# The Faces of Medicaid Expansion: Filling Gaps in Coverage

*By David Machledt*

For more than 50 years, Medicaid coverage has helped people succeed. But prior to the Affordable Care Act (ACA) the eligibility structure left huge coverage gaps. Parents, adolescents, low-wage workers and people with mental health and substance use disorders often fell through the eligibility gaps and were left with no affordable health care options. Many were forced to delay needed care or faced financial ruin when finally a medical emergency landed them in a hospital. The ACA created a new catchall eligibility category for low-income adults that aimed to bridge some of those gaps and simplify the eligibility process. Despite a Supreme Court ruling that effectively allowed states to not implement the new category, the Medicaid expansion has largely achieved its goals in the majority of states that did expand. Millions have gained coverage, while uncompensated care has declined sharply.[1] For new Medicaid enrollees, financial catastrophe due to medical debt nearly disappeared.[2] Screening and utilization of preventive services and medications for chronic conditions like diabetes increased. Self-reported health increased, while depression dropped markedly.[3]

*The adult Medicaid expansion includes mostly low-income workers, people with disabling conditions, students, and parents and family caregivers.*

In some circles, adults in the new catchall eligibility group have been typecast, masking the wide range of individuals and families covered under this category, and, more importantly, masking their powerful personal stories. This group largely consists of people with disabling conditions, including mental health and substance use disorders; parents and family caregivers; and low-income workers, including a large number of direct care workers that millions of older adults and people with disabilities depend on for essential supports. This paper highlights some of the millions who previously fell through the cracks but finally have opportunities to use Medicaid as a springboard to better health, better employment and better engagement with their communities.

### *Medicaid Expansion and People with Disabilities*

The adult Medicaid expansion category includes millions of people with disabling conditions. For example, an evaluation of Ohio's expansion identified 21% of newly eligible enrollees with claims histories that correspond to a serious disability.[4] This could include a person with epilepsy whose job earnings exceed the low threshold for her state's disability category (roughly $9,000 per year in most states). Or someone who suffered a brain injury in a car crash but is still in the lengthy process of obtaining a formal disability determination from the Social Security Administration (SSA) (See box). Or a coal miner with lung disease who retired after decades of manual labor only to lose his health and pension benefits when his employer filed for bankruptcy.[5] Or a person with bipolar disorder who may not meet the strict requirements for an Medicaid disability determination, but needs medications to function effectively and hold down a job. These are all examples of individuals who, without access to Medicaid through the catchall adult group, would likely have no access to affordable coverage at all.

#### Social Security & the Medicare Waiting Period

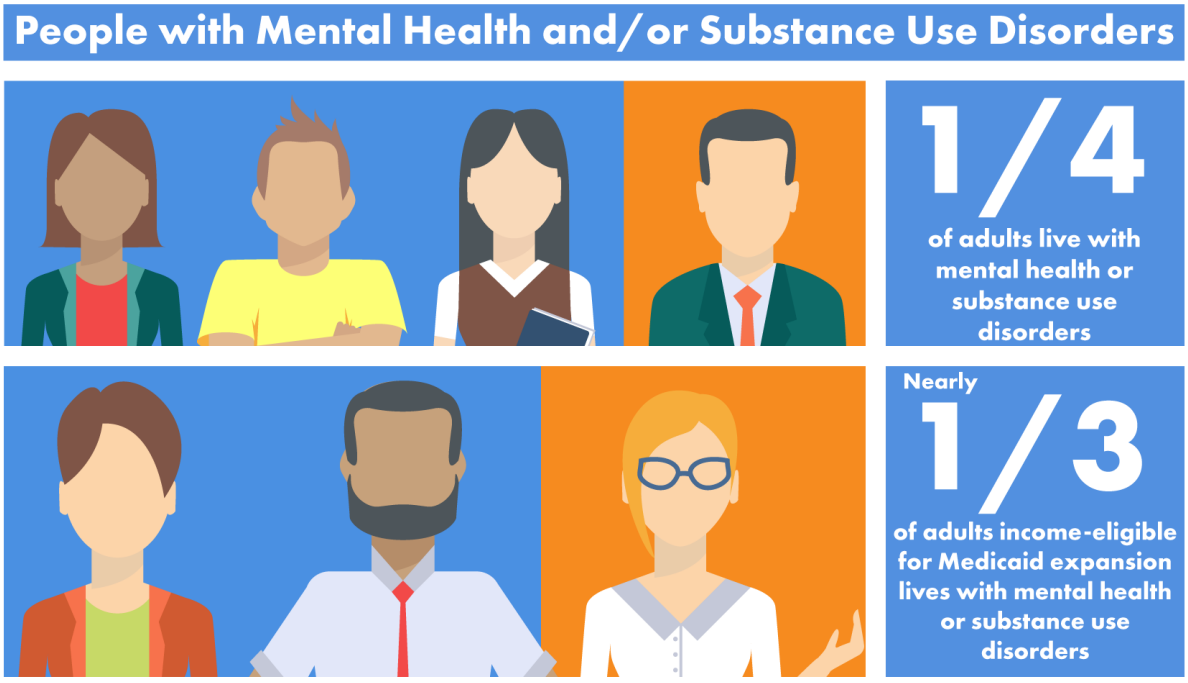
Applying for disability benefits is a long and arduous process and people in that process have often struggled to maintain access to needed care.

