Robert Wood Johnson Foundation

URBAN INSTITUTE

Support for this research was provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation.

Unemployment, Health Insurance, and the COVID-19 Recession

Anuj Gangopadhyaya and Bowen Garrett

Timely Analysis of Immediate Health Policy Issues

APRIL 2020

Introduction

The sharp reduction in US economic activity associated with public health efforts to slow the spread of the COVID-19 virus is likely to result in millions of Americans losing their jobs and livelihoods, at least temporarily. The global economy is likely already in recession.[1] Economic forecasts suggest that job losses in the second quarter of 2020 could exceed those experienced during the Great Recession.[2] Whereas the monthly U.S. unemployment rate peaked at 10.0 percent in October 2009, Morgan Stanley forecasts unemployment to rise to 12.8 percent in the coming months, and the head of the Federal Reserve Bank of St. Louis predicts it could rise as high as 30 percent in the second quarter.[2,3,4] During the week ending March 21, 3.3 million workers filed initial claims for unemployment insurance, up from 211,000 claims just two weeks earlier.[5]

Adding insult to injury, many Americans who lose their jobs during this health and economic crisis could also lose their health insurance. Most workers have health insurance coverage through their jobs or through a spouse's employer. Workers who lose their jobs may be able to retain coverage through the Consolidated Omnibus Budget Reconciliation Act (COBRA), but that requires former employees to pay the full premium (including their employer's prior contribution toward the premium) and a 2 percent administration fee, which is very expensive and unaffordable for many given their reduced income. Those losing their jobs and employer-sponsored health insurance (ESI) would be able to purchase individual health insurance (single or family coverage) through the marketplaces established by the Affordable Care Act (ACA), possibly with access to subsidies (tax credits) depending on their family income. Under current law, they must enroll in nongroup coverage within 60 days of the qualifying event (e.g., job, income, or coverage loss) that initiates a special enrollment period.

Workers who lose their source of income and access to ESI may also qualify for health insurance through Medicaid. In the 36 states (including DC) that expanded Medicaid eligibility under the ACA, most nondisabled adults in households with income below 138 percent of the federal poverty level (FPL) would qualify for Medicaid coverage.[6] In the 15 states that did not expand Medicaid under the ACA, including large states like Florida and Texas, working-age, nondisabled adults without dependent children are ineligible for Medicaid.[7] Though working-age parents are eligible for Medicaid in all states, the income limits vary widely across states, ranging from 18 percent of FPL (Texas) to 221 percent of FPL (DC).

In anticipation of millions of Americans losing their jobs and access to ESI, and as Congress has just passed a third major piece of legislation to address the COVID-19 health crisis and mitigate its necessary but painful effects on families and the economy, we examine the kinds of health insurance unemployed workers have and how coverage patterns have shifted over time under the ACA. Workers who lose their jobs may search for employment or might leave the labor market entirely. After a while, unemployed workers searching for jobs may become discouraged and they could also leave the labor market. We compare health insurance coverage for working-age, unemployed adults with that for employed adults and people not in the labor force across three time periods: 2008 to 2010 (years during which the Great Recession unfolded), 2011 to 2013 (years of economic recovery before implementation of the ACA's major coverage provisions), and 2014 to 2018 (years of prolonged economic expansion and following full ACA implementation). We also compare coverage patterns among unemployed people, which vary depending on whether a person's state of residence expanded Medicaid under the ACA.

We find the following:

- Before full implementation of the ACA's coverage provisions, 46 percent of unemployed adults also lacked health insurance. As the ACA's coverage provisions took effect, the likelihood of unemployed adults being uninsured dropped by 16.4 percentage points, almost entirely because of a rise in Medicaid (a 10.9 percentage-point increase) and marketplace/other

private coverage (3.1 percentage-point increase).

