal relief. Each state meeting the criteria would receive the same level of help, for a period of time that would be defined by Congress. For example, the Economic Recovery in Health Care Act of 2008 (S. 2819) would provide five quarters of federal fiscal relief to a specified number of states with the highest annual decreases in employment, increases in food stamp participation, and increases in foreclosure rates.³¹ Each qualifying state would receive a uniform (1.667 percentage point) increase in its federal matching rate. In addition, the bill would provide these states with federal block grants usable for a broad range of purposes. This approach combines some advantages and disadvantages of both the uniform approach, described above, and a fully targeted policy, analyzed in the following section.

C. A Fully Targeted Approach

Under a fully targeted approach, changes in unemployment rates or other economic indicators would trigger the timing and extent of enhanced federal matching funds. If the policy is structured effectively, assistance begins when it is needed and ends when economic conditions return to normal. States in difficult circumstances are not denied help while federal policymakers

take the time required to hammer out an agreement and supplemental federal resources do not continue after economic health is restored.

With a fixed amount of federal funds available for Medicaid-related stimulus, a fully targeted policy means that the states in the most trouble receive more help than under other approaches. Greater assistance for states experiencing economic difficulty means less need to cut health coverage. According to the Congressional Budget Office, a more targeted approach that reduces the total amount of health cutbacks provides more effective economic stimulus.³² Focusing federal dollars on states experiencing the greatest level of economic distress likewise directs stimulus to the geographic areas where it is most needed.

Compared to a uniform increase in match rates, a fully targeted approach would greatly reduce possible mismatches between state need and federal dollars. Like the partially targeted policy described above, this approach may appeal to policymakers who are concerned about the federal budget deficit, since it limits federal spending to states that need assistance. As noted above, state circumstances vary greatly today, so giving the same amount of help to every state would assist some that are doing fine while other states that are in serious trouble receive much less than they need.

Of course, the fully targeted approach is more responsive to state circumstances than is the partially targeted strategy. Only a fully targeted program would provide well-timed help to states that experience their deepest economic harm outside the period when a partially targeted policy would provide assistance. By the same token, if a state that is now in trouble remains in economic difficulty for only one or two more quarters, federal assistance will nevertheless continue, under the partially targeted approach. With the fully targeted approach, by contrast, assistance ends in each state once its economic conditions return to normal.

Poorly targeted stimulus can exacerbate macroeconomic problems, even during a national economic downturn. If fiscal relief dollars go to states with relatively healthy economies, the federal deficit can increase without the countervailing advantage of providing stimulus by preventing Medicaid cutbacks in an area of the country experiencing economic distress. An increased federal budget deficit ultimately increases long-term interest rates, harming economic growth.³³ As applied specifically to state fiscal relief, such effects would be quite small, relative to the entire federal budget deficit and U.S. economy. However, Medicaid/SCHIP fiscal relief could be part of a much larger package of stimulus legislation; policymakers may wish to avoid federal spending, in any portion of such a package, that is not effective in providing necessary stimulus.

A more targeted approach can also yield significant benefits when, as now, the country is beginning an economic downturn. Many of the largest Medicaid cutbacks may take place at the later stages of an economic slow-down, well after a formal recession has ended, as explained above. A short, fixed-term stimulus package runs the risk of ending before it is most needed. By contrast, a mechanism of longer duration that reserves assistance to states experiencing significant difficulty can potentially help with the later stages of the current downturn.

Temporary vs. Ongoing Duration of Fully Targeted Assistance – Policymakers could provide fully targeted aid through temporary federal legislation, which can be tailored to fit the unique features of the current economic downturn and which can limit, more reliably than any other approach, the federal government’s cost exposure. For example, such legislation might appropriate a specific amount of federal funds that could be used during the current or subsequent fiscal years. Such dollars would be spent only when a state’s economic conditions met requirements specified in the legislation. If a state qualified for aid during a particular quarter, its assistance would be included as an adjustment to its Medicaid matching funds for that quarter.

Alternatively, policymakers could adjust the ongoing structure of Medicaid and SCHIP to provide automatic, countercyclical adjustments during economic downturns, both with the present slowdown and in the future. If done properly, the latter approach would:

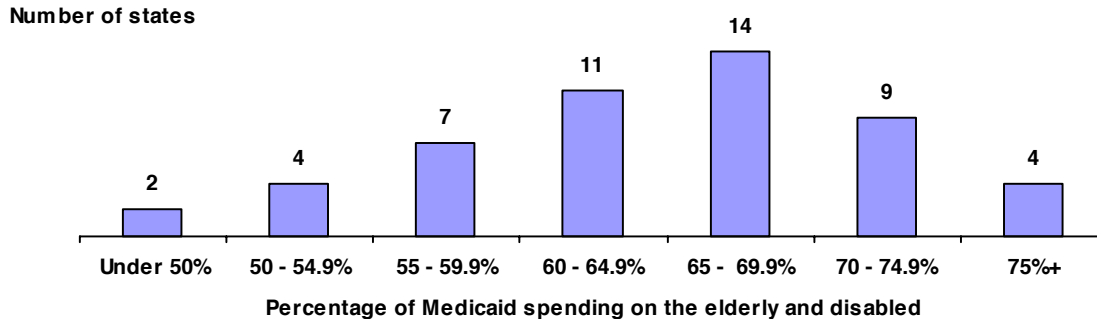
- Eliminate the need for Congress to revisit this issue if the current downturn lasts more than five quarters;
- Eliminate the need for future Congresses, at least once per recession, to decide whether and, if so, how to provide Medicaid-related state fiscal relief;
- Help the program serve as an automatic fiscal stabilizer, aiding economic recovery during the current and future downturns; and
- Both in future downturns and if the current slowdown lasts more than five quarters, avoid the delays that are inevitable when elected officials must take the time required to agree on a new federal statute.

