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Many Working Parents and Families in North Carolina Would Benefit from Medicaid Coverage

Key Points

1. While North Carolina's General Assembly has not yet this year considered accepting the federal money available under the Affordable Care Act (ACA) for extending Medicaid coverage, North Carolina's Governor has indicated he intends to propose a plan to use North Carolina's share of federal money to extend coverage with an alternative Medicaid health plan that would cover over 500,000 people.
2. North Carolina has high rates and numbers of uninsured parents and adults. **Over one-quarter (27 percent) of people potentially eligible for coverage should North Carolina choose to extend Medicaid are parents with dependent children residing in their home**. Providing health coverage to North Carolina'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 extended Medicaid eligibility, nearly two-thirds (64 percent) are employed. Half of all uninsured parents (53 percent) work in restaurants, retail, medical, or professional service occupations.

North Carolina is one of the 22 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 North Carolina are not eligible for Medicaid *or* premium tax credits if their incomes exceed 45 percent of the poverty line ($8,840 annually, or $737 per month, for a family of three in 2015) but remain below 100 percent of the poverty line ($20,090 annually, or $1,674 per month for a family of three).[1] As a result, there are an estimated 357,000 North Carolinians (including childless adults) who fall into this coverage gap and a total of 587,000 adults excluded from Medicaid coverage due to North Carolina's decision not to expand Medicaid.[2]

Should North Carolina choose to extend Medicaid coverage to adults with incomes up to 138 percent of FPL, federal funding will be available to cover 100 percent of the costs for this new coverage through 2016. North Carolina has the option to join six other states in creating its own plan to extend coverage through a waiver of certain Medicaid provisions. All six states that have proposed Medicaid waivers so far have come to agreement with the federal government and extended coverage.[3] According to a study done by researchers at the George Washington University, a Medicaid coverage extension in North Carolina would generate $21 billion in new economic activity and more than 43,000 new jobs between 2016 and 2020.[4]

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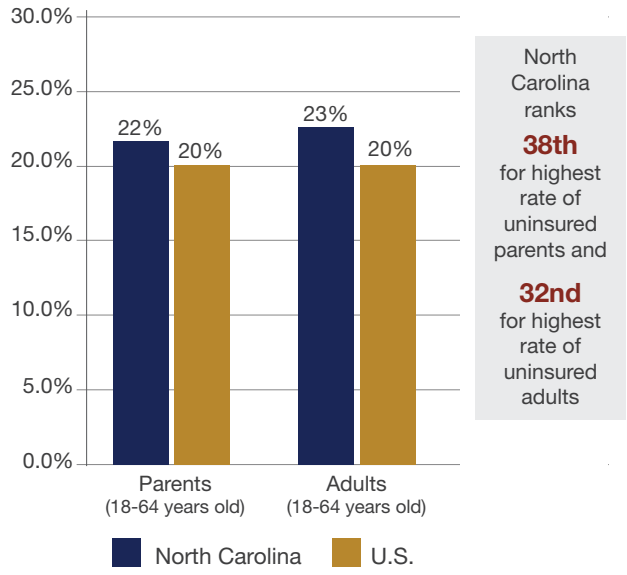
North Carolina has some of the highest rates of uninsured parents in the nation. While the rate of uninsured children remains low (6.3 percent in North Carolina compared to 7.1 percent nationally), North Carolina has the 44th highest number of uninsured children in the United States, with over 144,000 children without health coverage. Research based on the experience of other states shows that insurance rates for children improve when coverage is available to the whole family. In North Carolina, uninsured parents with children present in the home account for over one quarter (27 percent) of the population potentially eligible for health coverage if the state expands Medicaid.[5] The population of low-income uninsured parents in North Carolina most likely to be helped are employed and have one to two children.