- Nearly one in four working-age adults not in the labor force was uninsured from 2008 to 2013. After 2014, under full ACA implementation, about 18 percent of those not in the labor force were uninsured, a 28 percent decrease relative to 2011 to 2013. Like unemployed people, people not in the labor force also saw their uninsurance rate decrease due to increases in Medicaid coverage (5.2 percentage points) and marketplace/other private coverage (2.1 percentage points).

- Following full ACA implementation, unemployed adults' uninsurance rates fell sharply in both states that did and did not expand Medicaid. However, these decreases were greater in states that expanded Medicaid; unemployed adults' uninsurance rates dropped by 19.4 percentage points (46 percent) from the 2011–13 period to the 2014–18 period in expansion states but dropped by just 11.2 percentage points (21 percent) in nonexpansion states.

- From 2014 to 2018, after full ACA implementation, the unemployed in Medicaid expansion states were most likely to be covered by Medicaid (36 percent), whereas unemployed adults in nonexpansion states were most likely to be uninsured (43 percent).

Our findings indicate that though joblessness will likely affect uninsurance rates throughout the country, states that did not expand Medicaid under the ACA will see larger increases in uninsurance if current policy fails to adapt. Proposed policy recommendations such as temporary Medicaid expansions, expanding eligibility for subsidies for marketplace coverage, and providing subsidies for COBRA benefits could help mitigate the rise in uninsurance driven by the pandemic's effects on the economy.

Moreover, our findings also indicate that Medicaid coverage will sharply increase as workers become unemployed, particularly in Medicaid expansion states. This is the purpose of the Medicaid program. However, given that jobless rates may reach unprecedented heights under the COVID-19 pandemic, steep increases in Medicaid coverage will strain state budgets, restricting already limited resources in the very communities hardest hit by the pandemic. To help blunt this, current legislation has already enhanced the federal matching rate for Medicaid financing. Still, because our findings indicate that Medicaid coverage will reach unprecedented heights, further increasing the federal matching rate could help provide the critical resources needed to protect the states most in need.

The Distribution of Health Insurance Types by Employment Status and Time Period

Using 2008–18 American Community Survey (ACS) data, we examine health insurance coverage for three groups: (1) those unemployed at the time of the survey; (2) those who reported they were not in the labor force; and (3) those employed at the time of the survey.[8] We limit our sample to adults ages 19 to 64, and we use coverage types reported in the ACS and edited by the Integrated Public Use Microdata Series to improve comparability of coverage types over time.[9,10] A relatively small number of respondents report multiple types of health insurance coverage, and for these cases we classify coverage type using the following hierarchy: ESI, Medicare, Medicaid, marketplace or other private insurance, and other public insurance.[11] Table 1 presents health insurance coverage types among nonelderly adults by employment status.

The Unemployed. The top panel of Table 1 presents changes in coverage types and uninsurance rates among the unemployed. During and shortly after the Great Recession, the number of working-age unemployed adults ranged from 12.5 to 13.4 million and fell to 8.4 million by the 2014–18 period.[12] Among the unemployed, Medicaid coverage rates were 15.3 percent from 2008 to 2010 and 17.9 percent from 2011 to 2013. In the ACA reform period (2014–18), however, their Medicaid coverage rate increased dramatically, rising by 10.9 percentage points from the 2011-2013 period to 28.8 percent following the 2014 expansion of Medicaid to low-income childless adults in 26 states, with additional states following in subsequent years.[13] Individually purchased (nongroup) insurance increased under the ACA for this population as well, increasing by about 40 percent from a stable 7.2 to 7.4 percent from 2008 to 2013 to 10.3 percent following the establishment of the ACA's marketplaces, premium subsidies, and cost-sharing reductions (2014–18). The ESI coverage rate among this group is low regardless of the period, as expected.[14]

