Georgetown University Health Policy Institute
CENTER FOR CHILDREN AND FAMILIES
The Commonwealth Institute
Voices For Virginia's Children

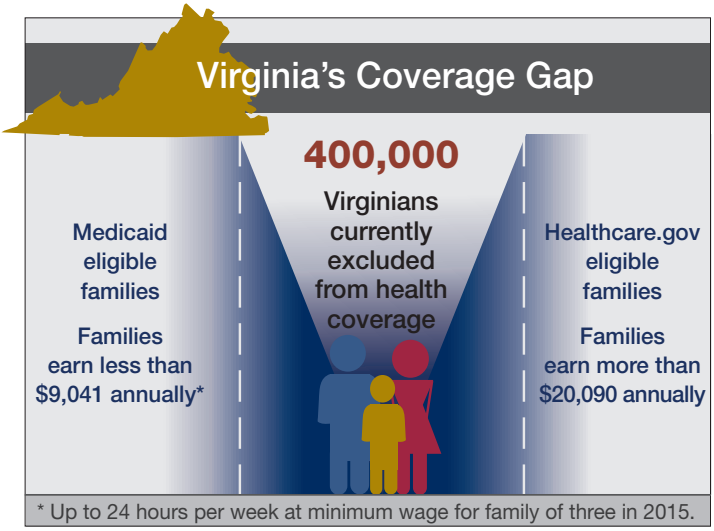
Many Working Parents and Families in Virginia Would Benefit from Medicaid Coverage

by Georgetown University Center for Children and Families

Key Points

1. Virginia's General Assembly has chosen not to use federal funds available under the Affordable Care Act (ACA) for extending Medicaid coverage. Virginia's Governor continues to support use of Virginia's share of federal money to cover as many as 400,000 uninsured adults.
2. Virginia has large numbers of uninsured children and parents. **Almost one third (29 percent) of people potentially eligible for coverage should Virginia close the gap are parents with dependent children residing in their home.** Providing health coverage to Virginia's parents would reduce children's uninsurance rate and enhance families' financial security. Experience from other states shows that an extremely effective way to reduce the uninsured rate for children is to extend coverage to parents so the entire family can get covered.
3. Of those parents that could benefit from closing the coverage gap, over two-thirds (68 percent) are employed. Over half of all uninsured parents (54 percent) work in restaurants, retail, construction, or medical occupations.

Virginia is one of the 20 states that has elected not to accept federal funding under the ACA to extend Medicaid coverage to parents and other low-income adults. Consequently, parents in Virginia are not eligible for Medicaid or premium tax credits if their incomes exceed approximately 45 percent of the poverty line (45 percent of poverty is $9,041 in annual income for a family of three in 2015) but remain below 100 percent of the poverty line ($20,090 in annual income for a family of three).[1] As a result, there are nearly 230,000 Virginians (including childless adults) who fall into this coverage gap and as many as 400,000 adults excluded from Medicaid coverage due to Virginia's refusal to accept the federal funds.[2]



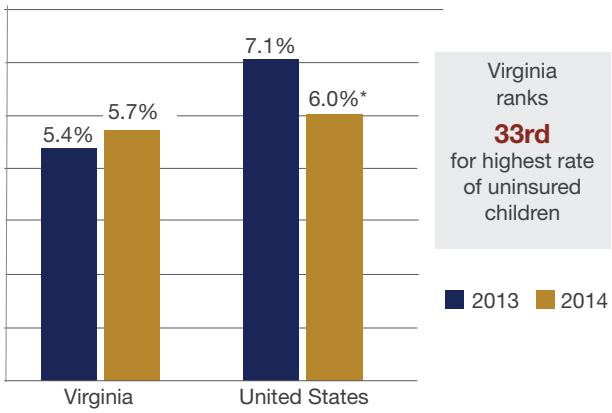
Should Virginia choose to extend Medicaid to adults with incomes up to 138 percent of FPL, billions in federal funding will cover 100 percent of the costs for this new coverage through 2016 and no less than 90 percent after that. According to a study commissioned by the Virginia Hospital and Healthcare Association, the total economic impact from drawing down these federal funds is estimated to average $3.5 billion and 26,500 jobs from 2015 to 2020.[3] As a result of not expanding Medicaid, Urban Institute researchers estimate that over 200,000 Virginians will remain uninsured and the state will forego $21 billion in federal funds from 2013 to 2022.[4]

