How Effectively Does the American Recovery and Reinvestment Act Help Laid-Off Workers and States Cope with Health Care Costs?

Timely Analysis of Immediate Health Policy Issues

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Summary

The American Recovery and Reinvestment Act of 2009 (ARRA) sought to strengthen the country's ailing economy by enacting a broad range of policies, two of which are the subject of this paper. One helps laid-off workers obtain health coverage, and the other provides fiscal relief to state Medicaid programs.

The first policy pays 65 percent of premiums for coverage offered by former employers under the Comprehensive Omnibus Budget Reconciliation Act of 1985 (COBRA). These subsidies are likely to be too small to make coverage affordable to many people who have lost their jobs. An existing program that pays 65 percent of premiums for workers laid off because of trade liberalization—the Health Coverage Tax Credit program—enrolls only 12 to 15 percent of eligible workers. ARRA almost certainly will raise participation above those levels, but enrollment is likely to remain quite limited.

Furthermore, ARRA does not cover uninsured, laid-off workers who are ineligible for COBRA. Some worked for companies that have gone out of business or were too small to be governed by COBRA or similar state laws; others did not receive health coverage from their former employers. Many without access to COBRA would have been helped by House-passed Medicaid expansions that covered two groups of uninsured, unemployed workers: recipients of unemployment insurance, no matter how high their income, and low-income laid-off workers and their families, who have the least access to coverage and care. These Medicaid expansions, however, were not included in the final legislation.

By providing state Medicaid programs with $87 billion in fiscal relief, ARRA is likely to be effective in preventing many large Medicaid cutbacks. Targeting 35 percent of assistance to states with particularly high unemployment rates, ARRA will provide more "bang for the buck" in preventing state cutbacks and stimulating the economy than did fiscal relief legislation in 2003–2004, which gave all states the same level of help. Nevertheless, since most of the fiscal relief is distributed without regard to each state's economic situation, the states with the most serious fiscal problems may not obtain sufficient assistance to avoid reducing health care services.

Introduction

Signed into law on February 17, 2009, the American Recovery and Reinvestment Act of 2009 (ARRA) subsidizes health coverage for uninsured, laid-off workers and provides state Medicaid programs with $87 billion in fiscal relief, delivered over nine calendar quarters.[1] This paper assesses the likelihood that these portions of the legislation will achieve their goals.

Health coverage for laid-off workers

The legislation

ARRA subsidizes insurance that employers offer laid-off workers under the Comprehensive Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA applies to companies that have 20 or more employees and that offer health insurance. When such a firm terminates a worker it previously insured, the company must continue to offer coverage for at least 18 months.[2] To enroll, the worker must pay the full premium plus a 2 percent administrative fee. Under ARRA,

- Subsidies pay 65 percent of the cost of enrolling in COBRA plans and coverage offered by smaller employers subject to similar state-law requirements. Forty states have such "mini-COBRA" laws.[3]
- The subsidies are available to workers who lost their jobs between September 1, 2008, and December 31, 2009. For each recipient, the subsidies end after nine months. Ineligible for subsidies are
  - Workers with access to employer-sponsored insurance (ESI) offered by any firm other than their former employer;

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- Workers who qualify for Medicare; and
- Workers with incomes above $145,000 a year for an individual or $290,000 a year for a couple.[4]

- After billing subsidy-eligible workers for their 35 percent share, health plans collect the 65 percent subsidies by reducing income and payroll tax withholding they would otherwise owe the federal government for all their employees.[5]

Both the House and Senate bills proposed 12 rather than 9 months of subsidies, and neither limited subsidies based on income. ARRA accepted the House-proposed subsidy level—65 percent of premiums—rather than the Senate's 50 percent subsidy. The Congressional Budget Office (CBO) projected that the enacted COBRA subsidy would cost $24.7 billion, roughly half-way between the House and Senate amounts (table 1).

However, ARRA rejected House-proposed optional Medicaid coverage for laid-off, uninsured workers in two major groups:[6] (a) recipients of unemployment insurance (UI), regardless of their income; and (b) laid-off workers and their families with incomes at or below 200 percent of the federal poverty level (FPL).[7] The House proposal had offered full federal funding, without any need for state matching dollars.