Average processing time for an initial application takes nearly four months, and only about one in three applications for disabled workers are ultimately approved. Appeals can easily last years, with a median processing time of 582 days in 2017. Most importantly, even if the process goes perfectly, all individuals must wait at least two years after they begin receiving their social security benefits to qualify for Medicare coverage. Each year roughly 1.5 million Americans with disabilities are in the required two year "Medicare waiting period" before they can become eligible for Medicare due to their disability.

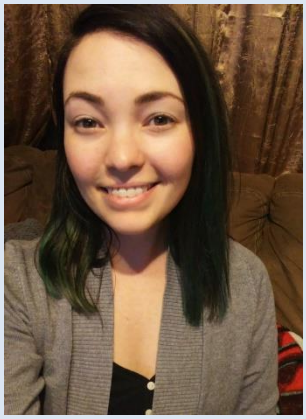
Prior to the ACA, many of these individuals in limbo had no other affordable options to obtain coverage for needed health care services despite their disability. Medicaid expansion can bridge the gap until Medicare coverage begins. Medicaid also helps fill gaps in Medicare coverage after the waiting period ends.

### *People with Mental Health and/or Substance Use Disorders*

Roughly a quarter of the adult population lives with significant mental health or substance use disorders.[6] That number is higher, 28.4%, for adults with incomes below the Medicaid expansion threshold.[7] Most people with low incomes previously had no access to affordable coverage. Pennsylvania found that more than 157,000 (18.8%) of its expansion enrollees had mental health conditions.[8] More than 97,000 (11.5%) were diagnosed with substance use disorders, nearly half of whom were dependent on opioids.[9] These numbers are roughly similar to adult expansion populations in other states.[10]



### Faces of Medicaid Expansion: *Amanda*



When Amanda from Illinois was 13, she was diagnosed with major depression. Amanda faced an uphill battle throughout high school as she tried many treatments such as antidepressants and counseling. This combination worked well enough to help her graduate. She did not have any severe issues until her early 20s when she stopped responding to her antidepressants. Her moods became increasingly unstable, sometimes violent. As Amanda's condition deteriorated, she began failing her college classes. Eventually, she found a new psychiatrist who diagnosed her with bipolar disorder, severe generalized anxiety and ADHD. The psychiatrist prescribed new mood stabilizers, which helped Amanda tremendously.

Then, at 23, Amanda lost her father's insurance (he had Tricare through the U.S. Army). Thanks to the ACA, she was able to stay on her mother's insurance until turning 26. This provision of the law literally saved Amanda's life when, at 25, she first attempted suicide. Because of her coverage, Amanda was able to spend a week in the hospital to receive the monitoring and care she needed.

The ACA was designed to ensure that when Amanda reached 26, she could shift to affordable coverage through Medicaid or the Marketplace. The Supreme Court's decision allowing states to opt out of Medicaid expansion could have created a crisis for Amanda. Luckily, she lives in Illinois, an expansion state. Because of her mental illness, Amanda has not finished college and could not work full time, so the Medicaid expansion is her only coverage option. Now, Medicaid covers Amanda's mood stabilizers that treat her mental health conditions. This coverage allows Amanda to work part time and continue receiving the treatment she needs.

## *Parents and Family Caregivers*

**Medicaid expansion covers millions of parents.** Before the ACA coverage expansion, Medicaid eligibility thresholds for parents and caretakers were abysmally low in most states. In 2013, nine states had eligibility levels below $505 per month for a family of three, which would not even cover rent for the vast majority of small families.[11] Today 12 of the 19 states that have refused Medicaid expansion maintain parental eligibility thresholds below half the poverty level (less than $10,210 per year for a three-person family).[12] The adult Medicaid group boosts eligibility for parents to $28,180 for a family of three, making it possible for low-wage working parents to get covered and better afford their other basic necessities.

**Adult Medicaid Expansion Eligibility (2017)**

| Family Size | 138%FPL |
|---|---|
| 1 | $16,394 |
| 2 | $22,108 |
| 3 | $27,821 |
| 4 | $33,534 |

***Face of Medicaid Expansion: Sandra***

For years after she divorced and was no longer able to get coverage through her ex-husband's employer, Sandra from Ohio was uninsured. One of her children has a disability and needed extra care. Sandra had to quit working full time to take care of her and make sure she gets to all of her medical and therapy appointments. Because Sandra was only able to work part time, she was not offered coverage through her employer. While her children were able to get on Medicaid, Sandra did not qualify.