Despite a recent decline in the number of uninsured, Virginia continues to have an unacceptably high number of uninsured parents, children, and adults in large part because of the decision not to close the coverage gap. While the rate of uninsured children remains comparatively low (5.7 percent in Virginia compared to 6 percent nationally), Virginia has more than 107,000 children without health coverage.[5] Between 2013 and 2014, the rate of uninsurance in the country dropped dramatically, with 24 states experiencing statistically significant declines in the rate of uninsured children. The rate of uninsured children in Virginia, however, did not change significantly.

Research based on the experience of other states shows that insurance rates for children improve when coverage is available to the whole family. In Virginia, uninsured parents with children present in the home account for nearly one third (29 percent) of the population potentially eligible for health coverage if the state expands Medicaid.[6] The typical low-income uninsured parents in Virginia most likely to be helped by closing the coverage gap are white, employed in a restaurant or retail industry, and have one or two children.

If Virginia closed the coverage gap, the state has the option to create its own state specific plan to extend coverage through a waiver of certain Medicaid provisions. Seven states that have proposed Medicaid waivers have come to agreement with the federal government and extended coverage.[7]

Figure 2. Rates of Children's Uninsurance in Virginia and the U.S., 2013-2014



* Indicates change is significant at the 90% confidence interval. There was no significant change in the rate of uninsured children in Virginia between 2013 and 2014.

Who Are the Uninsured in Virginia?

Data reported here is from 2014 and reflects the impact of the ACA's major provisions that took effect on January 1, 2014.

Employment

- Of those uninsured parents who could benefit from expanded Medicaid eligibility, the majority (68 percent) are employed outside of the home, one-fifth (22 percent) of parents are not in the labor force (meaning they are most likely students, homemakers, or otherwise retired workers), and only 10 percent are unemployed.
- One-fifth (20 percent) of potentially eligible parents are from families with two working parents in the home.
- Virginia's Medicaid expansion would lead to greater health coverage for the working poor. More than half (64 percent) of potentially eligible uninsured parents live below the poverty line (45 to 100 percent FPL). In Virginia, minimum wage workers make the Federal minimum wage of $7.25 per hour. This means that minimum wage workers in a family of three who work more than 24 hours per week have incomes too high to qualify for Medicaid (45 percent of the FPL is $174 per week). Employees in this situation would have to work 53 hours a week or more to qualify for subsidized coverage on the federal health exchange.

Family Demographics

- Two-thirds (66 percent) of potentially eligible uninsured parents are in young to middle adulthood, between ages 26 and 49 years of age.
- The vast majority of families (72 percent) have one or two children.
- More than half of families (63 percent) have school-aged children (those ages 6 to 17 years old).

Figure 3.
Uninsured Virginia Parents Potentially Eligible for Medicaid by Race and Ethnicity

