JOINT ECONOMIC COMMITTEE
CONGRESSMAN DON BEYER, VICE CHAIR

States Desperately Need an Increased Federal Match for Medicaid

Unemployment that exceeds the worst of the Great Recession likely will result in more than 25 million Americans losing access to employer-sponsored-insurance.[1] As a result, it is estimated that nearly13 million individuals will be able to enroll in Medicaid, which before the pandemic began insured about 71 million people in the United States, more than one-in-five Americans. [2]

On average, 20 percent of state budgets already are dedicated to Medicaid spending. States project that rapidly increasing enrollment due to the pandemic-induced recession, combined with increased spending on coronavirus treatment, will cause their spending on Medicaid to increase 5.7 percent in the next fiscal year, five times faster than the increase during the current fiscal year. This will place an enormous strain on state budgets, which could have large negative effects nationwide.

Rapidly rising Medicaid applications will force state governments, almost all of which are forced to balance their budgets, to choose between cutting Medicaid or slashing other vital state services and jobs. The effect of these cuts likely would ripple into the national economy, with increased unemployment and lower aggregate demand. Similar cuts made in the aftermath of the Great Recession substantially slowed the national economic recovery. Alternately, if states cut spending on fighting the coronavirus, failure to contain the pandemic would damage public health across the country and would further increase the likelihood of the re-imposition of several social distancing measures.

In March, Congress passed and the President signed into law the Families First Coronavirus Response Act (FFCRA), authorizing a 6.2 percentage point increase in the Federal Medical Assistance Percentages (FMAP), the federal match of state Medicaid spending. This FMAP "bump" is about half the average percentage increase during the Great Recession, despite the fact that the current recession is more severe than the previous one.

Medicaid is an automatic stabilizer for the economy, reflexively increasing its spending when the economy worsens and more people join the Medicaid program. Like unemployment insurance, it helps lessen the severity of an economic downturn by putting money where it is needed most and where it is most likely to be spent, supporting aggregate demand. As a result, the program can deliver needed money to states quickly, preventing political gamesmanship from delaying a vital fiscal response to an economic crisis.

In an ideal world, the FMAP percentage would rise when the economy craters, providing an additional boost to the automatic stabilizing effect. If the economy remains weak for an extended period, Congress may be pressed to consider an automatic mechanism for increasing the federal Medicaid match. In the meantime, Congress would be foolish to pass an FMAP increase that is insufficient to address the enormous scale of the current crisis.

States already are experiencing large increases to Medicaid enrollment and spending

Although there is typically a lag between loss of insurance and enrollment in Medicaid, Medicaid enrollment has already increased by 6.6 percent among 22 states that have enrollment data for June.[3] Some states have already reported double-digit percent increases in Medicaid enrollment.[4] For example, between February and June, enrollment increased 10.3 percent in Kentucky, and 11 percent in Minnesota.

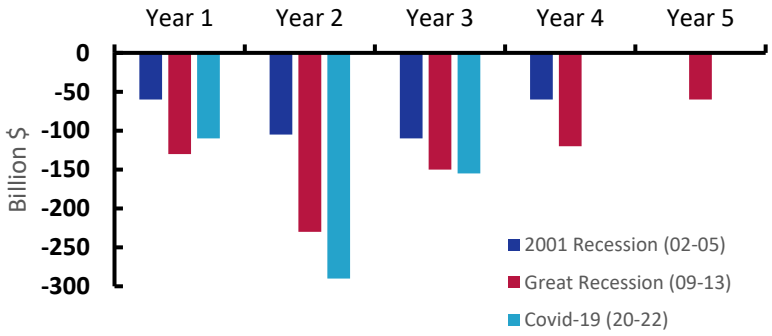
States project that during fiscal year 2020 (which started July 1), state Medicaid spending will increase an average of 5.7 percent, over five times the rate of the previous fiscal year's increase of 1.1 percent. [5]

State tax revenues have plummeted and budgets are under severe pressure

The Center on Budget and Policy Priorities (CBPP) estimates that state budget shortfalls will exceed the budget shortfalls during the peak of the Great Recession and its aftermath (Figure 1). Between 2020 and 2022, the CBPP projects that cumulative budget shortfalls will total $555 billion, exceeding the $510 billion shortfall during the first three years of the Great Recession.[6]

This will limit the ability of states to pay for Medicaid, which typically accounts for an average of about 20 percent of state budgets, excluding federal funds.[7] States already are being faced with the difficult task of choosing which essential service to cut—health care or education, nutrition or housing—in order to balance their budgets.