Designing a Fully Targeted Fiscal Stimulus Policy – Whether on a temporary or an ongoing basis, if policymakers wish to employ a fully targeted approach to providing federal assistance, several policy design issues are important to consider:

- *A Duration of Federal Assistance that is Sufficient but Not Excessive.* Policymakers may wish to make federal funds available throughout a multi-year economic downturn, including its latter stages, after recession has formally ended. As noted above, Medicaid cutbacks often take place towards the end of a period of economic slowdown. Funding would need to end immediately once a state’s economy returns to normal.
- *Cyclical Focus.* The goal of this approach is to help states with cyclical economic problems, not structural changes that are independent of the business cycle. That goal can be largely achieved by limiting federal assistance to periods in which more than a certain number of states are experiencing economic difficulty. Structural changes outside a downturn in the general business cycle include, for example, the effect on North Carolina of textile mill closures several years ago. These types of structural issues could be addressed by approaches other than those discussed in this paper.³⁴
- *An Amount of Assistance that Reflects State Economic Conditions.* Assistance would compensate for two distinct fiscal problems – namely, increased health care costs and the Medicaid and SCHIP programs’ share of reduced state revenue. Both of these components would need to be carefully defined:

- *The Downturn-Generated Increase in Health Care Costs.* The amount of federal funds a state receives for such expenses would be based on expected increases in state Medicaid and SCHIP costs. This needs to take into account each state's spending on the populations most likely to be affected by economic downturn – namely, low-income children and families.³⁵ States differ greatly in the proportion of Medicaid and SCHIP spending devoted to these eligibility groups (Figure 7).

FIGURE 7. THE NUMBER OF STATES WITH VARIOUS PERCENTAGES OF MEDICAID SPENDING ON THE POPULATIONS LEAST AFFECTED BY CHANGES IN THE BUSINESS CYCLE: FISCAL YEAR 2004



Source: Authors' calculations, using the Urban Institute and KCMU estimates based on data from Medicaid Statistical Information System reports from the Centers for Medicare and Medicaid Services, 2007.

- *Medicaid's Share of Reduced State Revenue.* If policymakers wish to prevent Medicaid and SCHIP cutbacks during recession, states need to be compensated for these health programs' share of revenue shortfalls.³⁶ For example, a state's FMAP could be increased by an amount that equaled, for each 1 percentage point increase in a state's unemployment rate, 3 to 4 percent of the state's share of Medicaid and SCHIP costs.

Examples of Specific Approaches to Fully Targeted Relief. Fully targeted fiscal relief proposals have been proposed by the Government Accountability Office (GAO)³⁷ and in legislation reauthorizing SCHIP³⁸ that the Senate passed during the summer of 2007. To illustrate the range of options and some key policy choices facing policymakers pursuing this approach, we have developed a series of variations on the GAO and Senate SCHIP formulas. These variations are described in detail in Appendix II and summarized in Table 4, below. While these formulae all use state unemployment rates as the key factor that determines a state's access to fiscal relief, similar policy design issues would arise if state economic conditions were measured using other criteria, such as those proposed in S. 2819.

TABLE 4. ALTERNATIVE APPROACHES TO STRUCTURING MEDICAID-RELATED FISCAL RELIEF

	DEFINITION OF CURRENT ECONOMIC CONDITIONS	BASELINE TO WHICH CURRENT CONDITIONS ARE COMPARED	REQUIREMENTS FOR FISCAL RELIEF		AMOUNT OF ASSISTANCE
			NATIONAL	STATE	
2003-2004 FMAP Increase	Not applicable. Each state received funding for each quarter covered by the legislation.				
Economic Recovery in Health Care Act of 2008	Average employment, food stamp participation, and foreclosure rate during most recent quarter or 3 months	The same period, 1 year in the past	Funding is available for five quarters, beginning in the second calendar quarter of 2008.	The 28 states with the highest average economic decline, as of 4/1/08, receive 5 quarters of aid. The 38 states with the highest decline, as of 10/1/08, receive 3 quarters of aid.	Each state received same increase Qualifying states receive the same increase
GAO I	The average unemployment rate during the 12 months ending in the quarter	The same period, 1 year in the past	At least 23 states have unemployment rates at least 10% higher than baseline	The state has higher unemployment than during any quarter since 1 year before national relief was triggered	Based on state conditions
GAO II	The average unemployment rate during the 6 months ending in the quarter	The same period, either 1 or 2 years in the past	At least 23 states have unemployment rates at least 10% higher than baseline Either: At least 3 states have unemployment rates at least 20% higher than baseline	The state has higher unemployment than during any quarter since 2 years before national relief is triggered The state has unemployment at least 20% higher than baseline	Based on state conditions
SCHIP I	The average unemployment rate during the quarter	The average during the three prior years	None	Unemployment is at least 5.5% and at least 20% higher than baseline	Based on state conditions
SCHIP II	The average unemployment rate during the quarter	The same period, either 1, 2, or 3 years in the past			
SCHIP III	The average unemployment rate during the 6 months ending in the quarter	The same period, either 1, 2, or 3 years in the past	At least six states have unemployment rates at least 1 percentage point higher than baseline	The state has unemployment at least 1 percentage point higher than baseline	Based on state conditions

*GAO I was included in "Strategies to Help States Address Increased Expenditures During Economic Downturns," GAO-07-097, and GAO II was developed by the Urban Institute. SCHIP I was based on the SCHIP Reauthorization bill adopted by the Senate, and SCHIP II and III are modifications developed by the Urban Institute. For more detailed information about these options, see Appendix II.