Figure 1. Rates of Uninsurance in North Carolina and the U.S., 2013



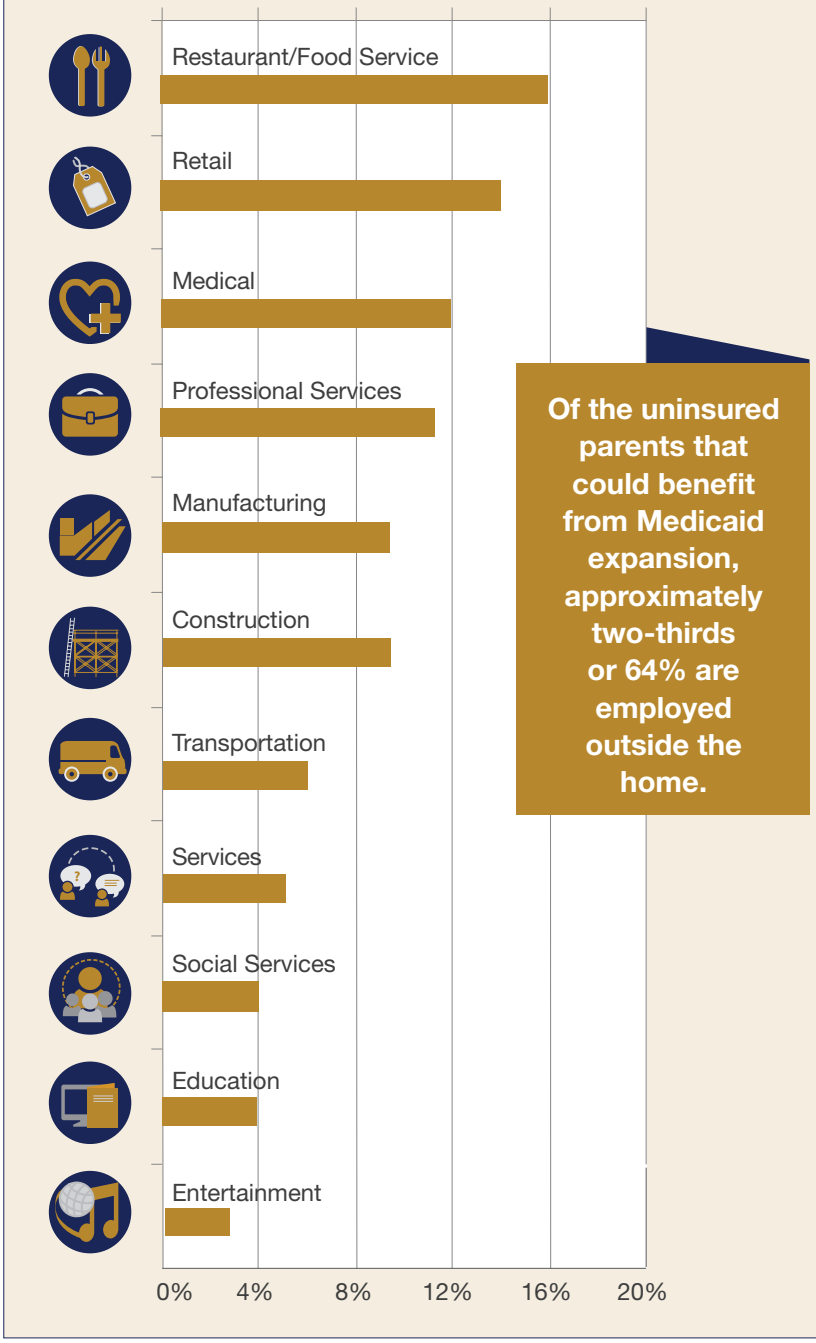
Who are the Uninsured in North Carolina?

Data reported here is from 2013 and does not reflect the impact of the ACA's major provisions that took effect on January 1, 2014. Full implementation of the ACA will likely improve coverage rates and will be reflected in 2014 data when it becomes available.[6]

Employment

- Of those uninsured parents who could potentially benefit from expanded Medicaid eligibility, the majority (64 percent) are employed outside of the home, one-fifth (20 percent) of parents are not in labor force (meaning they are most likely students, homemakers, or otherwise retired workers), and only 16 percent are unemployed.
- Nearly one-fifth (17 percent) of potentially eligible parents are from families with two working parents in the home.
- North Carolina's Medicaid expansion would lead to greater health coverage for the working poor. More than half (57 percent) of potentially eligible uninsured parents live below the poverty line (46 to 100 percent FPL). In North Carolina, 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 27 hours per week have incomes too high to qualify for Medicaid (46 percent of the FPL is $193 per week). Employees earning the minimum wage who work more than 27 hours per week but earn less than $419 per week (100 percent of the FPL) have incomes too high for Medicaid and too low for premium assistance through the exchanges.