Figure 1. Covid-19 Budget Shortfalls Could be Largest on Record



Source: CBPP

The Families First Act increased the federal Medicaid spending match by 6.2 percent

As noted previously, on average state Medicaid spending accounts for one-fifth of state budgets. For this reason, changes in Medicaid outlays caused by an increase in enrollment or expenditures can have a massive impact on state budgets.

Medicaid is funded by both the federal government and the states. The federal government's share of state Medicaid spending is determined by a state's per capita income. The lower a state's per capita income, the higher the share of Medicaid costs that the federal government pays. The statutory minimum and maximum share is 50 percent and 83 percent, respectively. In

previous periods of economic crisis, such as the Great Recession, the federal government increased its FMAP contribution to offset ballooning Medicaid spending by the states as state revenue declined.

To help support states as Medicaid enrollment and costs skyrocket, the Families First Coronavirus Response Act (FFCRA), signed into law in March, authorized a 6.2 percentage point increase to the federal government's share of a state's Medicaid spending (known as federal medical assistance percentage, or FMAP).[8] The increase is retroactive to January 1, 2020 and will be in effect through the end of the quarter in which the public health emergency (PHE) ends. Since the PHE was renewed on July 25 for another 90 days, the FMAP bump is guaranteed until the end of December 2020.

The FMAP increase applies only to Medicaid spending that is reimbursed at the state's regular FMAP, and therefore excludes spending already subject to increased matching, such as spending for the ACA expansion population (federal matching for the expansion population is 90 percent). To receive the increased funds, states need to meet a handful of criteria to ensure coverage is protected, such as ensuring that Medicaid eligibility is no more restrictive than it was January 1, 2020, and that premiums are no higher than they were January 1, 2020.[9] States must also make Covid-19 testing and treatment free for beneficiaries, and provide continuous enrollment for beneficiaries until the public health emergency is lifted.

Experts agree that the 6.2 percentage point increase is far below what states need

The expert community is in agreement that an FMAP increase of 6.2 percentage points is far below what states need to weather the crisis. The Center on Budget and Policy Priorities (CBPP) has said that "[the] 6.2 percentage-point FMAP increase is much less than federal policymakers provided during the Great Recession and too small to significantly discourage Medicaid cuts or encourage investments to address COVID-19."[10] The Georgetown Center for Children and Families has argued that "it's critical that Congress provide further large increases in the FMAP to shore up state Medicaid programs and help states address their overall budget deficits."[11] The bipartisan National Governor's Association and National Association of Medicaid Directors also strongly support further increases to FMAP.[12]

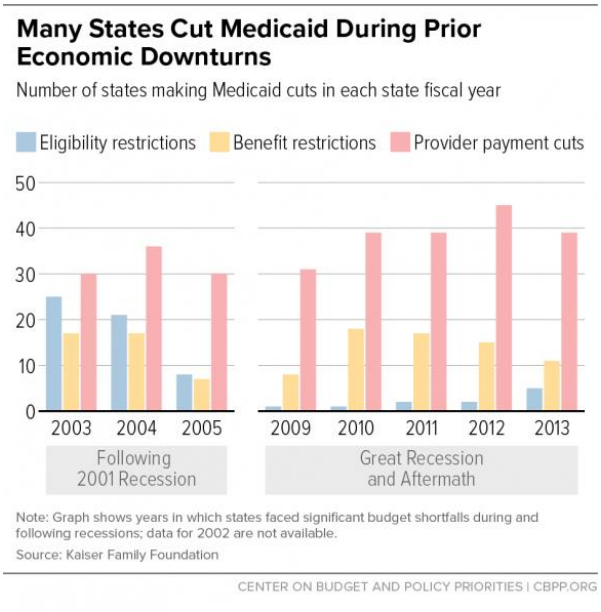
Without additional federal aid, many states likely will cut Medicaid spending