Brief Description of These Illustrative Policies and Their Impact- Table 5, below, shows, during the most recent economic downturn, how many states would have received help under each above-described approach to fully targeted assistance and, by contrast, under the enacted FMAP increase. For examples of how these fully targeted policies would have played out during earlier national and regional downturns, see Appendix III. As Table 5 demonstrates, each fully targeted approach would have provided states with assistance long before the FMAP increase in 2003-2004. Compared with the targeted formulas, the JGTRRA fiscal relief came relatively late in the economic downturn, because assistance was delayed until federal policymakers could reach agreement.

The GAO's Original Formula (GAO I) gave states fiscal relief if 23 states experienced at least a 10 percent increase in annual unemployment rates. Once this national trigger was met, a state would get help if it experienced *any increase* in unemployment, however slight. As a result, the GAO I approach helped almost all states for seven quarters, although the amount varied by state. Moreover, GAO I missed the early months of the economic downturn because the formula used a 12-month period to measure current economic conditions. Providing assistance only when 23 or more states experienced the requisite economic difficulty denied help during cyclical downturns that affected a smaller number of states, such as the “oil patch” recession of the mid- to late-1980s (See Appendix III, Appendix Table 2).

The GAO II Formula measured economic conditions based on 6 rather than 12 months of unemployment data. As a result, it took less time to “pick up” economic decline and so provided help before the original GAO formula. Assistance was based on a comparison between current economic conditions and those either one or two years in the past, so assistance extended slightly longer than under the GAO I formula. Finally, to help during regional downturns and when states entered a national slowdown unusually early or left it unusually late, GAO II also aided states with more severe increases in unemployment of 20 percent or more, so long as at least 3 states experienced such effects.

*The Original SCHIP Formula (SCHIP I)*³⁹ provided a contingency bonus to any state with an average quarterly unemployment rate that was at least 5.5 percent and at least 20 percent higher than the state's average over the past three years. While it provided help earlier than the 2003-2004 FMAP increase, the formula benefited fewer states because it helped only states with unemployment rates above specified levels.

The SCHIP II Formula slightly modified the original SCHIP approach by comparing current unemployment rates to the same period during *each* of the three previous years, rather than to the *average* over the previous three years. This small, seemingly technical change had an enormous impact. Under SCHIP I, a few quarters of high unemployment in a state often disqualified subsequent quarters from federal help, even if the state remained in serious economic trouble. By avoiding such averages and instead comparing current conditions to the same period of time during several earlier years, SCHIP II helped many more states, particularly during the latter stages of the downturn. For example, only SCHIP II would have provided any states with help during the final two quarters of the FMAP increase in 2003-2004.

The SCHIP III Formula made further changes, requiring at least six states to experience threshold levels of harm before any federal assistance was available. Unlike SCHIP I and II, this avoided helping a tiny number of states during 2005 that may have been experiencing structural rather than cyclical declines. SCHIP III also triggered aid based on a 1.0 percentage point increase in unemployment. By eliminating the 5.5 percent unemployment requirement of SCHIP I and II, SCHIP III aided states with low prior levels of unemployment; this was the main reason why SCHIP III helped more states than did SCHIP I and II. At the same time, by requiring a 1.0 percentage point increase in unemployment rather than a 20 percent increase, SCHIP III established a level playing field for states that had high prior levels of unemployment (see the following text box for further explanation).

States with Low, Medium, and High Unemployment: Effects of SCHIP I, II, and III

SCHIP I and II triggered assistance based on state unemployment rates that were at least (a) 5.5 percent and (b) 20 percent above prior levels. SCHIP III instead required a 1.0 percentage point increase. The latter approach provided more help to states with either unusually low and or unusually high prior levels of unemployment. The goal was to assist states that experience the same amount of economic decline, regardless of how well they generally fare in the global economy, independently of the business cycle. For example:

- In *State A*, unemployment rose from 4.0 percent to 5.0 percent. SCHIP I and II provided no help, since the later unemployment rate was below 5.5 percent. SCHIP III provided assistance, since that formula did not require a state to reach an absolute threshold level of current unemployment.
- In *State B*, unemployment rose from 5.0 percent to 6.0 percent. It qualified under all three formulae since its later unemployment rate exceeded 5.5 percent and was both 20 percent and 1.0 percentage points above prior levels.
- In *State C*, unemployment rose from 6.0 percent to 7.0 percent. SCHIP I and II provided no help, since unemployment increased by only 16.7 percent. The state qualified for aid under SCHIP III, since unemployment rose by 1.0 percentage points.

Among all the formulae, only SCHIP II and SCHIP III provided assistance during the later stages of the economic downturn, since they were the only policies that compared current levels of unemployment to those during the same calendar period in each of the three previous years. The goal of such a 3-year "look back" period was to provide each disrupted state with assistance until its economy returned to normal.

