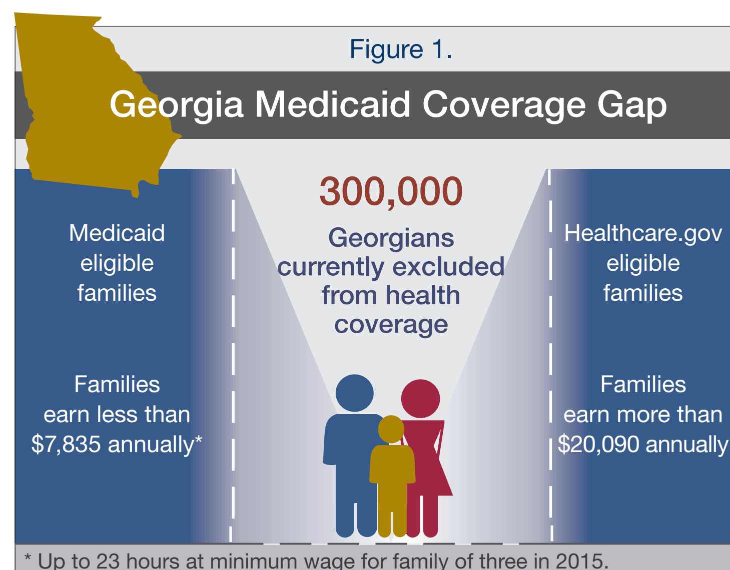
Many Working Parents and Families in Georgia Would Benefit from Extending Medicaid Coverage

Key Points

1. Georgia is one of 19 states that has elected not to accept federal funding under the ACA to extend Medicaid coverage to parents and other low-income adults and is not currently exploring coverage options.
2. Georgia has high rates and numbers of uninsured children and parents. **Nearly three-in-ten Georgians potentially eligible for coverage should Georgia choose to extend Medicaid are parents with dependent children residing in their home.** Providing health coverage to Georgia'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 (57 percent) are employed. Nearly half of all uninsured parents (46 percent) work in restaurants, retail, or professional service occupations.

Georgia is one of the 19 states that have elected not to accept federal funding under the ACA to extend Medicaid coverage to parents and other low-income adults and is not actively considering plans for coverage.[1] Consequently, parents in Georgia are not eligible for Medicaid or premium tax credits if their incomes exceed 39 percent of the poverty line ($7,835 annually, or $653 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).[2, 3] As a result, there are about 300,000 Georgians (including childless adults) who fall into this coverage gap and at least 500,000 adults excluded from Medicaid coverage due to Georgia's decision not to expand Medicaid.[4]