All states but Vermont are required to balance their budgets each year. During past recessions, as revenues have dried up and demand for services increased, states have responded to budget shortfalls by making harmful cuts to the Medicaid program. The CBPP notes that "even states that usually are strongly committed to maintaining and expanding health coverage have cut Medicaid when they faced severe budget pressures." [13]

Already, several states have cut Medicaid, or canceled and/or delayed planned program improvements. [14] For example, California has enacted cuts to provider rates, while Colorado has implemented a one percent pay cut to Medicaid community providers, as well as payments to children's hospitals, and dental benefits. Florida's governor vetoed planned increases in payments rates for providers of services to people with disabilities. Tennessee changed course

regarding a federal waiver to provide Medicaid coverage for a year post-partum, rather than 60 days, which would have helped address maternal mortality. It also reversed policies to extend dental coverage for pregnant and postpartum women, and to expand services for people with intellectual and developmental disabilities.

Figure 2. Many states cut Medicaid during prior economic downturns



During past recessions, Colorado and Texas restricted eligibility for pregnant women, while Florida, North Dakota and Oklahoma restricted eligibility for seniors and people with disabilities. Nine states, including Kentucky, Texas, and Wisconsin, increased premiums on Medicaid and/or CHIP beneficiaries. Research indicates that premiums reduce people's participation in health coverage.[15] Sixteen states dropped coverage for dental benefits, while others eliminated or restricted vision coverage. Lastly, several states made it more difficult for eligible people to get coverage or remain covered by reassessing eligibility every six months, rather than every twelve months. The Centers for Medicare & Medicaid Services has concluded that "many eligible beneficiaries lose coverage at renewal for procedural reasons, only to reapply and to regain eligibility, soon after losing coverage."[16]

During the Great Recession, increasing FMAP resulted in fewer state Medicaid spending cuts

Although the FMAP bump during the Great Recession did not prevent Medicaid programs from making Medicaid cuts to provider payments and by restricting benefits, states made "fewer Medicaid eligibility cuts during the Great Recession than in the much smaller 2001 downturn, largely due to timely, significant FMAP increases that included maintenance-of-eligibility (MOE) protections" (Figure 2). The Government Accountability Office reported that "increased FMAP funds were integral to maintaining current eligibility levels, benefits, and services and to avoiding further program reductions."[17]

Weakening FFCRA's continuous coverage protections will cause hundreds of thousands of people to become uninsured

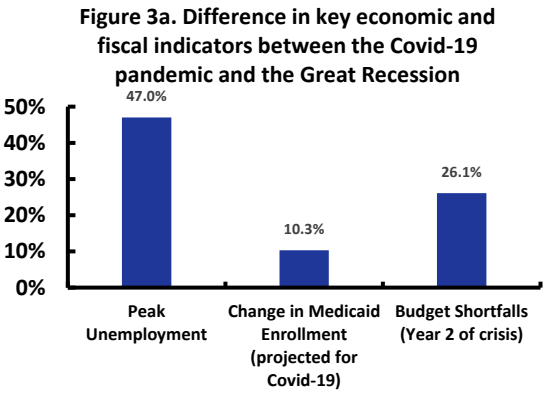
FFCRA's continuous coverage provisions, which states must abide by in order to receive the FMAP bump, ensure that eligible people maintain coverage and aren't dropped from Medicaid rolls due to paperwork.[18] Decades of research and experience indicates that increasing administrative burden on Medicaid beneficiaries results in eligible people losing coverage. For example, in 2003, when Washington began requiring children to renew their eligibility every six months instead of every 12 months, 30,000 children lost access to Medicaid over the next two years. When the state restored 12-month eligibility, children's enrollment increased by 30,000. Continuous coverage is especially critical during a public health crisis.