Altogether, the uninsurance rate for the unemployed was stable for the 2008–10 and 2011–13 periods but fell sharply under the ACA coverage reforms, dropping 16.4 percentage points (35 percent) from the 2011–13 period to the 2014–18 period. About 85 percent of the decline in uninsurance among the unemployed is attributable to increases in Medicaid and marketplace/nongroup coverage.[15]

People Not in the Labor Force. The second panel of Table 1 shows coverage among adults not in the labor force. This includes nonelderly adults not looking for work or who have retired, adults with disabilities who cannot work, and adults who are full-time students. Like the unemployed, people not in the labor force tend to have modest incomes. However, they are more likely to have a disability and therefore more likely than other working-age adults to have Medicaid (and Medicare) coverage in any of the three study periods.[16] Also like the unemployed, this population's Medicaid enrollment increased significantly from 16.7 to 18.1 percent in the periods before 2014 to 23.3 percent in the ACA eligibility expansion period (2014–18)—a roughly 30 percent increase (5.2 percentage points). With the establishment of the ACA marketplaces and associated premium subsidies, individually purchased insurance coverage also increased for this population, growing by about 20 percent (2.1 percentage points) from the 2011–13 period to the 2014–18 period.

Accounting for all changes in coverage

Table 1. Coverage Types among Adults Ages 19 to 64 Who Are Unemployed, Not in the Labor Force, or Employed, by Period

	2008–10	2011–13	2014–18
UNEMPLOYED			
Coverage type			
Employer-sponsored insurance	26.3%	26.1%	28.2%
Medicare	1.3%	1.5%	2.0%
Medicaid	15.3%	17.9%	28.8%
Marketplace or other private insurance	7.4%	7.2%	10.3%
Other public insurance	1.0%	1.0%	0.8%
Uninsured	48.6%	46.2%	29.8%
N (annual population estimate)	12,472,000	13,071,000	8,416,000
Share of all adults ages 19 to 64	6.6%	6.8%	4.3%
NOT IN THE LABOR FORCE			
Coverage type			
Employer-sponsored insurance	37.4%	35.6%	34.7%
Medicare	10.4%	11.2%	12.0%
Medicaid	16.7%	18.1%	23.3%
Marketplace or other private insurance	9.9%	9.6%	11.7%
Other public insurance	1.0%	1.0%	0.8%
Uninsured	24.6%	24.5%	17.5%
N (annual population estimate)	41,908,000	45,131,000	45,546,000
Share of all adults ages 19 to 64	22.2%	23.4%	23.2%
EMPLOYED			
Coverage type			
Employer-sponsored insurance	71.1%	69.9%	70.8%
Medicare	0.4%	0.5%	0.6%
Medicaid	3.5%	4.1%	7.0%
Marketplace or other private insurance	7.5%	7.6%	9.7%
Other public insurance	0.3%	0.3%	0.3%
Uninsured	17.2%	17.6%	11.6%
N (annual population estimate)	133,981,000	134,338,000	141,971,000
Share of all adults ages 19-64	71.1%	69.8%	72.5%

Source: American Community Survey, 2008–18.

for people not in the labor force, the uninsurance rate fell by about 30 percent (approximately 7 percentage points) in the ACA coverage reform period (2014–18).