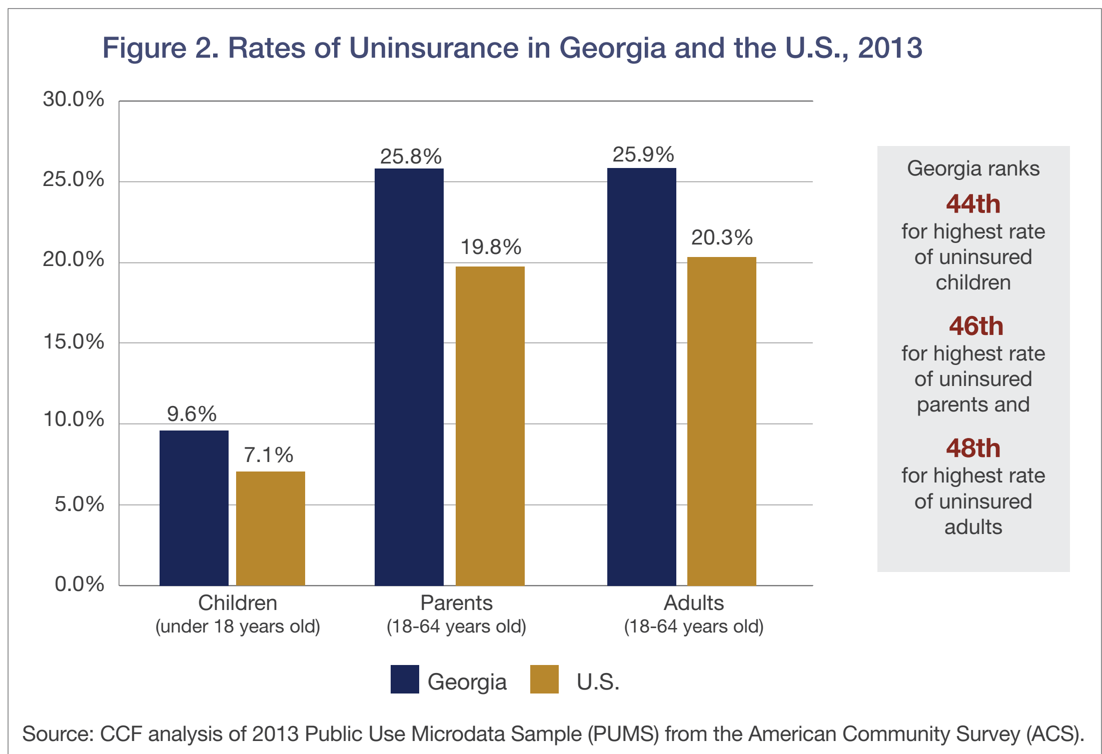


Georgia has some of the highest rates and numbers of uninsured children, parents, and adults in the nation.

Should Georgia 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 the newly covered through 2016. Georgia 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 of the states that have proposed Medicaid waivers so far have come to agreement with the federal government and extended coverage.[5] Georgia law currently requires the General Assembly approve any Medicaid expansion.[6]

According to a study by the Urban Institute, Georgia is foregoing $3 billion annually in federal funds and hospitals will lose $13 billion between 2013 and 2022 from Medicaid funding originally intended to increase care reimbursement funds.[7] In addition, between 2014 and 2023 Medicaid expansion would help create 56,000 jobs in Georgia.[8]

Georgia has some of the highest rates and numbers of uninsured children, parents, and adults in the nation. Research based on the experience of other states shows that insurance rates for children improve when coverage is available to the whole family. In Georgia, uninsured parents with children present in the home account for over one quarter (29 percent) of the population potentially eligible for health coverage if the state expands Medicaid.[9] The population of low-income uninsured parents in Georgia most likely to be helped by Medicaid expansion in Georgia are white, employed, and have one to two children.



Who Are the Uninsured in Georgia?

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.[10]

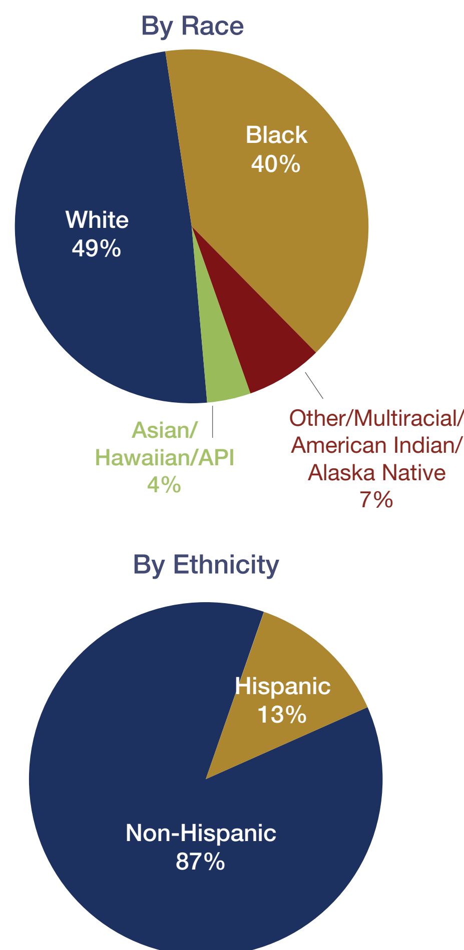
Employment

- Of those uninsured parents who could potentially benefit from expanded Medicaid eligibility, the majority (57 percent) are employed outside of the home, nearly one-third (30 percent) of parents are not in labor force (meaning they are most likely students, homemakers, or otherwise retired workers), and only 14 percent are unemployed.
- Nearly one-fifth (19 percent) of potentially eligible parents are from families with two working parents in the home.
- Georgia'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 (39 to 100 percent FPL). In Georgia, 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 23 hours per week have incomes too high to qualify for Medicaid (39 percent of the FPL is $163 per week). Employees earning the minimum wage who work more than 23 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.

Family Demographics

- Two-thirds (67 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 eligible for an extension of Medicaid (71 percent) are parents to one or two children living in the home.
- More than half of families (57 percent) have school-aged children (those ages 6 to 17 years old).