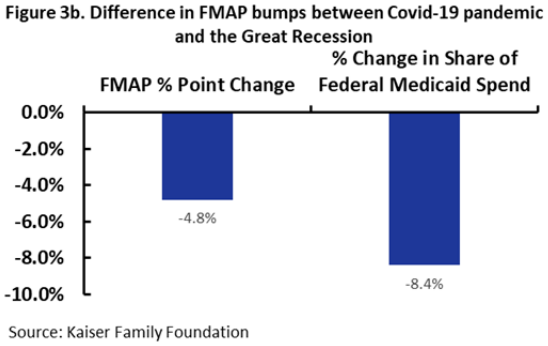
FFCRA's continuous coverage provisions also prevent disruptions in coverage for people with volatile incomes, who are likely experiencing pronounced income volatility and job stability due to the pandemic induced-recession. .[19] As CBPP notes: "Requiring people with volatile income to frequently shift among different forms of coverage is counterproductive. Most people won't transition successfully to marketplace or employer-based coverage for the months in which their income exceeds Medicaid limits; instead, they will become uninsured and experience disruptions in access to care before re-enrolling in Medicaid when their income drops." Further, frequent coverage changes results in increased use of the emergency room, decreased medication adherence and higher health care costs. .[20] Continuous coverage is especially critical for workers with low incomes population as they have been borne the brunt of the pandemic's health impact.

Opponents of continuous coverage have voiced concerns that the provisions will result in significant coverage expansions to people who don't need Medicaid, increasing program enrollment and costs. .[21] These costs are likely to be minimal—research indicates less than three percent of state Medicaid expenditures—and fall far short of the increased federal funding states are receiving due to the FMAP bump. Continuous coverage will ensure state Medicaid agencies use their scarce resources effectively, focusing on enrolling people "rather than following up on data checks that would likely glean outdated information for many enrollees, especially given the resurgence of COVID-19 in many states."[22]

The current FMAP bump is about half the average increase during the Great Recession

In many ways, the current economic crisis has been more severe than the Great Recession. Unemployment during the pandemic peaked at 14.7 percent in April 2020 (an underestimate due to a misclassification error, according to the Bureau of Labor Statistics), whereas unemployment during the Great Recession peaked at 10 percent in October 2009. [23] As discussed previously (see Figure 1) state budget shortfalls during due to the pandemic are projected to be larger than during the Great Recession. For fiscal year 2021, for example, budget shortfalls are projected to total $290 billion, 26 percent higher than during the Great Recession at its peak. Further, studies indicate that Medicaid enrollment is likely to increase by up to 16 percent, a greater increase than during the Great Recession.[24]





During the Great Recession, the American Recovery and Reinvestment Act (ARRA) included a blanket FMAP increase of 6.2 percentage points, and additional state-specific increases based on unemployment.[25] Although FMAP bumps by state varied throughout the recession, they were consistently higher than the increase of 6.2 percentage points authorized by FFCRA. For example, during the first quarter of the 2011 fiscal year, the average FMAP bump was 4.8 percentage points higher than the FMAP bump authorized by FFCRA, which ranged from a 9.1 percentage point increase in Kentucky to a 17.9 percentage point increase in Louisiana (see Table 1). The average percent increase in the federal government's share of total Medicaid spending was 18.9 percentage points during the Great Recession, versus 10.5 percentage points as authorized by FFCRA. The percent increase in the federal government's share of total Medicaid spending during the Great Recession ranged from 12.8 to 30 percent, versus 8.0 to 12.4 percent under FFCRA.