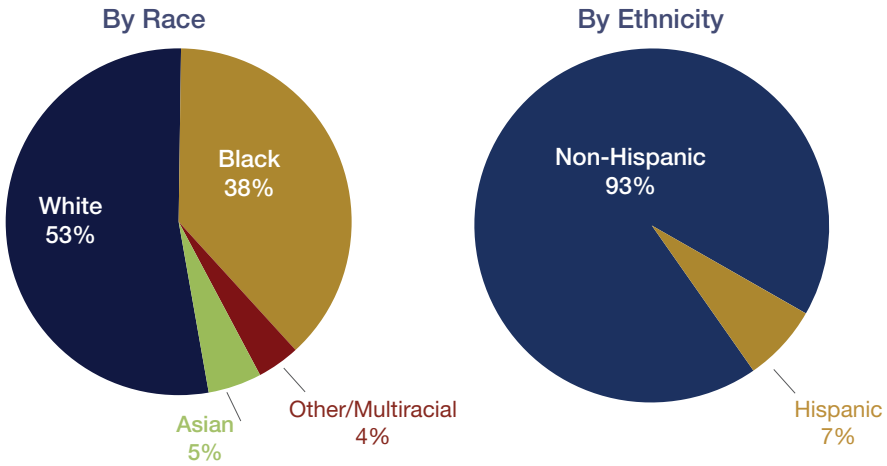
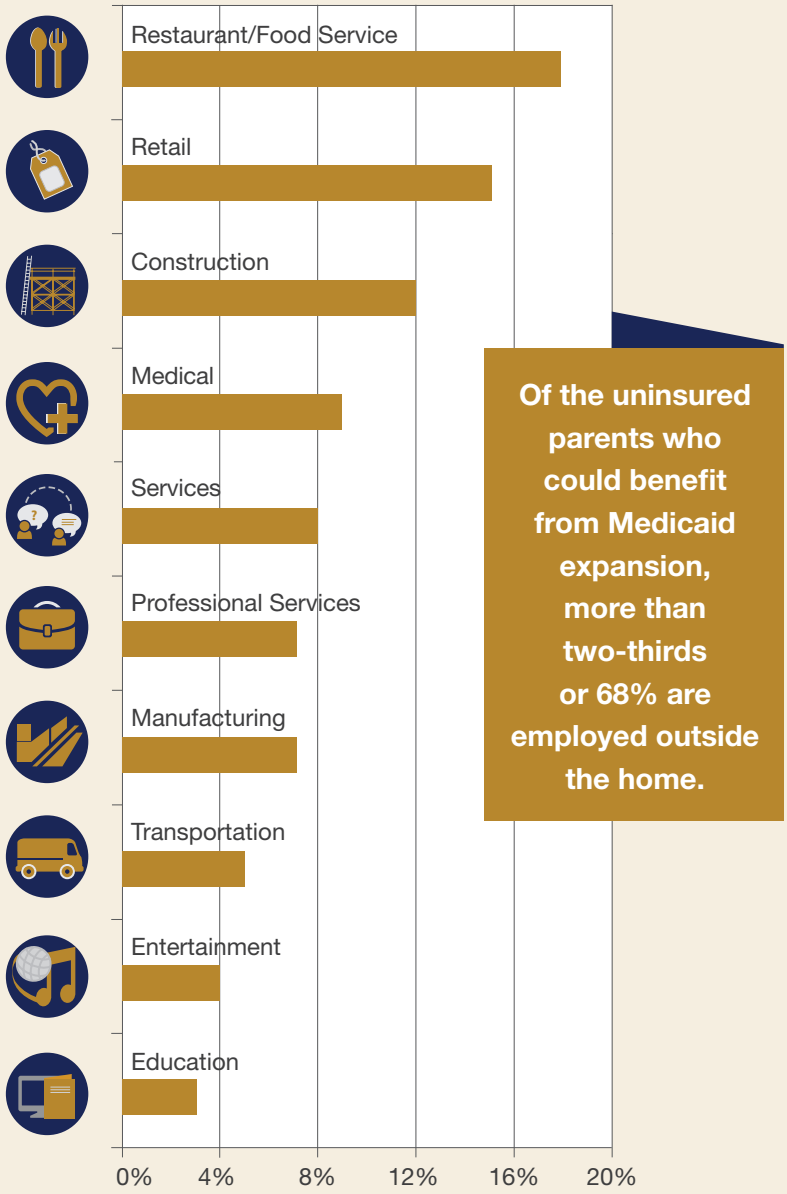


Figure 4. Top 10 Industry Sectors for Potentially Eligible Uninsured Parents in Virginia



Note: Based on CCF analysis of 2014 Public Use Microdata Sample (PUMS) from single year estimates of 2014 ACS data.

Children Benefit When Their Parents Have Coverage

States choosing to extend Medicaid coverage to parents directly help children by reducing the number of uninsured children, boosting a family's financial security, and enabling children to get better care from healthier parents.

