



Health Coverage in a Recession

Stan Dorn

Economic downturns create serious problems with health coverage. When unemployment rises, fewer workers and dependents receive employer-sponsored insurance (ESI). Some who lose ESI qualify for Medicaid or the State Children's Health Insurance Program (SCHIP), while others become uninsured.

That said, the relationship between economic conditions and health coverage is complex. Although Medicaid enrollment among the elderly and people with disabilities is modestly affected by changes in the business cycle, the number of eligible low-income families with children changes dramatically when economic conditions worsen. Other factors outside the business cycle that affect Medicaid and SCHIP costs include the ongoing decline in the number of workers receiving ESI and changes to federal and state policy. Important changes in the latter category include the "de-linking" of Medicaid from cash assistance in the wake of 1996 welfare reform legislation, which reduced the number of eligible families receiving health coverage, and enactment of SCHIP in 1997.

Broader coverage trends over time bear out this complexity. Until the start of this decade, the percentage of Americans with ESI and Medicaid varied with employment. When more people were out of work, fewer had ESI and more had Medicaid. When unemployment rates fell, more people had ESI and fewer relied on Medicaid. However, from 2001 to 2007, other factors swamped the effects of the business cycle; in good times and bad, ESI declined and Medicaid caseloads grew (figure 1).

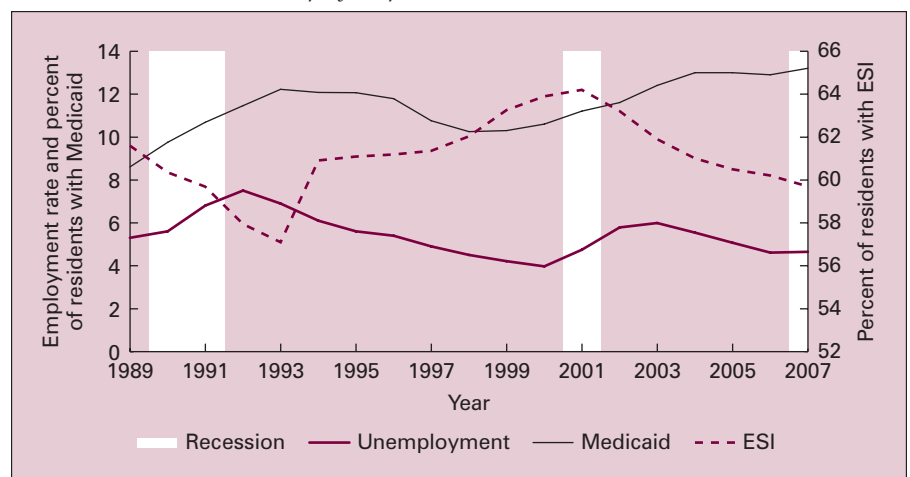
To isolate the effect of macroeconomic conditions on health coverage, Urban Institute researchers examined 14 years of state-level data, controlling for multiple confounding factors, including changing eligibility rules for health coverage in each state (Dorn et al. 2008). They found that each 1 percentage point rise in the national unemployment rate can be expected to increase Medicaid and SCHIP enrollment by 1 million people (600,000 children and 400,000 nonelderly adults). 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. Along with increasing Medicaid and SCHIP enrollment, a 1 percentage point increase in unemployment would also cause the number of uninsured adults to grow by 1.1 million.¹

If the current recession proves as deep as many fear, the decline in health insurance coverage would be greater than these estimates suggest, for two reasons. First, unlike Medicaid, which guarantees coverage to all eligible individuals, without any limit on the amount of federal matching funds received by a state, SCHIP is a block grant. If the number of children without ESI rises dramatically, some states will exhaust their SCHIP grants. When that occurs, additional children who lose coverage may be placed on waiting lists rather than enrolled into health coverage.

Second, during economic downturns, states frequently narrow eligibility criteria and take other steps to cut their Medicaid costs. An economic slowdown both lowers state revenue and increases the number of residents who qualify for need-based assistance, including

FIGURE 1. Unemployment Rate, Share of U.S. Residents with Medicaid, and Share of U.S. Residents with Employer-Sponsored Insurance (ESI), 1988–2007



Source: March Current Population Survey, 1989–2008.