A larger FMAP increase will help the increasing number of Americans who rely on Medicaid

There is consensus in the expert community that large FMAP increase during economic downturns have significant positive effects. In an analysis of FMAP increases during the Great Recession, the Kaiser Family Foundation concluded that "there is no doubt that the ARRA FMAP funds provided timely and necessary support to state Medicaid programs."[26] The KFF notes that states used the additional funds for multiple purposes, such as "addressing Medicaid or general fund budget shortfalls, helping to support increases in Medicaid enrollment, or to mitigate reductions in provider rates and benefits."[27]

Increasing the federal share of Medicaid spending is fast and effective economic stimulus

Crucially, FMAP increases are also an economic stimulus to states that increase employment and economic output.[28] Research by the Center on Budget and Policy Priorities finds that during the Great Recession, every additional $100,000 of state fiscal relief from FMAP increases employment by 3.8 job-years, and every dollar spent on increasing FMAP added two dollars to gross domestic product (GDP). As Christina Romer, chair of the Council of Economic Advisers under President Obama, has noted: "the easiest and fastest way to transfer money from the

federal government to the states was just to increase that federal Medicaid matching percentage."[29]

Medicaid is most needed during recessions when many workers lose their jobs and with them access to employer-sponsored health insurance. Cutting Medicaid during a typical recession is a bad outcome. In a recession with double-digit unemployment resulting from a highly infectious, deadly virus, cutting Medicaid can be deadly. During a pandemic-induced recession, it becomes even more imperative that we strengthen access to health care and invest in public health, rather than undercut it through cuts to Medicaid and other critical services.

Table 1. Medicaid FMAP Increases: Covid-19 vs. the Great Recession

State	Covid-19 (2020)			Great Recession (FFY 2011, Q1)			Difference Between FMAP Bump During Great Recession and Pandemic	
	Pre-Crisis FMAP (A)	FMAP Percentage Point Increase (B)	Percent Increase in Federal Share of Medicaid Spend (C)	Pre-Crisis FMAP (D)	FMAP Percentage Point Increase (E)	Percent Increase in Federal Share of Medicaid Spend (F)	FMAP Percentage Point Increase (E-B)	Percent Increase in Federal Share of Medicaid Spend (F – C)
Alabama	72.6%	6.2%	8.5%	68.5%	9.5%	13.8%	3.3%	5.3%
Alaska	50.0%	6.2%	12.4%	50.0%	12.5%	24.9%	6.3%	12.5%
Arizona	70.0%	6.2%	8.9%	65.9%	10.1%	15.3%	3.9%	6.5%
Arkansas	71.2%	6.2%	8.7%	71.4%	9.8%	13.7%	3.6%	5.0%
California	50.0%	6.2%	12.4%	50.0%	11.6%	23.2%	5.4%	10.8%
Colorado	50.0%	6.2%	12.4%	50.0%	11.6%	23.2%	5.4%	10.8%
Connecticut	50.0%	6.2%	12.4%	50.0%	11.6%	23.2%	5.4%	10.8%
Delaware	57.7%	6.2%	10.7%	53.2%	11.2%	21.1%	5.0%	10.4%
District of Columbia	70.0%	6.2%	8.9%	70.0%	9.3%	13.3%	3.1%	4.4%
Florida	62.0%	6.2%	10.0%	55.5%	12.2%	22.0%	6.0%	12.0%
Georgia	67.0%	6.2%	9.2%	65.3%	9.8%	15.0%	3.6%	5.8%
Hawaii	53.0%	6.2%	11.7%	51.8%	15.6%	30.0%	9.4%	18.4%
Idaho	70.4%	6.2%	8.8%	68.9%	10.3%	15.0%	4.1%	6.2%
Illinois	51.0%	6.2%	12.2%	50.2%	11.7%	23.3%	5.5%	11.1%
Indiana	65.8%	6.2%	9.4%	66.5%	9.7%	14.6%	3.5%	5.1%
Iowa	61.8%	6.2%	10.0%	62.6%	9.9%	15.8%	3.7%	5.8%