Table 1. The Projected Cost of ARRA's Health Coverage Subsidies for Laid-Off Workers: House, Senate and Final Versions (billions of dollars)

	House	Senate	Final legislation
COBRA subsidy	$26.7	$22.6	**$24.7**
New Medicaid options	$13.3	$0.0	**$0.0**
Total cost	$40.0	$22.6	**$24.7**

Sources: Congressional Budget Office, January 26, 2009, February 9, 2009, and February 13, 2009 (Cost estimates for H.R. 1).

Note: The table reduces COBRA subsidy costs to reflect offsetting increases in revenue forecast by CBO.

Analysis

The legislation's strengths

Subsidy administration is significantly improved over Health Coverage Tax Credits (HCTC), which pay 65 percent of health insurance premiums for workers certified by the U.S. Department of Labor as losing their jobs because of trade liberalization.[8] HCTCs can be either advanced directly to the insurer when monthly premiums are due or claimed at the end of the year on income tax forms. Fully refundable, the credits can provide laid-off workers with COBRA coverage and private insurance arranged by the state. HCTC has experienced serious administrative problems that ARRA avoids:

- *Cash flow for laid-off workers.* In many states, HCTC-eligible workers must pay premiums in full while they wait for advance payment to begin.[9] With ARRA, laid-off workers pay, from the start, just their 35 percent share of premiums.
- *Administrative costs.* To advance HCTC monthly to insurers when premiums are due, IRS spends $1 in administrative costs to deliver $4 in subsidies.[10] Such high costs result primarily from multiple federal transactions for each advance payment recipient every month.[11] Administrative costs should be much lower with ARRA, which delivers subsidies by having health plans reduce their federal income tax withholding and payroll taxes.

Among uninsured, COBRA-eligible workers, eligibility is well-targeted.

- *Subsidies are not limited to workers who receive unemployment insurance.* This recognizes that many fewer unemployed workers receive UI now than in the past.[12]
- *The proposal excludes laid-off workers with access to other ESI,* including spousal coverage and insurance offered by new employers. This focuses assistance on the laid-off workers who, without subsidies, are most likely to be uninsured. If no such restrictions had applied, much federal money would have substituted for employers' health insurance payments rather than covered the uninsured.[13]
- *The proposal excludes laid-off workers with annual incomes above specified levels,* thus focusing finite federal resources on households more likely to need assistance.

The legislation's weaknesses

The 65 percent subsidy is probably not large enough for many laid-off workers to afford health coverage.[14] With HCTC's 65 percent subsidy, only 12 to 15 percent of eligible households obtain health insurance.[15] The most important reason for this low participation is that HCTC-eligible workers are generally unable to afford to pay 35 percent of premiums.[16]

Other factors impede HCTC participation, including the cash flow problem described above.[17] By avoiding these barriers, the new program will raise participation rates above HCTC's 12 to 15 percent range. But affordability is likely to remain a major problem that keeps enrollment at low levels.

The 35 percent of premiums that ARRA requires from the newly unemployed is significantly more than what *employed* workers pay for coverage, which averages 16 percent of premiums for worker-only insurance and 27 percent for family coverage.[18] It is unrealistic to expect that many workers will increase the amount they pay for health insurance when their income drops because of job loss.

According to estimates from the Congressional Joint Committee on Taxation, ARRA's COBRA subsidies will cover approximately 7 million people (including workers and dependents)

at some point during 2009.[19] This projection includes those who would have enrolled in COBRA coverage without subsidies.

How many individuals will be eligible for subsidies is difficult to quantify. During January 2009, a seasonally-adjusted total of 11.8 million workers were involuntarily unemployed, with a 19.8-week average duration of unemployment.[20] If that level and duration of unemployment persist throughout 2009, 25.8 million workers will be unemployed from March 1 (when COBRA subsidies first become available) through the end of the year. While taking into account dependents would increase the estimated number of people who qualify for the subsidy, many laid-off workers are ineligible for COBRA, and others will be ineligible for subsidies under ARRA because of excess income, access to group plans offered by spousal employers or new employers, or eligibility for Medicare.