TABLE 5. QUARTERLY UNEMPLOYMENT RATES AND THE NUMBER OF STATES RECEIVING ASSISTANCE UNDER VARIOUS FORMULAE: 2000-2005

	National unemployment rate	Number of states receiving assistance under each formula					
		2003-2004 FMAP increase	GAO I	GAO II	SCHIP I	SCHIP II	SCHIP III
2000	4.0	0	0	0	0	0	0
	3.9	0	0	0	0	0	0
	4.0	0	0	0	0	0	0
	3.9	0	0	0	0	0	0
2001	4.2	0	0	5	0	0	0
	4.4	0	0	48	1	1	6
	4.8	0	0	49	5	5	13
	5.5	0	0	50	13	15	25
2002	5.7	0	50	50	18	20	35
	5.8	0	50	50	18	21	39
	5.7	0	50	50	16	22	39
	5.9	0	50	49	17	22	40
2003	5.9	0	49	49	15	24	42
	6.1	51	49	50	16	30	44
	6.1	51	50	50	11	30	41
	5.8	51	0	50	4	24	30
2004	5.7	51	0	3	0	20	37
	5.6	51	0	0	0	13	28
	5.4	0	0	0	0	6	17
	5.4	0	0	0	0	4	8
2005	5.3	0	0	0	0	1	0
	5.1	0	0	0	0	0	0
	5.0	0	0	0	2	2	0
	5.0	0	0	0	2	2	0

Source: Authors' calculations, Bureau of Labor Statistics, state monthly unemployment rates, seasonally adjusted.
 Notes: National unemployment rates represent the average, for each calendar quarter, of monthly, seasonally adjusted unemployment. For a description of these options see Table 4 and Appendix II.

5. Conclusion

As a new economic downturn unfolds, many states appear headed for serious budget shortfalls. Economic hard times reduce state revenues and increase the number of people who qualify for need-based benefit programs. Because of state balanced budget requirements, these trends eventually cause many states to increase taxes and fees or cut Medicaid, SCHIP, and other services. As a result, economic stimulus and help for vulnerable residents are withdrawn precisely when they are most needed. The federal government does not have balanced budget requirements, so it has the flexibility to provide additional resources to states that are experiencing an economic downturn. These resources could help lessen the need to make Medicaid and SCHIP cuts at times when publicly funded health care services and the resulting economic stimulus are most needed.

Federal policymakers have many different options for providing this assistance. In structuring fiscal relief, the basic question facing lawmakers is the extent to which aid should be based on the economic conditions in each state. More finely targeted aid can provide additional help to states experiencing the deepest level of economic distress. On the other hand, to the extent that policymakers seek to target aid based on state economic conditions, the relevant policy design issues grow more complex. Regardless of which approach federal lawmakers prefer, the severity of emerging state budget problems suggests that policymakers need to give serious consideration to providing troubled states with fiscal relief, including assistance that eliminates the need to cut back health coverage during economic downturn.

Appendix I

Estimating the Effects of Unemployment on Coverage: Methods

The regression models were estimated separately for non-elderly adults (aged 18-64) and children (aged 0-17). Both groups included disabled and non-disabled individuals. The key explanatory variables were the contemporary state unemployment rate and the unemployment rate one year in the past, using the sum of the two effects in our results. Control variables included those listed below, with asterisks identifying variables that included both contemporaneous measures and measures one year in the past:

- A proxy measure for state health insurance costs;*
- The percent of children under the state’s income threshold for child poverty-related Medicaid eligibility or SCHIP;*
- The percent of non-elderly adults under the state’s income threshold for Medicaid eligibility through 1115 waivers;*
- State income thresholds for a three-person family’s Medicaid eligibility under the former Aid to Families With Dependent Children program (AFDC) and Social Security Act Section 1931;*
- State demographic variables, including average age and state racial/ethnic composition;
- The average probability in the state that family income is less than 200% of the federal poverty level (FPL), based on factors assumed to be exogenous (e.g., age, gender, education, marital status);
- The share of state residents not living in a Metropolitan Statistical Area;
- Post-1993, post-1996, and post-1998 dummies (to capture changes in the CPS); and
- State fixed effects.

To estimate the effect of a 1.0 percentage point increase in the unemployment rate on Medicaid and SCHIP spending for 2008, we projected what insurance coverage in 2008 would be in the absence of an economic downturn. To estimate the increase in the number of children and adults in the U.S., we used population growth trends since 2000. This resulted in an estimated 2008 population of 78.6 million children and 186.4 million non-elderly adults.

We then estimated the insurance coverage rates for children and adults by extrapolating from the 2004-2006 change, assuming that observed changes in coverage for each of the four insurance categories from 2004-2006 would continue between 2006 and 2008. After determining the “baseline” coverage levels for 2008, we applied the estimated effects of increased unemployment on the percentage of individuals with various types of coverage to ascertain the number of children and adults who would enroll in Medicaid and SCHIP in response to a 1.0 percentage point increase in the unemployment rate.

The next step was to use data on Medicaid and SCHIP spending per enrollee to estimate the impact of these enrollment changes on Medicaid and SCHIP costs. Earlier research on this topic found that people with disabilities comprise 25% of the non-elderly adults who newly enroll because of increased unemployment.⁴⁰ Accordingly, we derived a weighted average of current Medicaid spending for adults under age 65, assuming that 25 percent of new enrollees would have disabilities. We then discounted this weighted average of current costs by 20 percent, based

on evidence that adults with employer-sponsored insurance cost less, on average, than adults already on Medicaid.⁴¹ This last step may have underestimated spending increases resulting from unemployment because, among non-elderly adults eligible for Medicaid, those with health problems are disproportionately likely to enroll.⁴² For children, we assumed that the newly enrolled would have the same average costs as current beneficiaries.

Appendix II

Description of Fully Targeted Fiscal Relief Approaches

The GAO's original approach (GAO I)

Several years ago, the Government Accountability Office (GAO) developed and analyzed several possible approaches to helping Medicaid programs during economic downturns.⁴³ One policy used a national trigger with federal resources targeted based on state need. To limit assistance to periods of national economic decline, federal funds would be available only if 23 or more states experienced unemployment levels at least 10 percent higher than during the same period the previous year. Once the national trigger was met, a state could qualify for aid by showing any increase in unemployment, no matter how slight. However, the amount of assistance would depend on the extent to which unemployment in a state was worse than in the past. To limit the possibility of statistical error, the formula measured current levels of unemployment by averaging the most recent 12 months of each state's unemployment data.