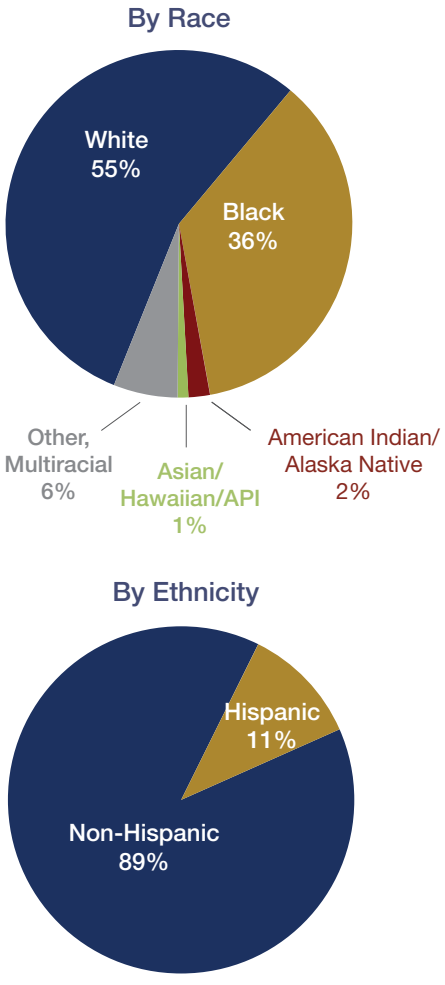
Figure 2. Top 10 Industry Sectors for Potentially Eligible Uninsured Parents in North Carolina



Family Demographics

- Two-thirds (69 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 (77 percent) have one or two children.
- More than half of families (59 percent) have school-aged children (those ages 6 to 17 years old).

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



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.

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.[7] A recently published study in Oregon showed the odds of eligible children receiving Medicaid or CHIP coverage doubled if their parents enrolled in Medicaid.[8] In Massachusetts, health coverage expansions for parents helped cut the uninsurance rate for children in half.[9]

Extending Medicaid coverage for parents and other low-income adults has proven to be an effective strategy to boost children's enrollment rates because most uninsured children are already eligible for Medicaid or CHIP but not enrolled. Arkansas enrolled significant numbers of already eligible children when the state expanded coverage to their parents. In just one month, Arkansas's enrollment effort resulted in 58,000 new enrollees, including 2,500 children.[10]

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.[11] Expanding Medicaid eligibility to children and parents reduces hospitalizations and leads to fewer emergency department visits later in life.[12]

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 childhood Medicaid eligibility significantly improves health, educational, and financial outcomes in adolescence and adulthood.

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.[13] Adults who had received Medicaid as children were also more likely to have higher earnings and economic mobility.[14] 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.[15]

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.[16] 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.[17] 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.[18]

Finally, in North Carolina, expanding Medicaid eligibility is particularly important to reduce the rates of infant mortality. Within the state, 22 percent of infant deaths are related to premature or low birth weight and 16 percent are related to maternal factors or other pregnancy-related complications.[19] Access to pre-conception and inter-conception care has the potential to significantly reduce infant mortality due to these factors. Without expansion, thousands of low-income women are effectively denied full and continuous health coverage and access to critical pre- and inter-conception services to improve their health before pregnancy occurs. Simply put, healthier women with regular access to medical care have healthier children. Thus, expansion is an important strategy to reduce infant mortality in North Carolina.