Notwithstanding those uncertainties, an estimate of 7 million people using COBRA subsidies at some point during 2009, including those who would have enrolled in COBRA without the subsidy, suggests that a relatively small percentage of eligible, uninsured workers will retain health coverage due to ARRA.

To avoid low participation, lawmakers may need to increase the subsidy percentage. One logical benchmark is the 80 percent COBRA subsidy paid by Massachusetts's Medical Security Program,[21] which for 20 years has provided health coverage to unemployed workers—the only such state-level program.[22] After long experience that includes varying subsidy levels, that state's policymakers have concluded that 80 percent subsidies are needed to make coverage affordable to the newly unemployed.[23]

Other provisions of ARRA raised the HCTC subsidy from 65 percent to 80 percent of premiums.[24] A similar change may turn out to be needed for ARRA's COBRA subsidy to reach most if its intended beneficiaries.

Raising the subsidy percentage would also increase the proportion of healthy workers who enroll into COBRA.[25] This could address some employers' concern that, even with a 65 percent subsidy, those who choose COBRA will have above-average health care expenses that exceed their COBRA premium payments, shifting the unpaid health care costs to employers and, ultimately, to remaining employees.[26]

Limiting subsidies to COBRA-eligible workers excludes many unemployed, uninsured workers—particularly those who most need help. ARRA does not cover the following groups of uninsured, laid-off workers and their families:

- Unemployed workers whose former employers are no longer governed by COBRA because they have gone out of business or stopped offering coverage to their current employees;
- Unemployed workers who, before job loss, were employed and covered by small firms that were governed by neither COBRA nor state mini-COBRA laws; and
- Unemployed workers who did not receive coverage from their employers before job loss.

This restriction adversely affects low-income households. Among workers with incomes below 200 percent of the federal poverty level in 2008, 38 percent would have likely qualified for COBRA if they lost their jobs, compared with 76 percent among workers with incomes above that threshold.[27]

By making access to COBRA the touchstone of subsidy eligibility, ARRA targets workers who lost coverage when they became unemployed, but that ignores the impact of job loss on workers who were uninsured before they were laid off. Unemployment can create or worsen significant medical problems,[28] increasing the adverse health consequences of uninsurance.[29] Also, job loss typically reduces household income by substantial amounts.[30] This may make it more difficult for the previously uninsured to obtain medical care; out-of-pocket payments from the uninsured now cover an average of 35 percent of all their health care costs.[31]

The House-proposed Medicaid options would have helped many unemployed, uninsured workers who lack access to COBRA. Policymakers did not have the time to carefully design and implement a new health coverage program to serve the group left behind by COBRA subsidies. The current economic emergency and the consequent need for speed made it hard to see a practical alternative to Medicaid, which already covers millions of low-income families and regularly determines eligibility for means-tested subsidies.[32]

Based on press accounts, legislators may have rejected the House Medicaid proposal because some of its eligibility groups were not means-tested.[33] But as noted above, other portions of the House bill were limited to laid-off uninsured workers who are poor or near-poor. Such targeted Medicaid options may need to be reconsidered if ARRA does not turn out to prevent uninsurance among low-income, unemployed workers and their families, whose difficult economic straits can leave them with very little access to coverage and care.