Because of the 12-month average used to define current unemployment levels, it can take a long time for this formula to pick up a sharp economic decline. As a result, federal assistance can miss the early portion of an economic slowdown. It can also stop during a downturn even if the national unemployment rate is still high and increasing, as would have happened in 1982 (see Appendix III, Appendix Table 1). Providing assistance only when 23 or more states experienced the requisite economic difficulty would have denied help during cyclical downturns that affected a smaller number of states, such as the "oil patch" recession of the mid- to late-1980s (see Appendix III, Appendix Table 2). It also would have denied assistance to states that entered a national downturn unusually early, compared to other states, or left it unusually late. Finally, using a 1-year rather than a longer "look back" period to compare current unemployment rates with previous levels meant that assistance would have been unavailable during later periods of economic slowdowns, including three out of the five quarters for which enhanced FMAP was paid during 2003-2004 (Table 5).

A modified version of the GAO formula (GAO II)

As GAO acknowledged, policymakers could modify each element of its illustrative formula. For example:

- To provide a speedier response to changed economic conditions, unemployment could be measured based on 6-month rather than 12-month averages.
- To make federal dollars available after the early stages of an economic downturn, the "look back" or comparison period could last 2 years rather than 1 year. For instance, assume that the unemployment rate increased from 5.0 percent in year one to 5.5 percent in year 2 and 5.8 percent in year 3. With a one year "look back" a state would satisfy the requirement of a 10 percent increase in unemployment over baseline levels in year 2 but not in year 3. With a two year "look back", the 5.8 percent rate would be compared to the 5.0 percent baseline and assistance could continue. The purpose of a lengthened look-back period (whether for 2 or 3 years) is to permit federal assistance to last until a state's economy returns to normal.

- During periods when the national trigger is not met, but a small number of states are experiencing severe downturns, help could be available to a state experiencing at least a 20 percent increase in unemployment, so long as it was one of at least three states experiencing that level of harm.

The SCHIP original formula (SCHIP I)

The original Senate-passed legislation reauthorizing SCHIP provided “contingency” bonuses to states when their unemployment rates reached certain levels. Under the bill, such bonuses would be paid if, during a three-month period, a state’s unemployment rate exceeded 5.5 percent and was at least 20 percent higher than during the average for the three prior years. This use of averages meant that, if a state experienced several quarters of very high unemployment, the state could be denied federal assistance in subsequent quarters, even if unemployment remained at high levels.

SCHIP formula – slight modifications (SCHIP II)

Under a modified version of the SCHIP contingency bonus proposal, assistance would go to a state if, during a calendar quarter, its seasonally-adjusted, average monthly unemployment rate was at least 5.5 percent and at least 20 percent higher than during the same quarter in any of the three prior years. The significant impact of this one small change – namely, using parallel calendar periods, rather than multi-year averages, as the basis for comparison with current unemployment rates – is shown by the period covered by the temporary FMAP increase earlier this decade:⁴⁴

- In the third quarter of 2003, the modified SCHIP formula would have helped 30 states, and the unmodified formula would have helped 11;
- During the fourth quarter of 2003, the modified formula would have helped 24 states, and the unmodified formula would have helped 4; and
- In the first quarter of 2004, the modified formula would have helped 20 states, and the unmodified formula would have helped none.

SCHIP formula – major modifications (SCHIP III)

The SCHIP formula could be further modified to base payments purely on the difference between current and former levels of unemployment, without requiring a state to exceed 5.5 percent unemployment. Eliminating the latter requirement would compensate states for economic declines even if their baseline economies were unusually healthy. To measure current economic conditions, 6-month averages could be used, thus providing more reliability than quarterly averages. To prevent assistance from going to one or two states that are experiencing structural rather than cyclical declines, while still providing help during significant but sub-national downturns in the business cycle, bonuses could be limited to periods in which at least 6 states experience elevated levels of unemployment. Finally, a 1 percentage point increase in unemployment, rather than a 20 percent increase, could lead to assistance, providing more of a level playing field for the states with the highest prior levels of unemployment. For example, an increase in a state’s unemployment rate from 5.0% to 6.0% would meet the 20 percent requirement, but a different state’s increase from 6.0% to 7.0% would not.

Appendix III The Impact of Alternative Formulas in Earlier Periods

The following tables show how each fully targeted formula described in the final part of the paper would have applied during several national and regional downturns from 1980 through 2000.

APPENDIX TABLE 1. QUARTERLY UNEMPLOYMENT RATES AND THE NUMBER OF STATES RECEIVING ASSISTANCE UNDER VARIOUS FORMULAE: NATIONAL DOWNTURN OF 1980-1984

	National unemployment rate	Number of states receiving assistance under each formula				
		GAO I	GAO II	SCHIP I	SCHIP II	SCHIP III
1980	6.3	0	10	7	13	11
	7.3	0	50	16	27	25
	7.7	0	51	24	34	37
	7.4	50	51	21	31	41
1981	7.4	51	51	19	26	37
	7.4	51	50	20	30	35
	7.4	51	51	20	32	38
	8.2	51	51	32	37	39
1982	8.8	51	51	35	42	46
	9.4	0	51	40	45	50
	9.9	0	51	43	49	49
	10.7	51	51	42	48	48
1983	10.4	51	51	35	49	50
	10.1	51	51	18	44	50
	9.4	51	51	5	29	43
	8.5	49	51	2	16	30
1984	7.9	0	4	0	10	21
	7.4	0	0	0	4	11
	7.4	0	0	0	3	0
	7.3	0	0	0	3	0

Source: Authors' calculations, Bureau of Labor Statistics, state monthly unemployment rates, seasonally adjusted
Notes: For an explanation of each formula, see notes to Table 5, in text.