Kansas	59.7%	6.2%	10.4%	59.1%	10.6%	18.0%	4.4%	7.6%
Kentucky	72.1%	6.2%	8.6%	71.5%	9.1%	12.8%	2.9%	4.2%
Louisiana	67.4%	6.2%	9.2%	63.6%	17.9%	28.1%	11.7%	18.9%
Maine	63.7%	6.2%	9.7%	63.8%	11.1%	17.3%	4.9%	7.6%
Maryland	50.0%	6.2%	12.4%	50.0%	11.6%	23.2%	5.4%	10.8%
Massachusetts	50.0%	6.2%	12.4%	50.0%	11.6%	23.2%	5.4%	10.8%
Michigan	64.1%	6.2%	9.7%	65.8%	9.8%	14.9%	3.6%	5.2%
Minnesota	50.0%	6.2%	12.4%	50.0%	11.6%	23.2%	5.4%	10.8%
Mississippi	77.8%	6.2%	8.0%	74.7%	10.1%	13.6%	3.9%	5.6%
Missouri	65.0%	6.2%	9.5%	63.3%	11.1%	17.6%	4.9%	8.1%
Montana	65.6%	6.2%	9.5%	66.8%	11.2%	16.7%	5.0%	7.3%
Nebraska	56.5%	6.2%	11.0%	58.4%	10.3%	17.7%	4.1%	6.7%
Nevada	63.3%	6.2%	9.8%	51.6%	12.3%	23.9%	6.1%	14.1%
New Hampshire	50.0%	6.2%	12.4%	50.0%	11.6%	23.2%	5.4%	10.8%
New Jersey	50.0%	6.2%	12.4%	50.0%	11.6%	23.2%	5.4%	10.8%
New Mexico	73.5%	6.2%	8.4%	69.8%	10.7%	15.3%	4.5%	6.9%
New York	50.0%	6.2%	12.4%	50.0%	11.6%	23.2%	5.4%	10.8%
North Carolina	67.4%	6.2%	9.2%	64.7%	10.3%	15.9%	4.1%	6.7%
North Dakota	52.4%	6.2%	11.8%	60.4%	9.6%	15.9%	3.4%	4.1%
Ohio	63.6%	6.2%	9.7%	63.7%	10.0%	15.7%	3.8%	6.0%
Oklahoma	68.0%	6.2%	9.1%	64.9%	11.8%	18.2%	5.6%	9.0%
Oregon	60.8%	6.2%	10.2%	62.9%	10.1%	16.1%	3.9%	5.9%
Pennsylvania	52.2%	6.2%	11.9%	55.6%	10.9%	19.7%	4.7%	7.8%

Rhode Island	54.1%	6.2%	11.5%	53.0%	11.3%	21.2%	5.1%	9.8%
South Carolina	70.6%	6.2%	8.8%	70.0%	9.8%	14.0%	3.6%	5.2%
South Dakota	58.3%	6.2%	10.6%	61.3%	9.5%	15.6%	3.3%	5.0%
Tennessee	66.1%	6.2%	9.4%	65.9%	9.8%	14.8%	3.6%	5.5%
Texas	61.8%	6.2%	10.0%	60.6%	10.4%	17.1%	4.2%	7.1%
Utah	67.5%	6.2%	9.2%	71.1%	9.7%	13.6%	3.5%	4.4%
Vermont	54.6%	6.2%	11.4%	58.7%	11.3%	19.2%	5.0%	7.8%
Virginia	50.0%	6.2%	12.4%	50.0%	11.6%	23.2%	5.4%	10.8%
Washington	50.0%	6.2%	12.4%	50.0%	12.9%	25.9%	6.7%	13.5%
West Virginia	75.0%	6.2%	8.3%	73.2%	9.8%	13.4%	3.6%	5.1%
Wisconsin	59.4%	6.2%	10.4%	60.2%	10.5%	17.4%	4.3%	7.0%
Wyoming	50.0%	6.2%	12.4%	50.0%	11.6%	23.2%	5.4%	10.8%
Mean	**60.4%**	**6.2%**	**10.5%**	**59.9%**	**11.0%**	**18.9%**	**4.8%**	**8.4%**
Median	**61.8%**	**6.2%**	**10.0%**	**60.6%**	**10.9%**	**17.6%**	**4.7%**	**7.6%**
Minimum	**50.0%**	**6.2%**	**8.0%**	**50.0%**	**9.1%**	**12.8%**	**2.9%**	**4.1%**
Maximum	**77.8%**	**6.2%**	**12.4%**	**74.7%**	**17.9%**	**30.0%**	**11.7%**	**18.9%**

Source: KFF (Pandemic data, Great Recession data)