Figure 3: Uninsured Georgia Parents Potentially Eligible for Medicaid by Race and Ethnicity



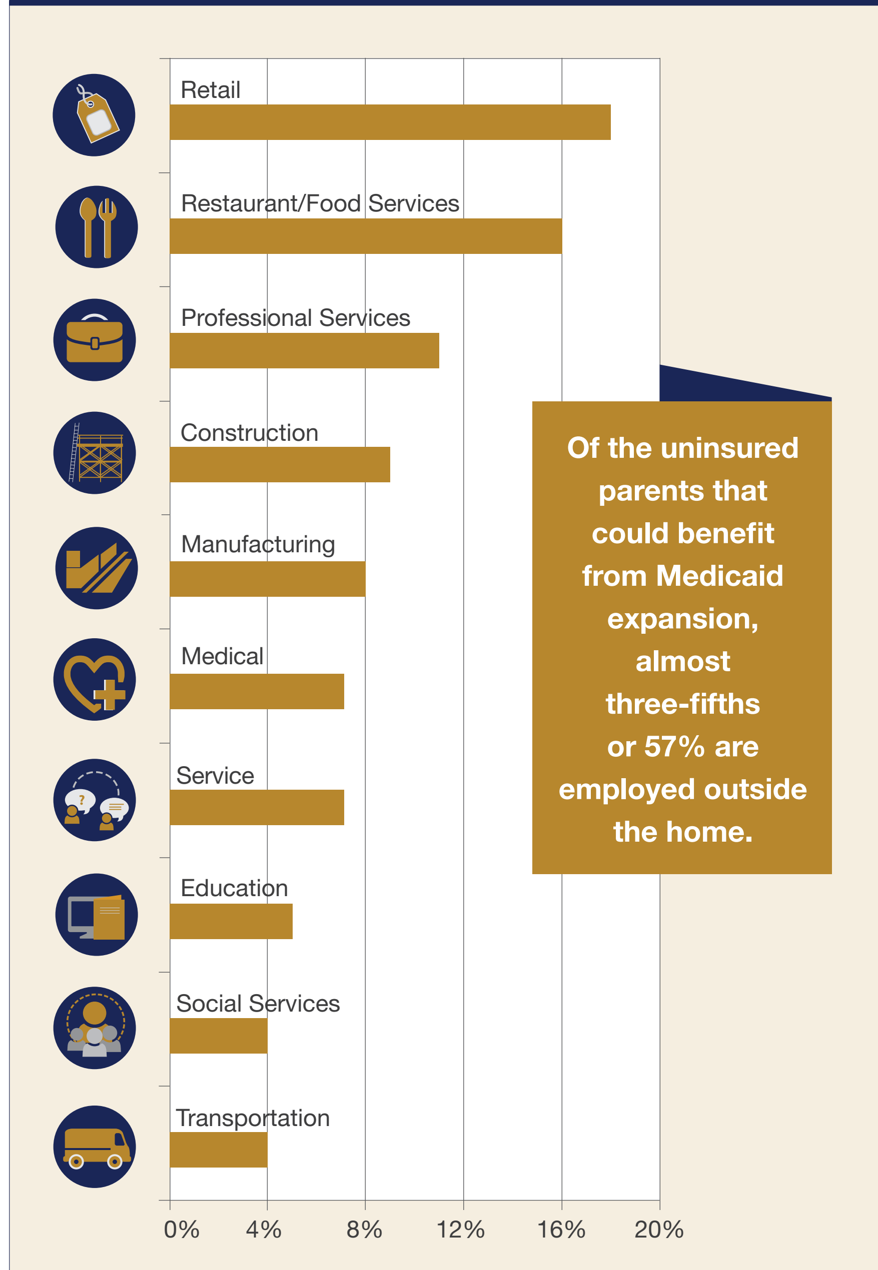


Figure 4. Top 10 Industry Sectors for Potentially Eligible Uninsured Parents in Georgia
Retail
Restaurant/Food Services
Professional Services
Construction
Manufacturing
Medical
Service
Education
Social Services
Transportation
0%
4%
8%
12%
16%
20%
Of the uninsured parents that could benefit from Medicaid expansion, almost three-fifths or 57% are employed outside the home.

Children Benefit When Their Parents Have Coverage

Extending Medicaid coverage to more parents directly helps 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.[11] This is because most uninsured children are already eligible for Medicaid or CHIP but not enrolled. A recently published study in Oregon showed the odds of eligible children receiving Medicaid or CHIP coverage doubled if their parents enrolled in Medicaid.[12]

Extending Medicaid coverage for parents and other low-income adults has proven to be an effective strategy to boost children's enrollment rates. 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.[13]

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.[14] Expanding Medicaid eligibility to children and parents reduces hospitalizations and leads to fewer emergency department visits later in life.[15]

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 including lower rates of mortality, improved educational attainment, and government savings. A growing body of research documents later-life outcomes improve with childhood access to Medicaid coverage.