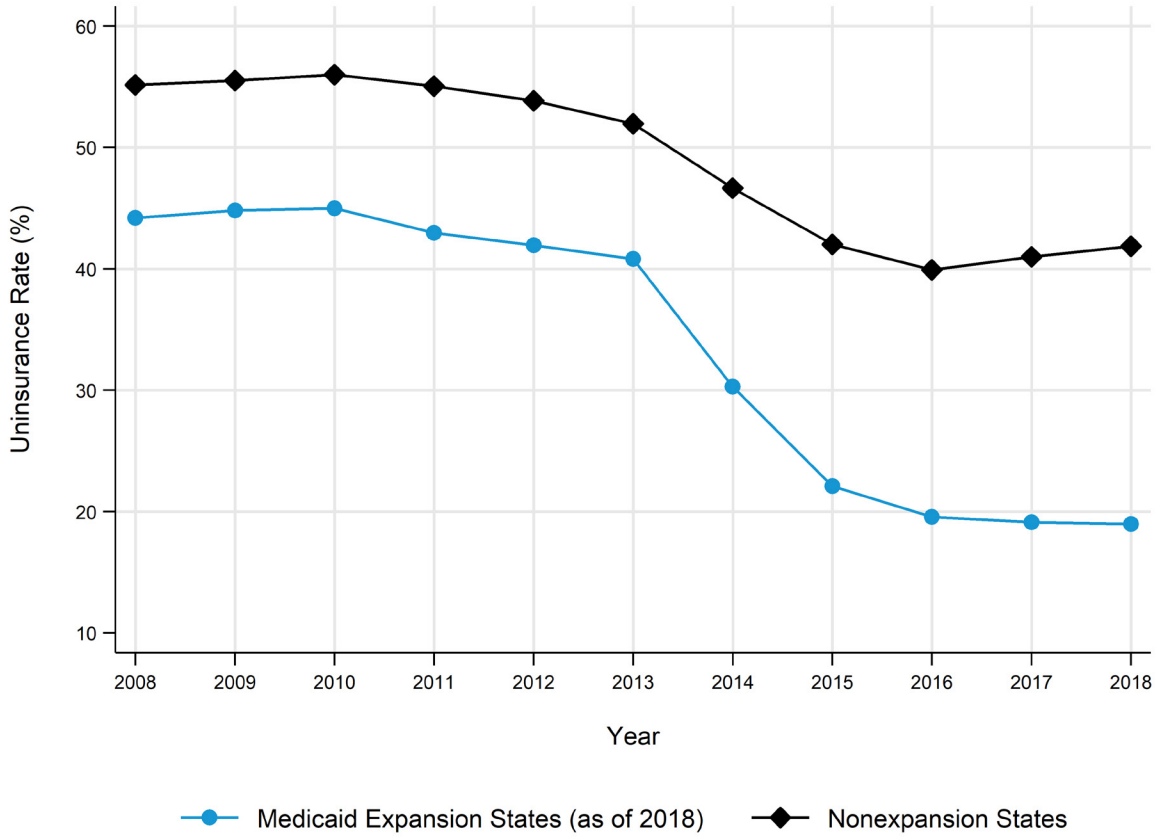
The Employed. For comparison, the bottom panel of Table 1 shows the distribution of coverage among employed people over these three periods. Under the ACA, coverage for the employed changed much less than it did for the unemployed and those not in the labor force. ESI coverage rates among the employed were stable, ranging from 69.9 percent in the 2011–13 period to 70.8 percent in the 2014–18 period. Employed people generally have higher household incomes than do the unemployed or those not in the labor force, making them less likely to qualify for Medicaid in every time period. Still, Medicaid coverage among the employed rose under the ACA's Medicaid eligibility expansion, as did individually purchased nongroup insurance coverage. Consequently, the uninsurance rate among workers fell by roughly one-third (6 percentage points) from the 2011–13 period to the 2014–18 period, a drop that is almost entirely attributable to the increase in Medicaid and marketplace coverage. This substantial increase in coverage shows that the ACA's coverage reforms were not merely a safety net for people when unemployed or not in the labor force, but also for many workers with low incomes or without access to ESI.

Differences in Health Coverage for the Unemployed in Medicaid Expansion and Nonexpansion States

Figure 1 presents uninsurance rates for nonelderly unemployed people from 2008 to 2018. We show the data separately for states that did and did not expand Medicaid eligibility under the ACA by 2018. Uninsurance rates for unemployed adults were noticeably higher in nonexpansion states than in expansion states in each year, but trended similarly in expansion and non-expansion states from 2008 to 2013. In 2014, there is a sharp drop in uninsurance rates in non-expansion states, but an even *steeper* drop in uninsurance rates in expansion states among unemployed adults. The decrease in uninsurance rates roughly stabilized in expansion states by 2016, but uninsurance rates in nonexpansion states began a modest *climb* in 2017. Figure 1 indicates that the ACA was associated with large reductions in uninsurance rates in both groups of states, but unemployed people in nonexpansion states still had a high likelihood (greater than 40 percent) of being uninsured through 2018.