The following table shows the unsurprising result that limiting assistance to periods of national economic decline, as with the GAO I formula, means that, in a sub-national recession, affected states get no help. It also shows that, when assistance is limited to periods in which a small, threshold number of states (such as 6, under the SCHIP III formula) experience significant economic harm, help can go to states experiencing significant, sub-national downturns without assisting one or two states that may be experiencing structural rather than cyclical problems; states in the latter category would receive federal funds under an approach like that taken under the SCHIP I and II formulas, in which any state experiencing severe harm receives federal help.

APPENDIX TABLE 2. QUARTERLY UNEMPLOYMENT RATES AND THE NUMBER OF STATES RECEIVING ASSISTANCE UNDER VARIOUS FORMULAE: “OIL-PATCH” RECESSION OF 1985-1988

	National unemployment rate	Number of states receiving assistance under each formula				
		GAO I	GAO II	SCHIP I	SCHIP II	SCHIP III
1985	7.2	0	0	0	3	0
	7.3	0	0	0	3	0
	7.2	0	0	0	2	0
	7.0	0	0	0	2	0
1986	7.0	0	0	0	3	0
	7.2	0	5	1	6	9
	7.0	0	6	3	6	9
	6.8	0	6	3	6	9
1987	6.6	0	4	3	5	8
	6.3	0	3	1	5	7
	6.0	0	3	0	4	6
	5.8	0	0	0	3	0
1988	5.7	0	0	0	0	0
	5.5	0	0	0	0	0
	5.5	0	0	0	0	0
	5.3	0	0	0	0	0

Source: Authors' calculations, Bureau of Labor Statistics, state monthly unemployment rates, seasonally adjusted
Notes: For an explanation of each formula, see notes to Table 5, in text.

APPENDIX TABLE 3. QUARTERLY UNEMPLOYMENT RATES AND THE NUMBER OF STATES RECEIVING ASSISTANCE UNDER VARIOUS FORMULAE: NATIONAL DOWNTURN OF 1990-1994

	National unemployment rate	Number of states receiving assistance under each formula				
		GAO I	GAO II	SCHIP I	SCHIP II	SCHIP III
1990	5.3	0	7	0	0	6
	5.3	0	8	2	2	7
	5.7	0	9	3	4	8
	6.1	0	15	10	13	14
1991	6.6	0	49	19	26	22
	6.8	0	50	19	29	28
	6.9	0	48	18	25	30
	7.1	48	48	24	27	28
1992	7.4	50	50	27	31	31
	7.6	50	50	25	31	35
	7.6	51	51	18	31	35
	7.4	49	51	6	27	34
1993	7.1	0	50	2	26	30
	7.1	0	5	1	17	27
	6.8	0	3	0	14	22
	6.6	0	0	0	8	14
1994	6.6	0	0	0	2	9
	6.2	0	0	0	0	0
	6.0	0	0	0	0	0
	5.6	0	0	0	0	0

Source: Authors' calculations, Bureau of Labor Statistics, state monthly unemployment rates, seasonally adjusted
Notes: For an explanation of each formula, see notes to Table 5, in text.

Notes

¹ National Governors Association, “State Countercyclical Funding,” EC-18 Interim Policy, January 23, 2008.

² Representatives Pallone, King (NY), Dingell, and Reynolds introduced H. R. 5268 on February 7, 2008. Senators Rockefeller, Lautenberg, Menendez, and Stabenow introduced S. 2620 on February 8, 2008. Senators Rockefeller, Snowe, and Kennedy introduced S. 2819 on April 3, 2008.

³ A coalition of over 70 groups including AFL-CIO, the American Federation of State, County, and Municipal Employees, the American Hospital Association, the American Health Care Association, the Association of Community Organizers for Reform Now, and MoveOn.org, has urged Congress to include a temporary enhanced FMAP in any fiscal stimulus package. F. Johnson, “Economy: As Labor, Healthcare Groups Jointly Push for State Aid,” CongressDailyPM, January 25, 2008.

⁴ SCHIP differs from Medicaid in two relevant respects: each state receives a capped allotment of federal SCHIP dollars; and states are permitted to place eligible applicants on waiting lists rather than enroll them into coverage. Depending on the state, these program features can limit the extent to which SCHIP costs increase when the economy worsens. On the other hand, federal policymakers could enhance SCHIP’s ability to respond to worsened economic circumstances by providing the kind of contingency funding incorporated in the Senate bill reauthorizing SCHIP, as discussed below.

⁵ See, e.g., Federal Reserve Governor F.S. Mishkin, Outlook and Risks for the U.S. Economy, at the National Association for Business Economics Washington Policy Conference, March 4, 2008, available at <http://www.federalreserve.gov/newsevents/speech/mishkin20080304a.htm>.

⁶ E. McNichol and I. Lav, 22 States Face Total Budget Shortfall of at Least \$39 Billion in 2009; 8 Others Expect Budget Problems, Center on Budget and Policy Priorities (CBPP), Revised April 15, 2008, available at <http://www.cbpp.org/1-15-08sfp.htm>.

⁷ McNichol and Lav, *op cit*.

⁸ National League of Cities, Housing Finance and Foreclosures Insta-Poll Fact Sheet (Questions), March 11, 2008, available at <http://nlc.org/ASSETS/FE012FE470DF484598072D1AA67091F5/Housing%20Inst-Poll%20Fact%20Sheet.doc>.