State fiscal relief

The legislation

The legislation offers fiscal relief to states by increasing federal Medicaid payments from October 1, 2008, through December 31, 2010. To qualify for assistance, a state may not apply more restrictive eligibility standards, methodologies, or procedures than were in effect on July 1, 2008. Payments come in two main forms:[34]

- Each state receives a 6.2 percentage point increase in its federal medical assistance percentage (FMAP), the portion of Medicaid costs paid by the federal government. Before ARRA, state FMAPs ranged from 50 to 75.4 percent,[35] averaging about 57 percent.[36]

Table 2. Amount of Targeted Fiscal Relief ARRA Provides to States Experiencing Increased Unemployment

Increase in state unemployment rates over baseline period (percentage points)	Amount of targeted fiscal relief (percent of Medicaid costs)
Under 1.5	None
1.5 to 2.49	5.5
2.5 to 3.49	8.5
3.5 or more	11.5

- If during a quarter, a state's most recent three-month average unemployment rate is at least 1.5 percentage points higher than it was during any three-month period starting in January 2006, the state qualifies for an additional FMAP increase. The amount of additional funding ranges between 5.5 and 11.5 percent of a state's Medicaid costs, depending on the state's increase in unemployment (table 2).

The targeted fiscal relief is calculated as a percentage of state costs.[37] For example, if a state's share of Medicaid costs is 35 percent and the state's unemployment rate is 2 percentage points above baseline levels, the targeted fiscal relief would equal 5.5 percent of the state's 35 percent Medicaid share—in other words, the state would get a 1.925 percentage point increase in its FMAP, in addition to the universally available FMAP boost of 6.2 percentage points.[38]

The House and Senate versions of the proposal provided almost identical amounts of relief but differed in the proportion of assistance that was targeted to states experiencing unusually high increases in unemployment rates. The final legislation compromised at the midpoint between the two proposals, directing approximately 35 percent of all assistance to states in particularly difficult economic straits (table 3).

Analysis

The legislation addresses a compelling need. Almost every state is legally forbidden from running deficits, even in a recession. As a result, the combination of falling revenue and rising caseloads for Medicaid and other need-based programs means that, without significant federal help, service cutbacks or tax increases are inevitable during a downturn. Such steps can harm households and state economies.

Shortly before the enactment of ARRA, 46 states faced current or projected budget deficits that totaled approximately $350 billion dollars.[39] The District of Columbia and 32 states had enacted or proposed cuts to health care services for low-income families, seniors, or people with disabilities; 26 states had proposed or enacted cuts to k–12 education; and 32 states had proposed or enacted cuts to funding for higher education.[40]

ARRA significantly improves on previous state fiscal relief legislation in several ways:

- *"Bang for the buck."* During the 2003–2004 downturn, Congress gave each state an identical 2.95 percentage point FMAP increase, along with block grants based on state population. By contrast, ARRA provides extra help to states in particularly dire economic straits. As a result, a fixed amount of federal fiscal relief goes further toward preventing state cuts, which translates into additional stimulus and more help to vulnerable households. At the same time, comparatively well-off states are less likely to receive more federal money than they need.
- *State accountability.* A state accepting the 2003–2004 fiscal relief was forbidden from cutting back eligibility standards. Between this requirement and the estimated $20 billion in federal funds dispensed over five quarters, about half of the states rescinded prior cutbacks or avoided planned reductions.[41] However, 10 states made procedural changes that trimmed Medicaid caseloads, such as requiring more frequent documentation of continued eligibility. States also cut benefits, reduced provider reimbursement, increased cost-sharing, and took other measures to cut spending, even while eligibility standards remained intact. ARRA avoids many of these problems, since a state accepting fiscal relief must eschew both cutbacks in eligibility standards and more restrictive eligibility methodologies and procedures. On the other hand, ARRA permits states to control costs

Table 3. Fiscal Relief Provisions in ARRA: House, Senate, and Final Versions

	House	Senate	Final legislation
Total amount of fiscal relief from October 1, 2008 through December 31, 2010	$87.0 billion	$86.6 billion	$87.0 billion
Approximate proportion of fiscal relief targeted to states with the largest increases in unemployment rates	50 percent	20 percent	35 percent

Sources: Author's calculation, Government Accountability Office, "State Medicaid Assistance under House and Senate ARRA," February 2009 (unpublished analysis); Conference Committee Report (H. Rept. 111-16), H.R. 1, February 2009.

in other ways, which reduces the stimulative impact of the legislation and may harm beneficiaries. However, since ARRA will lessen but not eliminate state budget shortfalls, it is hard to argue that states should be left without any tools to lower projected Medicaid spending.