Table 2 presents changes in coverage types among the unemployed by state

Figure 1. Uninsurance Rates for Unemployed Adults Ages 19 to 64, by State Medicaid Expansion Status, 2008–18



Source: American Community Survey, 2008–18.

Medicaid expansion status. As expected, changes in Medicaid coverage over the 2011–13 and 2014–18 periods differ dramatically in expansion and nonexpansion states; between these periods, Medicaid coverage among unemployed adults increased by 15.4 percentage points in expansion states, compared with a 2.9 percentage-point increase in nonexpansion states. Nongroup coverage (marketplace and other individually purchased private coverage) was similar in expansion and nonexpansion states before 2014, and both groups of states saw increases from 2014 to 2018. These increases were greater in nonexpansion states (4.7 percentage points) than in expansion states (2.2 percentage points), possibly because people with incomes between 100 and 138 percent of FPL are eligible for subsidized marketplace coverage in nonexpansion states, whereas they are generally eligible for Medicaid in expansion states.

Because of these coverage shifts, the most likely coverage type for unemployed working-age adults in Medicaid expansion states was Medicaid in the period after full implementation of the ACA's coverage provisions (2014–18). In nonexpansion states, unemployed workers were most likely to have no coverage at all over the same period.

Discussion

The ACA created new pathways for unemployed adults and other working-age adults not in the labor force to obtain health insurance coverage. Unemployed workers have been far less likely to be uninsured since 2014, following implementation of the ACA's main coverage provisions However, uninsurance rates fell much more in states that took advantage of the ACA's Medicaid expansion. As millions of workers lose jobs in the COVID-19 crisis, Medicaid, particularly in expansion states, will act as an automatic fiscal stabilizer, supporting unemployed workers' and low-income families' access to health care, as well as hospital finances and state economies. Marketplace-based subsidies will help as well, but even in Medicaid expansion states, about one in five unemployed workers was uninsured in 2018 (Figure 1).

Table 2. Coverage Types among Unemployed Adults Ages 19 to 64, by Period and State Medicaid Expansion Status

	2008–10	2011–13	2014–18
MEDICAID EXPANSION STATES			
Coverage type			
Employer-sponsored insurance	28.2%	28.1%	29.5%
Medicare	1.3%	1.5%	2.1%
Medicaid	17.4%	20.4%	35.8%
Marketplace or other private insurance	7.4%	7.1%	9.3%
Other public insurance	0.9%	0.9%	0.7%
Uninsured	44.7%	42.0%	22.6%
N (annual population estimate)	8,004,000	8,359,000	5,357,000
Share of all adults ages 19 to 64	6.8%	7.0%	4.4%
NONEXPANSION STATES			
Coverage type			
Employer-sponsored insurance	22.9%	22.6%	26.0%
Medicare	1.2%	1.5%	1.9%
Medicaid	11.7%	13.5%	16.4%
Marketplace or other private insurance	7.4%	7.4%	12.1%
Other public insurance	1.2%	1.3%	1.1%
Uninsured	55.6%	53.7%	42.5%
N (annual population estimate)	4,468,000	4,712,000	3,059,000
Share of all adults ages 19 to 64	6.3%	6.5%	4.1%

Source: American Community Survey, 2008–18.
Note: States are classified as Medicaid expansion states if they implemented expansion in 2018 or earlier.

