SAFETY NET

The Stanford Center on Poverty and Inequality

BY MARK DUGGAN AND VALERIE SCIMECA

Federal, state, and local governments provide assistance to individuals with low incomes and assets through dozens of different "safety net" programs. The purpose of this article is to examine how safety net usage varies across racial and ethnic groups in the most recent year for which data are available. This variability might of course be structured in many ways, but two possibilities that are usefully distinguished are (a) a "compensation effect" in which racial and ethnic groups that have historically faced especially severe problems in the labor market (e.g., blacks, American Indians) are enrolled in safety net programs at rates in excess of their underlying poverty rates, or (b) a "double disadvantage effect" in which such groups are instead underenrolled (again, relative to their underlying poverty rates). Given the constraints of space, this question cannot be exhaustively examined here, but it will be possible to explore it for three especially important federal safety net programs.

An Example of Double Disadvantage

The largest federal safety net program in terms of both enrollment and expenditures is Medicaid. It provided health insurance to 72 million low-income U.S. residents in 2015,[1] with total expenditures of $545 billion.[2] Medicaid enrollment grew substantially during the last several years, in spite of the improving economy, because of the Affordable Care Act (ACA). This increase would have been much larger if all states, as called for in the legislation, had expanded the program to individuals with incomes below 138 percent of the federal poverty line. Instead, 19 states have not expanded their Medicaid programs,[3] resulting in very different rates of Medicaid enrollment across states. In California, a state that did expand its Medicaid program, 32 percent of all state residents are now enrolled in Medicaid. In contrast, only 18 percent of residents in Texas are covered, even though its poverty rate is similar to California's. This is primarily because Texas did not expand Medicaid following ACA passage.

KEY FINDINGS

- Given that poverty rates are significantly higher among blacks, Hispanics, and American Indians than in the general population, it is not surprising that their enrollment in federal safety net programs, such as Medicaid and food stamps, is also higher.
- However, poor blacks and American Indians are significantly less likely than other racial and ethnic groups to enroll in Medicaid, which is the largest federal safety net program. No similar gap exists for enrollment in the food stamp or Supplemental Security Income programs.

Like most government agencies, the Centers for Medicare and Medicaid Services, which administers Medicaid, does not report data on the race and ethnicity of program recipients. Arguably, the best available source of racial and ethnic data is the March Current Population Survey (CPS), which is conducted annually by the Bureau of Labor Statistics.[4] One limitation with using survey data is that individuals are known to underreport their enrollment for many government programs.[5] However, the fraction reporting Medicaid coverage in the 2015 CPS (19.7%) is relatively close to the actual share enrolled (22.4%). The CPS also contains detailed demographic information along with information on the economic circumstances of respondents and their families. Taken together, these data can shed light on how enrollment in Medicaid and other government programs varies by race and ethnicity.

The March 2016 CPS reports each person's race as white, black, American Indian/Alaska Native (AIAN), Asian, Hawaiian/Pacific Islander, or one of more than 20 other categories for different race combinations.[6] The most common categories are white (77.1%), black (13.1%), and Asian (5.7%). If one groups together all individuals listing two or more races, the resulting "mixed" group is the next most common, accounting for 2.4 percent of the

population. Additionally, the survey includes information on whether an individual (of any race) is of Hispanic origin, with an estimated 17.8 percent of the population in this group.

An examination of the individual-level survey data reveals that, as one would expect given differences in poverty rates by race and ethnicity, Medicaid enrollment varies substantially across groups. Table 1 lists poverty rates for each group,[7] along with the fraction of each group enrolled in the Medicaid program.

The table also lists the ratio of the number of Medicaid recipients to the number in poverty in 2015. To the extent that a group has a higher poverty rate, one would expect (all else equal) a higher share on Medicaid. On average, there are 1.46 individuals on Medicaid for each 1 person who is poor. However, this ratio varies substantially across groups. For example, for blacks and the AIAN group, the ratios are 1.28 and 1.22, respectively, while for whites and those of Hispanic origin they are 1.52 and 1.57, respectively. This pattern thus takes the form of a "double disadvantage" for both blacks and AIANs, given their higher poverty rates and their relatively low enrollment rates.