⁹ I.J. Lav and E. Hudgins, Facing Deficits, Many States Are Imposing Cuts That Hurt Vulnerable Residents, Center on Budget and Policy Priorities, Revised April 15, 2008, available at <http://www.cbpp.org/3-13-08sfp.pdf>.

¹⁰ Bureau of Labor Statistics, Regional and State Employment and Unemployment: January 2008, March 11, 2008.

¹¹ K. Rueben, Urban Institute, unpublished multivariate calculations based on data from the National Association of State Budget Officers, February 2008. This estimate measures the difference between General Fund revenue projections and actual revenue, subtracting any increased General Fund dollars attributable to changes in state tax laws. Put differently, the estimate shows the unexpected revenue shock to General Fund revenue resulting from a 1 percentage point increase in unemployment.

¹² For example, during the economic downturn earlier this decade, 34 states cut eligibility for health coverage, causing more than 1 million people to lose coverage. E.C. McNichol and I.J. Lav, 21 States Face Budget Shortfall of at Least \$37 Billion in 2009; 7 Others Expect Budget Problems, the Center on Budget and Policy Priorities, Revised March 10, 2008, available at <http://www.cbpp.org/1-15-08sfp.pdf>.

¹³ B.C. Edwards, Health Care and the Economic Slowdown, National Association of State Medicaid Directors for the Kaiser Commission on Medicaid and the Uninsured and the Alliance for Health Reform, February 15, 2008, oral remarks, available at <http://www.allhealth.org/briefingmaterials/Transcript-1110.pdf>.

¹⁴ L. Blumberg, et al., Building the Roadmap to Coverage: Policy Choices and the Cost and Coverage Implications, prepared by the Urban Institute for the Blue Cross Blue Shield of Massachusetts Foundation, June 2005, available at http://www.bcbsmafoundation.org/foundationroot/en_US/documents/roadmapTocoverage.pdf.

¹⁵ See discussion in S. Dorn, B. Smith, and B. Garrett, Medicaid Responsiveness, Health Coverage, and Economic Resilience: A Preliminary Analysis, prepared by the Economic and Social Research Institute, Health Policy Innovation, Inc., and the Urban Institute for the Joint Center for Political and Economic Studies, September 27, 2005, available at http://www.esresearch.org/documents_1-05/Medicaid_Responsive.pdf.

¹⁶ See, e.g., M. Feldstein, “Is There a Role for Discretionary Fiscal Policy?” Comment on Alan Auerbach, “Is There a Role for Discretionary Fiscal Policy?” at the Jackson Hole Federal Reserve Conference, August 29-31, 2002, available at <http://www.nber.org/feldstein/auerbach2002.pdf>.

¹⁷ 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, available at <http://wdr.doleta.gov/owsdrr/99-8/99-8.pdf>.

¹⁸ G.C. Cornia and R.D. Nelson, “Rainy Day Funds and Value at Risk,” State Tax Notes, August 25, 2003, 563-567.

¹⁹ BEA, NIPA Table, Table 3.12., Government Social Benefits.

²⁰ As noted in Dorn, et al., *op cit.*, even identical total dollar amounts do not translate into identical levels of stimulus, since UI and Medicaid spend money in different ways that may have different macroeconomic effects; Medicaid spending rises each year, although changes in Medicaid tracked changes in unemployment rates and UI spending during the last two economic downturns; the UI spending totals include special supplements, providing extended benefits, enacted by Congress during each recession in recent decades; and the pattern shown in the charts in the text did not continue after 2003, perhaps because of numerous changes that were then being made to national Medicaid policy, including the 2003-2004 temporary FMAP increase; the Medicare Modernization Act of 2003, which redefined state responsibilities with respect to prescription drugs for Medicare beneficiaries; and the Deficit Reduction Act of 2005, which made numerous changes to the federal Medicaid statute.

²¹ T. A. Coughlin and S. Zuckerman, “Three Years of State Fiscal Struggle: How Did Medicaid and SCHIP Fare?” Health Affairs Web Exclusive, August 16, 2005.

²² The legislation also prevented each state’s underlying FMAP from declining below prior levels. V. Wachino, M. O’Malley and R. Rudowitz, *Financing Health Coverage: The Fiscal Relief Experience*, Kaiser Commission on Medicaid and the Uninsured, November 9, 2005.

²³ Wachino, et al., *op cit.*

²⁴ Both surveys are described in Wachino, et al., *op cit.*

²⁵ Coughlin and Zuckerman, *op cit.*

²⁶ Wachino, et al., *op cit.*

²⁷ In another, somewhat less egregious example, Michigan used the FMAP increase to replenish a reserve fund that pays for Medicaid shortfalls in the event of an economic downturn; this allowed the state to balance its budget without increasing taxes or fees. Wachino, et al., *op cit.*

²⁸ Dorn, et al., *op cit.*

²⁹ During FY 2002-2003, 50 states cut or froze provider payments under Medicaid; 46 states cut payments for prescription drugs; 25 states cut back eligibility standards; 18 states eliminated covered benefits; and 17 states increased cost-sharing for low-income beneficiaries. 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 Kaiser Commission on Medicaid and the Uninsured, September 2003.