While ARRA will lessen the severity of state cutbacks, it will not eliminate them. Within days of ARRA's enactment, officials in at least four states rescinded previously announced Medicaid cutbacks.[42] However, ARRA will leave untouched approximately 60 percent of aggregate state budget shortfalls.[43] And despite the improvements over previous fiscal relief legislation, most of ARRA's Medicaid dollars pay for a uniform increase in each state's FMAP, regardless of the state's need for help. As a result, the hardest-hit states are likely find the fiscal relief insufficient to prevent major reductions. Depending on how the recession unfolds in these states, federal policymakers may need to consider additional, targeted relief.

Conclusion

While ARRA will help some laid-off workers and their families retain health coverage, many are likely to remain uninsured. For ARRA to cover the bulk of unemployed, uninsured workers, two changes may turn out to be necessary: the subsidy likely needs to pay a higher percentage of COBRA premiums; and as proposed in the House bill, state Medicaid programs will probably need the option to cover laid-off workers and their families who have low incomes.

The state fiscal relief provisions of the bill are likely to prove effective in forestalling many major Medicaid cutbacks, thus helping vulnerable households and shoring up our ailing economy. This effectiveness results from both the total amount of assistance that ARRA provides and the legislation's targeting of a significant percentage of fiscal relief to states experiencing unusually severe economic harm. However, some states' fiscal crises are so serious that federal policymakers will need to monitor the situation carefully to see whether additional, targeted assistance is required.

Notes

[1] Rather than describe in comprehensive detail these two portions of ARRA, this paper highlights key features of the legislation.

[2] For further information about COBRA, see U.S. Department of Labor (DOL), Employee Benefits Security Administration, *Frequently Asked Questions about COBRA Continuation Health Coverage,* http://www.dol.gov/ebsa/FAQs/faq_compliance_cobra.html.

[3] Kaiser Family Foundation, "Expanded COBRA Continuation Coverage for Small Firm Employees, 2007," http://www.statehealthfacts.org.

[4] When a worker who receives these subsidies in a given year files a federal income tax form showing income for that year above permitted levels, such a worker repays the subsidies in the form of higher tax obligations.

[5] If such steps are not sufficient to fund all of the subsidies for plan enrollees, the Treasury Department pays the remainder.

[6] Not listed in the text were two other Medicaid eligibility groups made up of involuntarily unemployed, uninsured workers and their families: namely, those who exhausted their time-limited unemployment insurance, to whom no income or asset test applied; and those who received food stamps and so had already been found to be poor.

[7] In 2009, the federal poverty level is $10,830 for a single person, $22,050 for a family of four, etc.

[8] HCTC also goes to certain early retirees who receive payments from the Pension Benefit Guaranty Corporation because their former employers no longer pay promised defined benefit pensions. For more information about HCTC, see Stan Dorn, "Health Coverage Tax Credits: A Small Program Offering Large Policy Lessons" (Washington, DC: The Urban Institute, 2008).

[9] However, 18 states, many of which contain the heaviest concentration of HCTC-eligible workers, use DOL grants to pay 65 percent of premiums while workers wait for HCTC advance payment to start. Dorn, "Health Coverage Tax Credits."

[10] Dorn, "Health Coverage Tax Credits."

[11] Each month federal tax officials send an invoice to the beneficiary requesting the beneficiary's 35 percent premium share; track the receipt of payment from the beneficiary; add an HCTC to the beneficiary's payment; and forward the full premium to the health plan electronically, along with information identifying the enrollee, all done by the plan's regular monthly due date for premium payment. Of course, increasing the number of enrollees could achieve economies of scale that lower per capita administrative costs. Nevertheless, the structure of subsidy delivery makes HCTC an expensive program to administer.

[12] Only 36.7 percent of unemployed workers obtained UI in 2007, compared to 60 percent in the early 1970s. Margaret C. Simms and Daniel Kuehn, *Unemployment Insurance during a Recession* (Washington, DC: The Urban Institute, 2008). Other provisions of ARRA may increase the proportion of workers who receive UI.