One study found that Medicaid eligible children were more likely to attend college and had lower rates of mortality than their non-Medicaid eligible counterparts.[16] Expanding Medicaid eligibility improved the economic outcomes for low-income children who experienced positive economic mobility in adulthood.[17] In addition, children enrolled in Medicaid had higher wages and, because they contributed more taxes later in life, led the government to recoup most of the dollars spent on Medicaid for children.[18]

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.[19]

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.[20] 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.[21]

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.

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.

Appendix:

Profile of Uninsured Parents in Georgia Potentially Eligible for Medicaid

Age	
18-25	25%
26-34	33%
35-49	35%
50-64	7%

Federal Poverty Level	
39-100% of FPL	57%
101-138% of FPL	43%

Race	
White	49%
Black	40%
Asian/Hawaiian/API	4%
Other/Multiracial/ American Indian/ Alaska Native	7%

Ethnicity	
Hispanic	13%
Non-Hispanic	87%

Number of Children	
1	39%
2	32%
3	20%
4	5%
5 to 7	4%

Age of Children	
Presence of young children (under 6 years only)	18%
Presence of school-aged children (6-17 years only)	57%
Presence of both young and school-aged children (under 6 and 6-17 years)	25%

Employment Status	
Employed (Civilian)	65%
Unemployed	15%
Not in Labor Force	20%

Top 10 Industry Sectors	
Retail	18%
Restaurants/Food Services	16%
Professional Services (accounting, architecture business support, etc.)	11%
Construction	9%
Manufacturing	8%
Medical (hospitals, dentist, outpatient care)	7%
Service (beauty, car wash, maintenance, other)	7%
Education	5%
Social Services (child care)	4%
Transportation	4%

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 39 percent to 138 percent of Federal Poverty Level ($7,835 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 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.

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] Kaiser Commission on Medicaid and the Uninsured, "Status of state Action on the Medicaid Expansion Debate," Kaiser Family Foundation (September 1, 2015), available at http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/.

[2] Georgia, as in some other states, determines eligibility limits for Section 1931 parents based on a dollar amount. The exact Federal Poverty limit may vary based on calculations from the dollar limit.

[3] 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).

[4] 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); State of Georgia Medicaid Enrollment Forecast – 2012 Estimate.

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

[6] G. Bluestein and M. Williams, "Georgia Weighs Medicaid Experiment (But Not Expansion)," Kaiser Health News and Atlanta Journal-Constitution (May 7, 2015), available at http://khn.org/news/georgia-weighs-medicaid-experiment-but-not-expansion/.

[7] 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.

[8] W. S. Custer, "The Economic Impact of Medicaid Expansion in Georgia," Health Georgia Foundation (February 2013), available at http://www.healthcaregeorgia.org/uploads/file/Georgia_Medicaid_Economic_Impact.pdf.

[9] 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 151,000 uninsured parents potentially eligible for Medicaid if Georgia 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.

[10] 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."

[11] 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.

[12] 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).

[13] 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/.

[14] 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).

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

[16] 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).

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

[18] 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).

[19] 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).

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

[21] 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).

For more information about the research and data presented in this brief, contact Alisa Chester or Adam Searing at the Georgetown University Center for Children and Families. Design and layout assistance provided by Nancy Magill.

Alisa Chester
Alisa.Chester@georgetown.edu
(202) 687-4917

Adam Searing
ags68@georgetown.edu
(202) 740-1744

Center for Children and Families
Health Policy Institute
Georgetown University
Box 571444
3300 Whitehaven Street, NW, Suite 5000
Washington, DC 20057-1485
Phone (202) 687-0880
Email childhealth@georgetown.edu

ccf.georgetown.edu/blog/

facebook.com/georgetownccf

twitter.com/georgetownccf

The Center for Children and Families (CCF) is an independent, nonpartisan policy and research center whose mission is to expand and improve health coverage for America's children and families. CCF is based at Georgetown University's Health Policy Institute. Visit ccf.georgetown.edu

GEORGIANS FOR A HEALTHY FUTURE

Georgians for a Healthy Future is a nonprofit consumer health advocacy organization with a mission to build and mobilize a unified voice, vision, and leadership to achieve a healthy future for all Georgians. Visit healthyfuturega.org.