[1] Rachel Garfield et al. "Eligibility for ACA Health Coverage Following Job Loss," Kaiser Family Foundation, May 13, 2020, https://www.kff.org/coronavirus-covid-19/issue-brief/eligibility-for-aca-health-coverage-following-job-loss/;
[2] 72 million includes Medicaid and CHIP. Medicaid.gov, "Monthly Medicaid & CHIP Application, Eligibility Determination, and Enrollment Reports & Data: April 2020," July 2020, https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-chip-enrollment-data/monthly-medicaid-chip-application-eligibility-determination-and-enrollment-reports-data/index.html
[3] Aviva Aron-Dine, Kyle Hayes, and Matt Broaddus, "With Need Rising, Medicaid Is at Risk for Cuts," Center on Budget and Policy Priorities, July 22, 2020, https://www.cbpp.org/research/health/with-need-rising-medicaid-is-at-risk-for-cuts
[4] Andrew Sprung, "Medicaid enrollment in a pandemic: 16-state snapshot (expansion only)," Xpostfactoid, July 13, 2020, https://xpostfactoid.blogspot.com/2020/07/medicaid-enrollment-in-pandemic-15.html
[5] Robin Rudowitz and Elizabeth Hinton, "Early Look at Medicaid Spending and Enrollment Trends Amid COVID-19," Kaiser Family Foundation, May 15, 2020, https://www.kff.org/coronavirus-covid-19/issue-brief/early-look-at-medicaid-spending-and-enrollment-trends-amid-covid-19/
[6] Elizabeth McNichol and Michael Leachman, "States Continue to Face Large Shortfalls Due to COVID-19 Effects," CBPP, July 7, 2020, https://www.cbpp.org/research/state-budget-and-tax/states-continue-to-face-large-shortfalls-due-to-covid-19-effects
[7] MACPAC, "Medicaid's share of state budgets," https://www.macpac.gov/subtopic/medicaids-share-of-state-budgets/
[8] MaryBeth Musumeci, "Key Questions About the New Increase in Federal Medicaid Matching Funds for COVID-19," KFF, May 4, 2020, https://www.kff.org/coronavirus-covid-19/issue-brief/key-questions-about-the-new-increase-in-federal-medicaid-matching-funds-for-covid-19/
[9] MaryBeth Musumeci, "Key Questions About the New Increase in Federal Medicaid Matching Funds for COVID-19," KFF, May 4, 2020, https://www.kff.org/coronavirus-covid-19/issue-brief/key-questions-about-the-new-increase-in-federal-medicaid-matching-funds-for-covid-19/
[10] Aviva Aron-Dine, Jessica Schubel, Judith Solomon, Matt Broaddus, and Kyle Haye, "Larger, Longer-Lasting Increases in Federal Medicaid Funding Needed to Protect Coverage," CBPP, May 5, 2020, https://www.cbpp.org/sites/default/files/atoms/files/5-5-20health.pdf
[11] Edwin Park, "Critical Need for Further, Large FMAP Increases to Sustain State Medicaid Programs During Economic Crisis," Georgetown University Center for Children and Families, May 4, 2020, https://ccf.georgetown.edu/2020/05/04/critical-need-for-further-large-fmap-increases-to-sustain-state-medicaid-programs-during-economic-crisis/
[12] National Governor's Association, "Governors' Letter Regarding COVID-19 Aid Request," April 21, 2020, https://www.nga.org/policy-communications/letters-nga/governors-letter-regarding-covid-19-aid-request/; National Association of Medicaid Directors, "NAMD Medicaid Request for Covid-19 Legislation," https://medicaiddirectors.org/wp-content/uploads/2020/04/NAMD-Medicaid-Requests-for-COVID-19-Legislation.pdf
[13] Aviva Aron-Dine, Jessica Schubel, Judith Solomon, Matt Broaddus, and Kyle Haye, "Larger, Longer-Lasting Increases in Federal Medicaid Funding Needed to Protect Coverage," CBPP, May 5, 2020, https://www.cbpp.org/sites/default/files/atoms/files/5-5-20health.pdf
[14] Aviva Aron-Dine, Jessica Schubel, Judith Solomon, Matt Broaddus, and Kyle Haye, "Larger, Longer-Lasting Increases in Federal Medicaid Funding Needed to Protect Coverage," CBPP, May 5, 2020, https://www.cbpp.org/sites/default/files/atoms/files/5-5-20health.pdf
[15] Samantha Artiga, Petry Ubri, and Julia Zur, "The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings," KFF, June 1, 2017, https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/
[16] Department of Health and Human Services, "Federal Register, Vol. 76, No. 159," August 17, 2011, https://www.govinfo.gov/content/pkg/FR-2011-08-17/pdf/2011-20756.pdf
[17] Government Accountability Office, "One Year Later, States' and Localities' Uses of Funds and Opportunities to Strengthen Accountability," March 2010, https://www.gao.gov/assets/310/301348.pdf
[18] Judith Solomon, "Continuous Coverage Protections in Families First Act Prevent Coverage Gaps by Reducing "Churn," Center on Budget and Policy Priorities, July 16, 2020, https://www.cbpp.org/research/health/continuous-coverage-protections-in-families-first-act-prevent-coverage-gaps-by