[13] On the other hand, the denial of subsidies to people with access to spousal coverage may limit the ability of this subsidy to make coverage affordable. At some firms, employers pay a small proportion of the cost of adding a spouse or other dependent to a worker's insurance policy. Among firms with fewer than 200 employees, for example, 30 percent require workers to pay more than half of the cost of family coverage. Kaiser Family Foundation and the Health Research and Educational Trust (KFF/HRET), *2008 Employer Health Benefits Survey* (Washington, DC: The Kaiser Family Foundation, 2008). In short, some laid-off workers who cannot afford to enroll in their spouses' employer-based plans will be ineligible for subsidies.

[14] An issue not addressed in the body of this paper is the legislation's limit of subsidies to nine months duration, which could terminate health coverage before some laid-off workers have found a job. As of December 2008, 1.3 million workers, or 12.8 percent of all the unemployed, had been out of work for one year or longer. These numbers may climb still higher as the economic downturn continues. They were only 700,000 and 9.1 percent as of December 2007. Bureau of Labor Statistics, *Unemployed total and full-time workers by duration of unemployment (not seasonally adjusted) January 2009.* (Washington, DC: Department of Labor, 2009). On the other hand, by limiting the duration of subsidies, conferees were able to keep subsidies at the 65 percent level, without exceeding desired spending levels for this portion of the legislation. Lawmakers made the reasonable decision to provide a more effective subsidy for a shorter period of time rather than a less effective subsidy for a longer period of time. In effect, they chose to help more laid-off workers obtain coverage for 9 months rather than help fewer laid-off workers obtain coverage for 12 months.

[15] Dorn, "Health Coverage Tax Credits."

[16] DOL Office of Inspector General, *Performance Audit of Health Coverage Tax Credit (HCTC) Bridge and Gap Programs,* Report no. 02-05-204-03-330 (Washington, DC: Department of Labor, 2005); Government Accountability Office (GAO), *Trade Adjustment Assistance: Most Workers in Five Layoffs Received Services, but Better Outreach Needed on New Benefits,* GAO-06-43 (Washington, DC: GAO, 2006); GAO, *Health Coverage Tax Credit: Simplified and More Timely Enrollment Process Could Increase Participation,* GAO-04-1029 (Washington, DC: GAO, 2004).

[17] Other factors include the very high underlying premiums charged by some non-COBRA, state-qualified plans, including high-risk pools and non-group plans, which, in most states, charge much more for laid-off workers who are older or have health problems; and the limited value offered by many HCTC plans for reasons that include the exclusion of preexisting conditions that is allowed for beneficiaries with coverage gaps. Dorn, "Health Coverage Tax Credits."

[18] KFF/HRET, "Health Benefits Survey."

[19] Personal communication, Drew Crouch, March 2, 2009; Joint Committee on Taxation, *Estimated Budget Effects of the Revenue Provisions Contained in the Conference Agreement for H.R. 1, Fiscal Years 2009–2019: The "American Recovery and Reinvestment Tax Act of 2009,"* JCX-19-09 (Washington, DC: JCT, 2009).

[20] Bureau of Labor Statistics, "Table A-9. Unemployed persons by duration of unemployment," in *The Employment Situation: January 2009* (Washington, DC: Bureau of Labor Statistics, 2009).

[21] No data show the take-up rate for the MSP program, but most state observers believe it is low, for several reasons: very little outreach and community education has taken place; state officials do not link the UI application with enrollment into MSP; UI offices are swamped with applications for UI benefits during times like the present, when demand for help is at very high levels, making it difficult for MSP applicants to obtain information or seek benefits; and the COBRA subsidy program requires workers to pay their first month's premium in full, receiving 80 percent reimbursement by the end of the month. Monica Hallas, personal communication, January 2009; Robb Smith, personal communication, February 2009.