Health insurance coverage and access to care is particularly important in the wake of the COVID-19 pandemic. Testing for the virus and isolating those who have been exposed and/or infected are critical to limiting the spread of the virus and having adequate medical providers and supplies available for people with the virus. The Families First Coronavirus Response Act, just enacted, will increase the federal Medicaid matching rate, require state Medicaid programs to cover COVID-19 testing without cost sharing, and allow states to extend Medicaid coverage to uninsured people for COVID-19 testing.[17] Still, it does not address coverage for general medical care for the uninsured. Lack of coverage for medical services for other illnesses unrelated to COVID-19 may dissuade uninsured people with COVID-19 symptoms from visiting their providers for proper testing. Congress has passed massive new stimulus legislation (totaling $2 trillion) to stabilize the economy and mitigate the pandemic's consequences. This bipartisan legislation expands unemployment insurance but does little to address Medicaid availability for workers losing their jobs—or the affordability of individual market or COBRA coverage.[18,19]

As noted, experts anticipate the COVID-19 crisis will result in unprecedented unemployment rates, and our findings indicate this will sharply increase both uninsurance and Medicaid coverage rates. Enabling temporary (at a minimum) and speedy Medicaid expansions in the 15 nonexpansion states and expanding the income range for eligibility for premium subsidies in the ACA marketplaces could help mitigate the rise in uninsurance.[20] Providing subsidies for COBRA coverage could help make previously held employer-sponsored coverage options affordable for those who are unemployed but ineligible for Medicaid or marketplace subsidies. Finally, enhancing Medicaid matching rates beyond those mandated under the Families First Coronavirus Response Act will help secure state finances as states prepare to provide Medicaid coverage to what will likely be record-setting numbers of new enrollees, especially in Medicaid expansion states.

The COVID-19 crisis focuses attention on long-standing gaps in the economic and health care safety nets. Depending on what new legislation emerges, many workers will simultaneously lose their health insurance and their ability to earn a living. With the ACA in place, these gaps will be far smaller than they would otherwise be. Though all states will experience severe adverse effects from this crisis, those that expanded Medicaid will be somewhat better positioned to face the difficult months ahead.

Finally, the Supreme Court will soon consider *California v. Texas*, which could completely overturn the ACA. Depending on the outcome, expanded eligibility for Medicaid, premium subsidies for nongroup insurance coverage, and marketplaces plans could be eliminated. Reversing the ACA would mean unemployment would likely lead to much more uninsurance than currently projected. We have estimated that uninsurance rates among the unemployed was about 46 percent in the 2011–13 period. Before the COVID-19 crisis, Urban Institute researchers estimated that reversing the ACA would result in 20 million people losing health insurance coverage.[21] Given the rising numbers of unemployed working-age adults, that estimate is outdated and far smaller than what may occur given the current circumstances. As experts predict unprecedented unemployment rates because of COVID-19's economic consequences, reversing the ACA, and thereby strengthening the relationship between joblessness and lack of health insurance coverage, would counteract efforts to contain the virus, improve public health, and stabilize the economy.

NOTES

1 Karunakar R, Sarkar S. Global economy already in recession on coronavirus devastation: Reuters poll. *Reuters*. March 19, 2020. https://www.reuters.com/article/us-health-coronavirus-global-economy/global-economy-already-in-recession-on-coronavirus-devastation-reuters-poll-idUSKBN21702Y. Accessed March 27, 2020.

2 Kennedy S. 30% GDP drop: Morgan Stanley joins Goldman Sachs in upping estimates of coronavirus economic pain. *Fortune*. March 23, 2020. https://fortune.com/2020/03/23/morgan-stanley-goldman-sachs-estimate-coronavirus-economic-pain/. Accessed March 27, 2020.

3 Faria-e-Castro M. (2020). *Back-of-the-Envelope Estimates of Next Quarter's Unemployment Rate*. On the Economy blog, Federal Reserve Bank of St. Louis. https://www.stlouisfed.org/on-the-economy/2020/march/back-envelope-estimates-next-quarters-unemployment-rate. Accessed March 27, 2020.