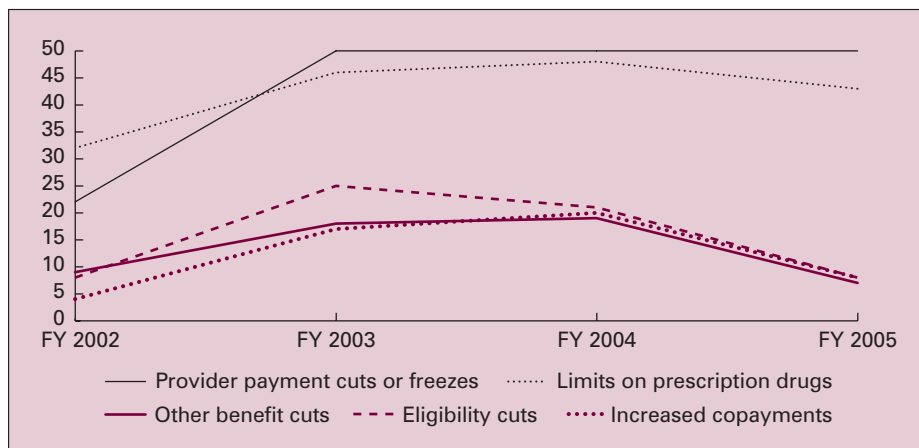
Notes: SCHIP cannot be reliably identified on the CPS; thus, Medicaid enrollment estimates include both Medicaid and SCHIP. Coverage estimates are based on unadjusted CPS data, which may understate Medicaid and SCHIP enrollment, relative to state administrative data. The Census Bureau made major revisions to the methodology used to estimate coverage on the CPS for data years 1994, 1999, and 2004. As a result, the data presented here do not represent a methodologically consistent trend over time, and changes in coverage before and after these revisions are not directly comparable. For more information, see http://www.shadac.org/files/CPSChanges_89-05.pdf and <http://www.census.gov/hhes/www/hlthins/usernote/usernote3-21rev.html>.

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but going beyond Medicaid and SCHIP. Because nearly all states are legally required to balance their budgets, the double-whammy of higher costs and lower revenue forces spending cuts precisely when state residents and economies most need help. With Medicaid representing the second-largest source of state general fund costs, outranked by only elementary and secondary education (NGA and NASBO 2008), reductions in Medicaid eligibility, covered services, and provider reimbursement rates are inevitable. Most states took such steps during the relatively mild economic slowdown earlier this decade. Many cutbacks took place during the portion of the downturn that followed the official end of the recession in November 2001 (figure 2).

In the current, much more severe downturn, states are already facing major deficits that they are addressing with large spending cuts, including reductions in health coverage. In their budgets for fiscal years 2009 and 2010, 43 states have faced deficits, including \$48 billion in gaps that had to be closed for fiscal year 2009 and an additional \$31.2 billion in emerging, mid-year shortfalls (McNichol and Lav 2008). At least 21 states have cut health care services for low-income children, families, seniors, or people with disabilities (Johnson, Hudgins, and Koulish 2008; author's calculations). Many states have also cut education funding, ranging from preschool to universities, and raised taxes and fees.

FIGURE 2. Number of States Making Various Medicaid Policy Changes, Fiscal Years (FY) 2002–2005



Source: Rudowitz and Marks (2008).

Note: In most states, fiscal years begin on July 1 of the prior calendar year. Thus, many states' fiscal year 2002 includes the final five months of the March–November 2001 recession.

Such steps can harm vulnerable residents while impeding economic recovery.

To address this problem, many in Congress have called for temporary enhancements in federal funding for Medicaid and SCHIP, conditioned on states' willingness to forgo eligibility cutbacks for health coverage. Likely included in forthcoming stimulus legislation, such an approach would broadly resemble the assistance federal lawmakers provided to states during 2003–04.² This health-specific funding would be supplemented with temporary block grants providing broader state fiscal relief. As a longer-term policy adjustment, lawmakers could revise Medicaid and SCHIP so state economic difficulty would automatically trigger increased federal financing, in proportion to state need, and such federal assistance would automatically retract when state economic conditions improve.³

Notes

1. Medicaid and SCHIP cover most children who lose ESI. This is presumably the reason no statistically significant relationship was observed between unemployment rates and children's uninsurance (Dorn et al. 2008). Medicaid coverage for adults is much less generous than for children, however. Some adults losing ESI qualify for Medicaid, and others become uninsured.
2. For a description of the earlier round of fiscal relief and its effects, see Dorn et al. (2008).
3. Such an approach was suggested by Dorn and colleagues and is included in the health reform proposal outline released by Senate Finance Committee Chairman Max Baucus (D-MT), "Call to Action Health Reform 2009, Senate Finance Committee Chairman Max Baucus D-Mont," November 12, 2008.

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