[22] The program also includes a "Direct Coverage" option that provides premium-free coverage through a Blue Cross/Blue Shield HMO to (a) unemployed workers without access to COBRA and (b) unemployed workers with incomes at or below 200 percent of the FPL, whether or not they have access to COBRA. Two-thirds of program participants use the Direct Coverage option, rather than COBRA subsidies. Wendy Hamlett, personal communication, January 2009.

[23] When the COBRA subsidy dropped to 75 percent of the premium, it was generally viewed as insufficient for many unemployed workers. Hallas, op cit. On the other hand, in a 2001 national survey, 59 percent of workers, including 64 percent of those with incomes above 200 percent of FPL, reported that, if they lost their jobs, a 75 percent premium subsidy would make them very likely to enroll in COBRA continuation coverage. Jennifer N. Edwards, Michelle M. Doty, and Cathy Schoen, *The Erosion of Employer-Based Health Coverage and the Threat to Workers' Health Care* (New York, NY: The Commonwealth Fund, 2002).

[24] ARRA Section 1899A.

[25] A lower cost means that people who foresee fewer health care expenses find enrollment worthwhile. Accordingly, employers pay a large percentage of premiums in part because generous subsidies reduce adverse selection. Congressional Budget Office, *Key Issues in Analyzing Major Health Insurance Proposals* (Washington, DC: Congressional Budget Office, 2008).

[26] See U.S. Chamber of Commerce, *Letter to the Senate on H.R. 1, the "American Recovery and Reinvestment Act of 2009,"* February 3, 2009, http://www.uschamber.com/issues/letters/2009/090203recoveryact.htm.

[27] Michelle M. Doty, Sheila D. Rustgi, Cathy Shoen, and Sara R. Collins, *Maintaining Health Insurance during a Recession: Likely COBRA Eligibility* (New York, NY: The Commonwealth Fund, 2009).

[28] See Colin D. Mathers and Deborah J. Schofield, "The Health Consequences of Unemployment: The Evidence," *Medical Journal of Australia* 168:178–82 (1998); Pekka T. Martikainen, Tapani Volkonen, "Excess Mortality of Unemployed Men and Women During a Period of Rapidly Increasing Unemployment," *Lancet* 348:909–12 (1996); Kath A. Moser, Peter O. Goldblatt, A. John Fox, David R. Jones, "Unemployment and Mortality: Comparison of the 1971 and 1981 Longitudinal Study Census Samples" *British Medical Journal* 1:86–90 (1987); Margaret W. Linn , Richard Sandifer, Shayna Stein, "Effects of Unemployment on Mental and Physical Health," *American Journal of Public Health,* 75:502–6 (1985); Samuel Shortt, "Is Unemployment Pathogenic? A Review of Current Concepts with Lessons for Policy Planners," *International Journal of Health Services* 26(3): 569–89 (1996); Robert L. Jin, Chandrakant P. Shah, Tomislav J. Svobada, "The Impact of Unemployment on Health: A Review of the Evidence," *Canadian Medical Association Journal* 153(5): 529–40 (1995).

[29] The Institute of Medicine, *America's Uninsured Crisis: Consequences for Health and Health Care,* forthcoming.

[30] Median income of UI recipients falls by 60 percent when UI payments are not included in the analysis. Taking into account UI payments cuts the median income drop to 40 percent. Ralph E. Smith, *Family Income of Unemployment Insurance Recipients,* Congressional Budget Office, March 2004.

[31] Fourteen percent of the uninsured's care is covered by public programs, 20 percent is paid by private sources, and 32 percent is uncompensated. Author's calculation from Jack Hadley, John Holahan, Teresa Coughlin, and Dawn Miller, "Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs," *Health Affairs* 27(5): w399-w415 (2008).