4 Matthews S. U.S. unemployment rate may soar to 30%, Fed's Bullard says. Bloomberg. March 22, 2020. https://www.bloomberg.com/news/articles/2020-03-22/fed-s-bullard-says-u-s-jobless-rate-may-soar-to-30-in-2q. Accessed March 27, 2020.

5 U.S. Department of Labor. *COVID-19 Impact*. Washington, DC: U.S. Department of Labor; 2020. https://www.dol.gov/ui/data.pdf. Accessed March 27, 2020.

6 Eligibility for Medicaid depends on current monthly income, whereas eligibility for marketplace premium subsidies is based on estimates of full-year income. Thus, large changes in household income could make recently unemployed adults newly eligible for both Medicaid and marketplace premium subsidies. However, unemployment compensation also contributes toward the calculation of modified adjusted gross income (used for determining eligibility for Medicaid and marketplace premium subsidies) and could reduce eligibility for these programs while providing needed income.

7 To date, 36 states have expanded Medicaid eligibility to low-income, nondisabled, nonelderly childless adults. Four of these states (Idaho, Maine, Utah, and Virginia) did not expand their Medicaid programs by 2018 (the last year for which we have data). Among the 15 remaining nonexpansion states, only Wisconsin has expanded Medicaid eligibility to childless adults—but not under the ACA; nondisabled adults with incomes below 100 percent of FPL are eligible for Medicaid in Wisconsin.

8 The Bureau of Labor Statistics defines people with jobs as employed. People who are jobless, available for work, and looking for work are defined as unemployed. The labor force consists of all people employed or unemployed. People that are not at work and are either not looking for work or not available for work are defined as not in the labor force. See https://www.bls.gov/cps/cps_htgm.htm.

9 For detailed information on the health insurance edits applied by the Integrated Public Use Microdata Series, see https://usa.ipums.org/usa/acs_healthins.shtml.

10 Ruggles S, Flood S, Goeken R, Grover J, Meyer E, Pacas J, et al. IPUMS USA: Version 10.0 [dataset]. Integrated Public Use Microdata Series USA website. https://doi.org/10.18128/D010.V10.0. Accessed March 29, 2020.

11 Additional edits to address potential misclassification of coverage in the ACS were not applied in this analysis (see Lynch V, Kenney GM, Haley J, Resnick D. *Improving the Validity of the Medicaid/CHIP Estimates on the American Community Survey: The Role of Logical Coverage Edits*. Washington, DC: U.S. Census Bureau; 2011. https://www.census.gov/content/dam/Census/library/working-papers/2011/demo/improving-the-validity-of-the-medicaid-chip-estimates-on-the-acs.pdf. Accessed March 27, 2020). For adults, such edits would slightly reduce estimates of employer-sponsored and nongroup coverage and slightly increase estimates of Medicaid coverage. However, these edits' effects are relatively small for adults and would therefore be unlikely to meaningfully affect assessments of changes over time or the variation across subgroups presented here.

12 In Tables 1 and 2, we report the share of the population ages 19 to 64 that is unemployed. This is not the same as the official unemployment rate reported by the Bureau of Labor Statistics and calculated using the Current Population Survey, which excludes people not in the labor force. Moreover, the official unemployment rate is not restricted to nonelderly adults ages 19 to 64. The average Bureau of Labor Statistics–reported monthly unemployment rate between 2008 and 2010 was 8.2 percent. Making a similar calculation by including the elderly and removing people not in the labor force and using ACS data, we estimate that the unemployment rate was 8.4 percent between 2008 and 2010.

13 In the 2018 ACS, among unemployed adults ages 19 to 64, the median personal annual income was $4,500, and the median family income was $41,000. For people not in the labor force between ages 19 to 64, the median personal income was $1,300, and the median family income was $44,000. For employed adults ages 19 to 64, the median personal income was $40,000, and median family income was $79,500.