States that expanded Medicaid coverage to low-income adults and parents in 2014 saw a larger decline in the number and percent of uninsured children than those that did not. The substantial difference between expansion and non-expansion states is likely due to a robust "welcome mat" effect as parents enrolled their children when they signed up for newly available coverage. Despite having fewer uninsured children to start with, Medicaid expansion states also saw a sharper rate of decline in uninsured children. Medicaid expansion states saw a 22 percent decline in the number of uninsured children, from 2.3 million in 2013 to 1.8 million in 2014. Non-expansion states saw only a 12 percent decline in the number of uninsured children, from 2.9 million in 2013 to 2.6 million in 2014.[8]

Likely, this substantial difference between expansion states and non-expansion states rate of uninsured children and decline over this one year time period is thanks to the welcome mat effect. As parents learned about newly available affordable coverage, many children who were previously eligible but not enrolled in Medicaid and CHIP were signed up for coverage.

Covering parents increases the likelihood of children being enrolled in health coverage.

A number of studies find that when parents are insured, children are more likely to have health coverage.[9] A recently published study in Oregon showed the odds of eligible children receiving Medicaid or CHIP coverage doubled if their parents enrolled in Medicaid.[10] In Massachusetts, health coverage expansions for parents helped cut the uninsurance rate for children in half.[11]

Recent research shows that children with Medicaid coverage and Medicaid-eligible parents have improved physical well-being, earning potential, and educational attainment. Children enrolled in Medicaid are more likely to receive well-child care and are significantly less likely to have unmet or delayed needs for medical care, dental care, and prescription drug use due to cost.[12] Expanding Medicaid eligibility to children and parents reduces hospitalizations and leads to fewer emergency department visits later in life.[13]

Not only does Medicaid expansion for parents and Medicaid coverage for children lead to better health outcomes in the short-term, but it also leads to better long-term outcomes.

A growing body of research provides evidence that increasing childhood Medicaid eligibility levels significantly improves health, educational, and financial outcomes in adolescence and adulthood.[14] Childhood Medicaid eligibility is linked to decreased rates of hospitalizations, emergency room visits, and obesity as well as increased rates of high school graduation and college attendance for adolescents and adults.[15] Adults who had received Medicaid as children were also more likely to have higher earnings and economic

Extending Medicaid expansion for parents boosts family financial security and enables children to get better care from healthier parents.

mobility.[16] The government recoups much of the initial cost of expanding Medicaid eligibility with savings from fewer costly hospital visits and increased taxes from higher earners.[17]

When parents are covered, their health status improves along with the well-being of their children. Uninsured parents have more difficulty accessing needed care, potentially compromising their ability to work, support their families, and care for their children.[18] Medicaid coverage improves access to necessary health care and decreases out-of-pocket spending for low-income adults, improving financial stability for the whole family.

For example, more than half of all infants living in poverty have a mother suffering from depression.[19] Untreated maternal depression can be damaging to a child's cognitive, social, and emotional development. While depression is treatable, many poor mothers do not receive care. In Oregon, rates of depression decreased by 30 percent as a result of new Medicaid coverage.[20]

States choosing to extend Medicaid coverage to parents directly help children by reducing the number of uninsured children, boosting a family's financial security, and enabling children to get better care from healthier parents.

Appendix:

Profile of Uninsured Parents in Virginia Potentially Eligible for Medicaid

Age	
18-25	25%
26-34	31%
35-49	35%
50-64	9%

Federal Poverty Level	
45-99% of FPL	64%
100-138% of FPL	36%

Race	
White	53%
Black	38%
Asian	5%
Other/Multiracial	4%

* Note that there were no American Indian/Alaska Native or Native Hawaiian and Other Pacific Islander in this population.

Ethnicity	
Hispanic	7%
Non-Hispanic	93%

Number of Children	
1	43%
2	29%
3	20%
4	7%
5 to 7	1%

Age of Children	
Presence of young children (under 6 years only)	15%
Presence of school-aged children (6-17 years only)	63%
Presence of both young and school-aged children (under 6 and 6-17 years)	22%

Employment Status	
Employed (Civilian)	68%
Unemployed	10%
Not in Labor Force	22%

Top 10 Industry Sectors	
Restaurants/Food Services	18%
Retail	15%
Construction	12%
Medical (hospitals, dentist, outpatient care)	9%
Service (beauty, car wash, maintenance, other)	8%
Professional Services (accounting, architecture business support, etc.)	7%
Manufacturing	7%
Transportation	5%
Entertainment	4%
Education	3%

Note: Due to rounding, percentages may not add to 100 percent.