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Appendix:

Profile of Uninsured Parents in North Carolina Potentially Eligible for Medicaid

Age	
18-25	24%
26-34	31%
35-49	38%
50-64	7%

Federal Poverty Level	
46-100% of FPL	57%
101-138% of FPL	43%

Race	
White	55%
Black	36%
American Indian/Alaska Native	2%
Asian/Hawaiian/API	1%
Other/Multiracial	6%

Ethnicity	
Hispanic	11%
Non-Hispanic	89%

Number of Children	
1	47%
2	30%
3	17%
4 to 7	8%

Age of Children	
Presence of young children (under 6 years only)	19%
Presence of school-aged children (6-17 years only)	59%
Presence of both young and school-aged children (under 6 and 6-17 years)	22%

Employment Status	
Employed (Civilian)	64%
Unemployed	16%
Not in Labor Force	20%

Top 10 Industry Sectors	
Restaurants/Food Services	16%
Retail	14%
Medical (hospitals, dentist, outpatient care)	12%
Professional Services (accounting, architecture business support, etc.)	11%
Manufacturing	9%
Construction	9%
Transportation	6%
Service (beauty, car wash, maintenance, other)	5%
Social Services (child care)	4%
Education	4%
Entertainment (arts, recreation)	3%

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

Methodology

Data Source

This brief analyzes 2013 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 46 percent to 138 percent of Federal Poverty Level ($9,241 to $27,724 for a family of three in 2015).

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 the 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.

To report on an individual's race, we merge the data for "Asian alone" and "Native Hawaiian or other Pacific Islander alone." In addition, 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 2013 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] 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.M. 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] The six states with approved Medicaid expansion waivers are Arkansas, Indiana, Iowa, Michigan, New Hampshire, and Pennsylvania.

[4] L. Ku, B. Bruen, *et al*., "The Economic and Employment Costs of Not Expanding Medicaid in North Carolina: A County-Level Analysis," Center for Health Policy Research at The George Washington University funded by the Cone Health Foundation and the Kate B. Reynolds Charitable Trust, available at http://www.conehealthfoundation.com/app/files/public/4202/The-Economic-and-Employment-Costs-of-Not-Expanding-Medicaid-in-North-Carolina.pdf.

[5] Based on a Georgetown CCF analysis of U.S. Census Bureau American Community Survey (ACS) data, 2013 single year estimates. Georgetown CCF estimated that there are about 120,000 uninsured parents potentially eligible for Medicaid if North Carolina expands eligibility, accounting for 27 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. See Methodology section for complete methodological notes.

[6] For examples of preliminary data on uninsurance rates in 2014, see federal data from the CDC in "Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, January-September 2014"; policy briefs from the Urban Institute's Health Reform Monitoring Survey including "A First Look at Children's Health Insurance Coverage under the ACA in 2014" and "Taking Stock: Health Insurance Coverage for Parents under the ACA in 2014."

[7] 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.

[8] 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).

[9] 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).

[10] A. Strong, "Early Results in Arkansas Show ACA is Reaching Uninsured Children and Families," Say Ahh! Blog (October 6, 2013), available at http://ccf. georgetown.edu/all/early-results-in-arkansas-show-aca-is-reaching-uninsured-children-and-families/.

[11] 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).

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

[13] 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).

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

[15] D. Brown, *et al*., "Medicaid as an Investment in Children: What is the Long-Term Impact on Tax Receipts?," National Bureau of Economic Research, Working Paper 20835 (January 2015).

[16] C. Lowenstein, *et al*., "Linking Depressed Mothers to Effective Services and Supports: A Policy and Systems Agenda to Enhance Children's Development and Prevent Child Abuse and Neglect: Summary of May 2013 Culminating Roundtable," Urban Institute (October 2013).

[17] T. Vericker, *et al.*, "Infants of Depressed Mothers Living in Poverty: Opportunities to Identify and Service," Urban Institute (August 2010).

[18] 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).

[19] "2013 North Carolina Infant Mortality Report, Table 7," North Carolina Department of Health & Human Services State Center for Health Statistics (September 15, 2014), available at http://www.schs.state.nc.us/data/vital/ims/2013/table7.html.

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Georgetown University Health Policy Institute
CENTER FOR CHILDREN AND FAMILIES

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