³⁰ Moral hazard may be a concern to some federal policymakers, at least in theory. If federal policymakers provide assistance during hard times, states may, during future good times, feel less of a need to establish budget stabilization funds or take similar steps to protect against a coming “rainy day.” In practice, however, the magnitude of this risk is unclear. While a permanent change in the Medicaid statute might cause greater changes to state policy, the temporary FMAP increase and accompanying block grants in 2003-2004 did not cause states to throw caution to the winds. By the end of Fiscal Year 2006, state budget balances (including budget stabilization funds) equaled 11.5 percent of expenditures – the highest level in 30 years. (Note: by Fiscal Year 2008, based on enacted budgets such balances had dropped to 6.7 percent.) National Governors Association (NGA) and National Association of State Budget Officers (NASBO), *The Fiscal Survey of States*, December 2007.

³¹ The top 28 states as of April 1, 2008 would receive five quarters of assistance. Three quarters of assistance would go to states that, as of October 1, 2008, are in the top 38.

³² Congressional Budget Office, Letter to the Honorable John D. Rockefeller IV, April 17, 2008, available at <http://www.cbo.gov/ftpdocs/91xx/doc9146/4-17-RockefellerLetter.pdf>.

³³ For an example of long-term interest rates rising while the Federal Reserve Board is taking vigorous action to lower short-term interest rates, see N. Irwin and D. Cho, “Fed to Make \$200 Billion Available to Lenders,” *Washington Post*, March 8, 2008, p. D1 (chart entitled, “Interest Rates Rise”).

³⁴ In particular, the standard FMAP formula, which is supposed to increase federal matching percentages for states with ongoing economic difficulty, could be reformed so that it responds more quickly to serious changes to a state’s permanent economy.

³⁵ For example, for each percentage point increase in a state’s unemployment rate, the FMAP applicable to services for children and non-elderly adults could rise enough to compensate for 2 percent and 1 percent growth, respectively, in the state’s costs to serve those populations. This would reduce the state’s normal share of Medicaid and SCHIP costs by 2 percent (not 2 percentage points) and 1 percent (not 1 percentage point) for children and non-elderly adults, respectively. Given a specified increase in unemployment, a state’s percentage point FMAP increase would depend on the state’s underlying, basic FMAP. For example, consider a state with Medicaid costs for non-elderly adults that rose from \$100 million to \$101 million because of a 1 percentage point increase in unemployment. If the state’s standard FMAP was 50 percent, and its normal share of Medicaid costs was thus 50 percent, the FMAP would need to increase to 50.5 percent for the federal government to pay \$51 million and for the state cost to remain at \$50 million. If the state’s standard FMAP was 60 percent, and its normal share of Medicaid costs was thus 40 percent, its FMAP would need to increase to 60.4 percent for the federal government to pay \$61 million and for the state cost to

remain at \$40 million. In each case, the state's share of Medicaid costs would decline by 1 percent (from 50 to 49.5 percent and from 40 to 39.6 percent).

³⁶ Policymakers need to decide whether to adjust federal funding to take into account each state's particular revenue structure. This would achieve the advantage of tailoring funding levels to actual state revenue effects. State revenue sources vary substantially in their responsiveness to the business cycle. R. Sobel and R. Holcombe, "Measuring the Growth and Variability of Tax Bases Over the Business Cycle," *National Tax Journal*, December 1996, 535-552; R. Die and T. McGuire, "Growth and Variability of State and Individual Income and General Sales Taxes," *National Tax Journal*, March 1991, 55-66. On the other hand, providing assistance based on national averages, rather than an analysis of each state's revenue streams, involves simpler calculations; it is not obvious how one could easily adjust these national averages to reflect each state's revenue structure in effect before the start of economic downturn. Using national averages, in this case, also avoids moral hazard problems. Some observers have urged states to shift from cyclically responsive revenue sources, like the corporate income tax, to more stable revenue sources, like taxes on sales and gross receipts. W. Seyfried and L. Pantuosco, "Estimating the Sensitivity of State Tax Revenue to Cyclical and Wealth Effects," *Journal of Economics and Finance*, Spring 2003, Vol. 27, No. 1: 114-124; F. Thompson and B. Gates, "Betting on the Future with a Cloudy Crystal Ball? How Financial Theory Can Improve Revenue Forecasting and Budgets in the States," *Public Administration Review*, September/October 2007, 825-836. Structuring federal funding to provide additional compensation for states that disproportionately rely on highly responsive revenue sources would mean that states could realize the substantial gains of such revenue sources when times are good without experiencing the full consequences of revenue declines when recession hits. This would lessen state incentives to move towards revenue structures that "smooth out" cyclical variations.

³⁷ Government Accountability Office (GAO), *Strategies to Help States Address Increased Expenditures during Economic Downturns*, GAO-07-097, October 2006.

³⁸ H.R. 976, as passed in the Senate on August 2, 2007, Section 108, adding new subsection (k)(3)(D)(iii)(II) to Social Security Act Section 2104 (42 USC 1397dd).

³⁹ The version of the SCHIP I contingency bonus formula shown in the Tables make one change not described in the text. The Senate bill provided contingency bonuses based on economic conditions during any three month period within a given year, rather than based on calendar quarters. The SCHIP I formula portrayed in the Tables uses calendar quarters to align with the quarterly timing of federal payments to state Medicaid programs.

⁴⁰ J. Holahan and B. Garrett, *Rising Unemployment and Medicaid*, The Urban Institute, October 16, 2001, available at <http://www.urban.org/publications/410306.html>.

⁴¹ J. Holahan, "Health Status And The Cost Of Expanding Insurance Coverage," *Health Affairs*, November/December 2001; 20(6): 279-286.

⁴² Holahan, *op cit*.

⁴³ GAO, *op cit*.

⁴⁴ More broadly, during every economic downturn since 1980, the unmodified SCHIP formula would have provided significantly less assistance during the downturn's latter stage, as is evident in the Appendix Tables.

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