[32] Medicaid also has the advantage of providing coverage with little or no cost-sharing, thus addressing the needs of laid-off workers who have little discretionary income. In addition, after adjusting for enrollee risk levels, Medicaid is much less costly than private coverage. Adjusted Medicaid costs per capita are 29 percent below private levels for adults and 10 percent lower for children. Jack Hadley and John Holahan, "Is Health Care Spending Higher under Medicaid or Private Insurance?" *Inquiry* 40(4): 323–342 (2003/2004). On the other hand, not all states will implement the new Medicaid options; low provider reimbursement rates limit access to care; Medicaid application procedures may deter enrollment by laid-off workers unaccustomed to dealing with welfare agencies; and 100 percent federal matching payments lessen state incentives to efficiently manage premium payment levels and fee-for-service costs. The first two problems are inherent in the basic approach of creating new Medicaid eligibility options to serve laid-off workers. However, the latter two problems could be addressed through effective program management. See generally Section 1903(m)(2)(A)(iii) of the Social Security Act, requiring capitated payments to be "actuarially sound," and Section 1902(a)(4)(A), requiring states to apply "methods of administration" that "are found by the Secretary to be necessary for the proper and efficient operation of" the Medicaid program.

[33] John Reichard, "Conference Agreement Includes Health Concessions to the House," *Washington Health Policy Week in Review,* (New York, NY: The Commonwealth Fund, 2009).

[34] In addition, underlying state FMAP rates for 2009 and 2010 are not permitted to decline below levels in effect during 2008; state allotments for Disproportion Share Hospital payments increase for fiscal years 2009 and 2010; certain moratoria delay implementation of Medicaid regulations proposed by the Bush Administration that would have reduced the amount of federal funding for states; and certain Medicaid eligibility categories that were slated to sunset are continued, including coverage for families who would otherwise become ineligible because of a recent transition from cash assistance to employment.

[35] Department of Health and Human Services, Office of the Secretary, "Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the State Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2008, through September 30, 2009," *Federal Register,* November 28, 2007, 72(228): 67304–6.

[36] Kaiser Commission on Medicaid and the Uninsured (KCMU), *Medicaid: A Primer* (Washington, DC: KCMU, 2009).

[37] This approach makes sense on the assumption that a given increase in a state's unemployment rate causes the same proportionate increase in state Medicaid costs, regardless of the state's underlying FMAP. Whether a state's normal share of Medicaid is 50 percent or 25 percent, a 1 percentage point increase in its unemployment rate is, on average, associated with a 1 percent increase in its Medicaid costs, according to earlier research. Stan Dorn, Bowen Garrett, John Holahan, and Aimee Williams, *Medicaid, SCHIP and Economic Downturn: Policy Challenges and Policy Responses* (Washington, DC: The Urban Institute, 2008). The responsiveness of state Medicaid costs to macroeconomic conditions will depend on many factors—the generosity of its eligibility rules, the proportion of its spending on non-elderly, non-disabled enrollees, whose enrollment is most responsive to economic changes, etc.—but the size of a state's FMAP is not one of those factors.

[38] To be more precise, the applicable percentage of state Medicaid costs is applied, not to the state's share of Medicaid costs under current law, but to such share after taking into account (a) the "hold harmless" provisions that prevent FMAP reductions in 2009 and 2010 and (b) half of the baseline 6.2 percentage point increase in FMAP.

[39] Elizabeth McNichol and Iris J. Lav, *State Budget Troubles Worsen* (Washington, DC: Center on Budget and Policy Priorities, 2009).

[40] Nicholas Johnson, Phil Oliff, and Jeremy Koulish, *Facing Deficits, at Least 40 States Are Imposing or Planning Cuts That Hurt Vulnerable Residents* (Washington, DC: Center on Budget and Policy Priorities, 2009).

[41] Victoria Wachino, Molly O'Malley, and Robin Rudowitz, *Financing Health Coverage: The Fiscal Relief Experience* (Washington, DC: KCMU, 2005).

[42] Kaiser Family Foundation, "Kaiser Daily Health Policy Report, February 20, 2009" (Washington, DC: Kaiser Family Foundation, 2009).

[43] This analysis includes fiscal relief provisions in ARRA that go beyond enhanced Medicaid matching funds. Nicholas Johnson, Elizabeth C. McNichol, and Iris J. Lav, *Funding for States in Economic Recovery Package Will Close Less Than Half of State Deficits* (Washington, DC: Center on Budget and Policy Priorities, 2009).

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