Methodology

Data Source

This brief analyzes 2014 Public Use Microdata Sample (PUMS) from the U.S. Census Bureau American Community Survey (ACS) and applies the PUMS person weight. The U.S. Census Bureau publishes PUMS data on Data Ferrett.

Parents

The estimates presented here focus on parents defined as civilian non-institutionalized adults age 18 to 64 living with a biological, adoptive, or step child under the age of 18 ("own" children). Note that the definition of "own" children excludes foster children since they are not related to the householder. We did not adjust the family unit definition to analyze health insurance units (HIUs), most likely resulting in an undercount of the total number of individuals.

Health Coverage

Data on health insurance coverage are point-in-time estimates that convey whether a person does not have coverage at the time of the survey. The estimates are not adjusted to address the Medicaid undercount often found in surveys, which may be accentuated by the absence of state-specific health insurance program names in the ACS.

Medicaid Eligibility

Under Current Rules Data on poverty levels includes only those individuals for whom the poverty status can be determined for the last year. Therefore, this population is lightly smaller than the total non-institutionalized population of the U.S. We include only those parents whose income-to-poverty status is determined to be 45 percent to 138 percent of Federal Poverty Level ($9,041 to $27,724).

The ACS does not contain sufficient information to determine whether an individual is an authorized immigrant and therefore potentially eligible for Medicaid coverage, thus we only include those who are classified as citizens (those who are born in the U.S.; Born in Puerto Rico, Guam, the U.S. Virgin Islands, or the Northern Marina; Born abroad of American parent(s); U.S. citizen by naturalization).

Demographic and Socio-economic Characteristics

In this brief we report data for all seven race categories and two ethnicity categories for which he ACS provides one-year health insurance coverage estimates. The U.S. Census Bureau recognizes and reports race and Hispanic origin (i.e., ethnicity) as separate and distinct concepts. We report the ACS category "some other race alone" and "two or more races" as "Other." Except for "Other," all other racial categories refer to respondents who indicated belonging to only one race.

We report "Hispanic or Latino," as "Hispanic." As this refers to a person's ethnicity, these individuals may be of any race. We report data for both "white" parents and "white non-Hispanic parents." The former refers to all parents whose race is reported as white, without regard to their ethnicity; the latter category refers to parents who reported their race as white and do not report their ethnicity as Hispanic. For more detail on how the ACS defines racial and ethnic groups see "American Community Survey and Puerto Rico Community Survey 2014 Subject Definitions."

Employment

This brief reports those who are employed as those who had a job or business and those who are unemployed as those who do not work or are actively looking for work. The labor force is everyone classified as employed or unemployed. People who are not in the labor force are mostly students, homemakers, retired workers, seasonal workers, institutionalized people, and people doing unpaid family work. As defined by the U.S. Department of Labor Bureau of Labor Statistics, working part-time is working between 1 and 34 hours per week and full time work is 35 hours or more per week.

Limitations of Data

Data provided in this brief should be noted as an estimate. Variables presented are defined using only the information provided on the PUMS and do not include adjustments for possible measurement problems. We did not use statistical models to impute for various socio-demographic factors (e.g., authorized immigration status and health insurance unit).

Endnotes

[1] T. Brooks, et al., "Modern Era Medicaid: Findings from a 50-State Survey of Eligibility, Enrollment, Renewal, and Cost-Sharing Policies in Medicaid and CHIP as of January 2015," Kaiser Commission on Medicaid and the Uninsured (January 2015).

[2] "How Medicaid Works: A Chartbook for Understanding Virginia's Medicaid Insurance and the Opportunity to Improve it," The Commonwealth Institute (2015), available at http://www.thecommonwealthinstitute.org/wp-content/uploads/2015/12/TCI-VPLC-Chartbook-2016.pdf; R. Garfield, et al., "The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid – An Update," Kaiser Commission on Medicaid and the Uninsured (April 17, 2015), available at http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid-an-update/; G. Kenney, et al., "Opting Out of the Medicaid Expansion under the ACA: How Many Uninsured Adults Would not Be Eligible for Medicaid," Urban Institute (July 2012).