14 Across the three study periods, unemployed people could receive employer-sponsored coverage through COBRA benefits from their previous employer or as a part of a spouse's employer plan. But starting in 2010, the ACA's dependent coverage requirement permitted adults under age 26 to enroll in their parents' employer coverage plans.

15 As the economy gradually improved from 2008 to 2018, it is possible that the composition of the unemployed shifted. These compositional changes could also be linked to insurance coverage, but are unlikely to lead to the magnitude of reduced uninsurance rates observed after 2014. We find little difference in age, sex, race/ethnicity, education, marital status, and disability status of the unemployed across the three periods.

16 In 2018, 19.3 percent of adults between ages 19 and 64 who were not in the labor force were identified as disabled (measured as whether a person either received Supplemental Security Income or had nonelderly Medicare coverage). Just 4.1 percent of unemployed adults and 0.9 percent of employed adults were identified as disabled.

17 Brooks T, Schneider A. The Families First Coronavirus Response Act: Medicaid and CHIP provisions explained. Georgetown University Health Policy Institute Center for Children and Families. 2020. https://ccf.georgetown.edu/wp-content/uploads/2020/03/Families-First-final-rev.pdf. Accessed March 27, 2020.

18 Keith K. (2020). *COVID-19 Package #3: The Coverage Provisions*. Health Affairs blog. https://www.healthaffairs.org/do/10.1377/hblog20200320.739699/full/. Accessed March 27, 2020.

19 Keith K. (2020). *Senate Passes COVID-19 Package #3: The Coverage Provisions*. Health Affairs blog. https://www.healthaffairs.org/do/10.1377/hblog20200326.765600/full/. Accessed March 27, 2020.

20 Blumberg LJ, Mann C. Quickly expanding Medicaid as an urgent response to the coronavirus pandemic. Urban Institute. 2020. https://www.urban.org/research/publication/quickly-expanding-medicaid-eligibility-urgent-response-coronavirus-pandemic. Accessed March 29, 2020.

21 Banthin J, Blumberg LJ, Buettgens M, Holahan J, Pan CW, Wang R. Implications of the Fifth Circuit Court decision in *Texas v. United States*: Losses of coverage, federal health spending, and provider revenue. Urban Institute. 2019. https://www.urban.org/research/publication/implications-fifth-circuit-court-decision-texas-v-united-states. Accessed March 27, 2020.

The views expressed are those of the authors and should not be attributed to the Robert Wood Johnson Foundation or the Urban Institute, its trustees, or its funders.

ABOUT THE AUTHORS & ACKNOWLEDGMENTS

Anuj Gangopadhyaya is a Research Associate and Bowen Garrett is a Senior Fellow in the Urban Institute's Health Policy Center. The authors are grateful for comments and suggestions from Linda Blumberg, John Holahan, Genevieve Kenney, and Stephen Zuckerman, and editing by Rachel Kenney.

ABOUT THE URBAN INSTITUTE

The nonprofit Urban Institute is dedicated to elevating the debate on social and economic policy. For nearly five decades, Urban scholars have conducted research and offered evidence-based solutions that improve lives and strengthen communities across a rapidly urbanizing world. Their objective research helps expand opportunities for all, reduce hardship among the most vulnerable, and strengthen the effectiveness of the public sector. For more information specific to the Urban Institute's Health Policy Center, its staff, and its recent research, visit *http://www.urban.org/policy-centers/health-policy-center*.

ABOUT THE ROBERT WOOD JOHNSON FOUNDATION

For more than 45 years the Robert Wood Johnson Foundation has worked to improve health and health care. We are working alongside others to build a national Culture of Health that provides everyone in America a fair and just opportunity for health and well-being. For more information, visit www.rwjf.org. Follow the Foundation on Twitter at www.rwjf.org/twitter or on Facebook at www.rwjf.org/facebook.