[19] Judith Solomon, "Continuous Coverage Protections in Families First Act Prevent Coverage Gaps by Reducing "Churn," Center on Budget and Policy Priorities, July 16, 2020, https://www.cbpp.org/research/health/continuous-coverage-protections-in-families-first-act-prevent-coverage-gaps-by
[20] Judith Solomon, "Continuous Coverage Protections in Families First Act Prevent Coverage Gaps by Reducing "Churn," Center on Budget and Policy Priorities, July 16, 2020, https://www.cbpp.org/research/health/continuous-coverage-protections-in-families-first-act-prevent-coverage-gaps-by
[21] Judith Solomon, "Continuous Coverage Protections in Families First Act Prevent Coverage Gaps by Reducing "Churn," Center on Budget and Policy Priorities, July 16, 2020, https://www.cbpp.org/research/health/continuous-coverage-protections-in-families-first-act-prevent-coverage-gaps-by
[22] Judith Solomon, "Continuous Coverage Protections in Families First Act Prevent Coverage Gaps by Reducing "Churn," Center on Budget and Policy Priorities, July 16, 2020, https://www.cbpp.org/research/health/continuous-coverage-protections-in-families-first-act-prevent-coverage-gaps-by
[23] Bureau of Labor Statistics, "Civilian unemployment rate," https://www.bls.gov/charts/employment-situation/civilian-unemployment-rate.htm
[24] Aviva Aron-Dine, Kyle Hayes, and Matt Broaddus, "With Need Rising, Medicaid Is at Risk for Cuts," Center on Budget and Policy Priorities, July 22, 2020, https://www.cbpp.org/research/health/with-need-rising-medicaid-is-at-risk-for-cuts
[25] Kaiser Family Foundation, "Impact of the Medicaid Fiscal Relief Provisions in the American Recovery and Reinvestment Act (ARRA)," October 2011, https://kff.org/wp-content/uploads/2013/01/8252.pdf
[26] Kaiser Family Foundation, "Impact of the Medicaid Fiscal Relief Provisions in the American Recovery and Reinvestment Act (ARRA)," October 2011, https://kff.org/wp-content/uploads/2013/01/8252.pdf
[27] Kaiser Family Foundation, "Impact of the Medicaid Fiscal Relief Provisions in the American Recovery and Reinvestment Act (ARRA)," October 2011, https://kff.org/wp-content/uploads/2013/01/8252.pdf
[28] Paul N. Van de Water, "Increasing Federal Medicaid Assistance Provides Effective Economic Stimulus," Center on Budget and Policy Priorities, July 17, 2020, https://www.cbpp.org/blog/increasing-federal-medicaid-assistance-provides-effective-economic-stimulus
[29] Christina Romer, "The Next Recession," Economic Policy Institute, May 15, 2019, https://www.epi.org/publication/the-next-recession-keynote-address-by-christina-romer/