One possible explanation for this large difference is that individuals in poverty and who are black are less likely to live in a state that expanded the Medicaid program. As shown in the next column, just 46 percent of blacks live in a state that expanded Medicaid, versus 60 percent of Hispanics and 56 percent overall. However, this type of racial-ethnic segregation cannot also explain why AIANs have the lowest ratio of 1.22, since they actually have the highest share of their population living in Medicaid-expansion states. This suggests that take-up rates of Medicaid benefits are quite low among AIANs.

TABLE 1. Poverty Rates and Medicaid Enrollment by Race and Ethnicity, 2015

	Poverty Rate	Percentage on Medicaid	Medicaid Ratio	Percentage in States That Expanded Medicaid	Percentage of U.S. Population
All	13.5%	19.7%	1.46	56.2%	100.0%
White	11.5%	17.5%	1.52	58.2%	77.1%
Black	23.9%	30.6%	1.28	45.9%	13.1%
Asian	11.2%	16.1%	1.43	67.9%	5.7%
American Indian/ Alaska Native	27.0%	33.0%	1.22	69.5%	1.4%
Hawaiian/ Pacific Islander	16.9%	28.3%	1.67	64.7%	0.4%
Mixed	16.9%	29.7%	1.76	58.9%	2.4%
Hispanic	20.8%	32.7%	1.57	60.0%	17.8%

Source: March Current Population Survey, 2016.

TABLE 2. SNAP and SSI Enrollment by Race and Ethnicity, 2015

	Percentage on SNAP	SNAP Ratio	Percentage in Poverty, Aged 15+	Percentage on SSI, Aged 15+	SSI Ratio
All	12.8%	0.95	11.8%	2.5%	0.22
White	10.6%	0.91	10.1%	2.1%	0.21
Black	25.3%	1.06	21.0%	5.4%	0.26
Asian	6.9%	0.62	10.9%	2.0%	0.19
American Indian/ Alaska Native	25.8%	0.95	23.1%	4.7%	0.20
Hawaiian/ Pacific Islander	19.2%	1.13	13.4%	1.2%	0.09
Mixed	20.7%	1.23	15.1%	3.0%	0.20
Hispanic	20.4%	0.98	17.7%	2.9%	0.16

Source: March Current Population Survey, 2016.

An Example of Compensation

Does the same "double disadvantage" effect obtain for other large-scale safety net programs? The simple answer: No. This can be shown, for example, with the next-largest program in terms of enrollment, the Supplemental Nutrition Assistance Program (SNAP), also known as food stamps.

There were 46 million SNAP recipients in 2015 with total program expenditures of $70 billion.[8] As with Medicaid, SNAP enrollment in the March CPS is somewhat underreported, with an estimated 41.2 million residing in a household with food stamp income. As shown in Table 2, Asians have the lowest SNAP enrollment rate (6.9%), while AIANs (25.8%) and blacks (25.3%) have the highest. This difference does not disappear when one takes poverty rates into account. In contrast to Medicaid, SNAP enrollment per person in poverty is higher among blacks (1.06) and AIANs (0.95) than among Asians (0.62) or whites (0.91). This is, then, an example of the "compensation" effect of safety net usage.

The final three columns in Table 2 pertain to the Supplemental Security Income (SSI) program. This federal government program

provides assistance to low-income aged, blind, and disabled individuals. It is the fourth-largest safety net program in terms of expenditures, with 8.3 million beneficiaries receiving $55 billion in SSI benefits in 2015.[9,10] The March CPS reports on SSI enrollment, but only for those aged 15 and up. Similar to Medicaid and food stamps, SSI enrollment is somewhat underreported, with 2.61 percent of adults aged 18 and up reporting SSI receipt versus 2.84 percent according to administrative data.