[3] C. Bailey, "The Economic Impact of the Medicaid Expansion on Virginia's Economy," Virginia Hospital and Healthcare Association, prepared by Chmura Economics and Analysis (December 2012), available at http://www.vhha.com/documents.html?id=845.

[4] S. Dorn, et al., "What Is the Result of States Not Expanding Medicaid?: Timely Analysis of Immediate Health Policy Issues," Urban Institute (August 2014), available at http://www.urban.org/sites/default/files/alfresco/publication-pdfs/413192-What-is-the-Result-of-States-Not-Expanding-Medicaid-PDF.

[5] J. Alker and A. Chester, "Children's Health Insurance Rates in 2014: ACA Results in Significant Improvements," Georgetown Center for Children and Families (October 2015), available at http://ccf.georgetown.edu/wp-content/uploads/2015/10/child_uninsurance_rates_2014_aca.pdf.

[6] Based on a Georgetown CCF analysis of U.S. Census Bureau American Community Survey (ACS) data, 2014 single year estimates. Georgetown CCF estimated that there are about 57,000 uninsured parents potentially eligible for Medicaid if Virginia expands eligibility, accounting for 29 percent of the total newly eligible adult population. We believe this likely underestimates the full number and should be used as an approximation for the population profile of uninsured parents potentially eligible for Medicaid expansion. Please refer to methodology for complete methodological notes.

[7] The seven states with approved Medicaid expansion waivers are Arkansas, Indiana, Iowa, Michigan, Montana, New Hampshire, and Pennsylvania.

[8] J. Alker and A. Chester, "Children's Health Insurance Rates in 2014: ACA Results in Significant Improvements," Georgetown Center for Children and Families (October 2015), available at http://ccf.georgetown.edu/wp-content/uploads/2015/11/ACS-report-2015.pdf.

[9] Georgetown Center for Children and Families, "Medicaid Expansion: Good for Parents and Children," (January 2014), available at http://ccf. georgetown.edu/wp-content/uploads/2013/12/ Expanding-Coverage-for-Parents-Helps-Children-2013.pdf.

[10] J. DeVoe, et al., "Effect of Expanding Medicaid for Parents on Children's Health Insurance Coverage: Lessons From the Oregon Experiment," *JAMA Pediatrics* 169 (January 2015).

[11] L. Dubay and G. Kenney, "Expanding Public Health Insurance to Parents: Effects on Children's Coverage under Medicaid," *HSR: Health Services Research*, vol. 38: 1283-1302 (2003).

[12] J. Paradise and R. Garfield, "What is Medicaid's Impact on Access to Care Outcomes, and Quality of Care? Setting the Record Straight on the Evidence," Kaiser Commission on Medicaid and the Uninsured (August 2013).

[13] L. Wherry, et al., "Childhood Medicaid Coverage and Later Life Health Care Utilizations," National Bureau of Economic Research, Working Paper 20929 (February 2015).

[14] A. Chester and J. Alker, "Medicaid at 50: A Look at the Long-Term Benefits of Childhood Medicaid," Georgetown Center for Children and Families (July 2015), available at http://ccf.georgetown.edu/wp-content/uploads/2015/08/Medicaid-at-50_final.pdf.

[15] S. Cohodes, et al., "The Effect of Child Health Insurance Access on Schooling: Evidence from Public Health Insurance Expansion," National Bureau of Economic Research, Working Paper 20178 (May 2014).

[16] R. O'Brien, et al., "Medicaid and Intergenerational Economic Mobility," University of Wisconsin-Madison Institute for Research on Poverty, No. 1428- 15 (April 2015).

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[20] K. Baicker, et al., "The Oregon Health Insurance Experiment – Effects of Medicaid and on Clinical Outcomes," *New England Journal of Medicine* 368:1713-1722 (May 2, 2013).

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Georgetown University Health Policy Institute
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