There is significant variation across groups in SSI enrollment. As with SNAP, blacks have 0.26 SSI recipients per individual in poverty, whereas Asians have 0.19 recipients. This is nominally an example again of a compensation pattern of enrollment. The Hispanic rate comes in especially low at 0.16. One factor that may partially explain low enrollment among Hispanics is that they are much younger than the rest of the U.S. population. Just 18 percent of Hispanics are at least 50 years old, compared with more than 40 percent of non-Hispanic whites and roughly 29 percent of non-Hispanic blacks and Asians.[11] The incidence of disability, however, is much higher among older people. Consistent with these differences, the fraction of Hispanics aged 15 and up reporting a disability or health condition that limits work is 7.3 percent versus 9.1 percent for whites and 13.6 percent for blacks. The younger average age of the Hispanic population lowers its disability rate, which automatically decreases SSI eligibility relative to other racial and ethnic groups with older populations.[12] Additionally, there may be significant language barriers in applying for SSI benefits, which may discourage some individuals of Hispanic origin from applying for the program.

Conclusion

The foregoing analysis of three safety net programs, all of which have grown substantially in recent years, provides a very partial account of how program enrollment varies by race and ethnicity. It does appear, however, that some programs are reducing racial and ethnic inequalities more than others. ■

Mark Duggan is Wayne and Jodi Cooperman Professor of Economics at Stanford University and Trione Director of the Stanford Institute of Economic Policy Research (SIEPR). He leads the safety net research group at the Stanford Center on Poverty and Inequality. Valerie Scimeca is Research Assistant at SIEPR.

NOTES

1. Centers for Medicare and Medicaid Services. Table 1A: Medicaid and CHIP: June and July 2015 Monthly Enrollment Updated September 2015. Retrieved from https://www.medicaid.gov/medicaid/program-information/downloads/updated-july-2015-enrollment-data.pdf.

2. Centers for Medicare and Medicaid Services. National Health Accounts Historical. Retrieved from https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html.

3. The median threshold for Medicaid eligibility in these 19 states is 44 percent of the federal poverty line. Garfield, Rachel, and Anthony Damico. 2016. "The Coverage Gap: Uninsured Poor Adults in States That Do Not Expand Medicaid." Kaiser Family Foundation. Retrieved from http://kff.org/uninsured/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid.

4. Barnett, Jessica C., and Marina S. Vornovitsky. 2016. "Health Insurance Coverage in the United States: 2015." Current Population Reports, U.S. Census Bureau; Proctor, Bernadette D., Jessica L. Semega, and Melissa A. Kollar. 2016. "Income and Poverty in the United States: 2015." Current Population Reports, U.S. Census Bureau.

5. Meyer, Bruce D., and Nikolas Mittag. 2015. "Using Linked Survey and Administrative Data to Better Measure Income: Implications for Poverty, Program Effectiveness, and Holes in the Safety Net." NBER Working Paper 21676.

6. The most common are white-black (36.7%), white-American Indian (26.5%), and white-Asian (18.8%).

7. Each individual is allocated to exactly one race category. For example, "white" includes whites of Hispanic origin as well as those not of Hispanic origin.

8. Supplemental Nutrition Assistance Program. FY14 through FY17 National View Summary. Retrieved from https://www.fns.usda.gov/sites/default/files/pd/34SNAPmonthly.pdf.

9. Social Security Administration. 2017. "Annual Statistical Supplement, 2016." Retrieved from https://www.ssa.gov/policy/docs/statcomps/supplement/2016/7a.pdf.

10. Expenditures on the Earned Income Tax Credit (EITC) in 2015 were actually somewhat higher at $67 billion. Because these transfers are substantially underreported in the March CPS, they will not be discussed here.

11. Patten, Eileen. 2016. "The Nation's Latino Population Is Defined by Its Youth." Retrieved from http://www.pewhispanic.org/2016/04/20/the-nations-latino-population-is-defined-by-its-youth/.

12. When compositional differences between racial and ethnic groups are taken into account, the "age-adjusted" Hispanic disability rate is in fact comparable to the overall population average. Among older Hispanics (age 50 and up), the disability rate is comparable to the rate for non-Hispanic blacks, which is much higher than the rate for non-Hispanic whites in this same age range. Hayward, Mark D., Robert A. Hummer, Chi-Tsun Chiu, César González-González, and Rebeca Wong. 2014. "Does the Hispanic Paradox in U.S. Adult Mortality Extend to Disability?" *Population Research and Policy Review* 33(1), 81–96; Brault, Matthew W. 2012. "Americans with Disabilities: 2010." Current Population Reports, U.S. Census Bureau.