While she was uninsured, she was "in a constant state of panic" worrying that she would get sick and be unable to take care of her kids. She worried about controlling her high cholesterol without coverage. For a period of time she was able to get her cholesterol medication through the drug manufacturer, but the program was only available for a limited time. When it ran out she could only afford to buy the medication occasionally, and often went without. When she felt sick, she "had to rely on over the counter remedies and a lot of prayer."

When Ohio expanded Medicaid in 2014, Sandra qualified for coverage. For the first time in years, she could continually treat her high cholesterol. She was also able to get a mammogram and other screening tests. Recently, she saw a doctor about her chronic back pain. She learned that taking care of her daughter with disabilities had taken a toll on her back. She was able to get physical therapy for a few weeks to give her techniques to ease her pain and reduce the strain when she lifts her daughter and her daughter's wheelchair. Sandra says that as a single parent, "I'm doing the best I can, but I need help to make sure I can be there for my children. Medicaid has been that help for me."

Covering parents helps cover more children. A child with uninsured parents is much more likely to be uninsured herself. Fully eighty-four percent of children share the same insurance status as their parents.[13] Several states, including Massachusetts and Arkansas, have documented increases in child coverage after adult coverage expansions.[14] And longer duration of Medicaid coverage has shown to improve children's long term achievement in education (at all levels), employment and future earnings.[15]

### *Nursing Assistants, Home Health Aides, and other Home Care Workers*

Home care workers -- including home health aides, personal care aides and nursing assistants – provide necessary care for older adults and people with disabilities. They form the backbone of our long-term care system by helping people with the tasks of daily living, but typically earn far less than a living wage and rarely have access to health coverage through their employer. It is cruel and unjust that they dedicate their lives to caring for others, yet often cannot get coverage for *themselves*. With average wages under $11 per hour, about one in three direct care workers lives in a household with income that would qualify for Medicaid expansion.[16] In states that refused the expansion, 40% of direct care workers remain uninsured. In all, more than 1.1 million home care workers across the country are enrolled or could qualify for Medicaid coverage if their state chose to accept federal funds to cover low-income adults.[17]

Providing coverage for these caregivers is even more important due to the relatively high injury rates for this physically taxing work, which includes heavy lifting to assist their clients to move around and bathe. No occupation – including construction workers, firefighters, and police officers – has a higher risk of on-the-job injury than nursing assistants.[18] Providing affordable coverage helps direct care workers to stay healthy, recover quickly, and keep on the job. It also helps create a more stable career path, which could improve care quality by reducing the exceptionally high turnover and increasing the average skill level of direct care workers.

### *Low-wage workers and self-employed business people*

Many individuals in low-wage jobs rely on Medicaid for their health coverage. The minimum wage is so low in many states that, even with full-time hours, individuals and families remain in or near poverty. A household with one full time worker earning ten dollars an hour – well above minimum wage in many states – will have an annual income of just $18,750 before taxes (See Table 1). Such low wages are not nearly enough to cover reasonable living expenses, much less health care (See Table 2).

***Table 1. A full time worker making $10/hour earns $18,750 per year.****

| **Household Size** | **$10/hr wage translated to Federal Poverty Level** |
|---|---|
| 1 person | **155% FPL** |
| 2 person | **115% FPL**[+] |
| 3 person | **92% FPL**[+] |
| 4 person | **76% FPL**[+] |

* Based on 50 weeks of work at 37.5 hrs./week.
[+] Income eligible for Medicaid expansion

Small businesses are not required to offer employees health insurance. While over half of all employees receive health insurance from their employer, only one in five low-wage workers buys insurance through their work.[19] For non-governmental low wage workers, only a third have access to insurance through their employers, while about one in five actually receives that coverage.[20] From restaurant employees to independent construction contractors to child care providers, these workers must seek coverage in the individual market or through Medicaid.

| *Table 2. Reasonable Expenses for Basic Living (Excluding Health Care) for 2 Adults and 1 Child* | | | | |
|---|---|---|---|---|
| **Expenses** | **Tucson, AZ** | **Bangor, ME** | **Des Moines, IA** | **Montgomery, AL** |
| **Housing** | $852 | $861 | $783 | $710 |
| **Food** | $618 | $618 | $618 | $618 |
| **Child Care** | $624 | $708 | $673 | $499 |
| **Transportation** | $620 | $608 | $620 | $613 |
| **Other Necessities** | $710 | $714 | $677 | $644 |
| **Taxes** | $510 | $672 | $598 | $547 |
| **Monthly Total** | **$3,984** | **$4,181** | **$3,968** | **$3,629** |
| **Annual Total** | **$47,808** | **$50,172** | **$47,616** | **$43,548** |

Data source: Economic Policy Institute Family Budget Calculator

A study by the nonpartisan Kaiser Family Foundation found that eight of ten nonelderly adult Medicaid enrollees lived in working families.[21] Nearly 60% of working enrollees log 40 or more hours per week at their jobs.[22] The vast majority of enrollees not currently working have very good reasons for not seeking employment. They include students, family caregivers, and people who recently lost their jobs. Another large fraction is people with disabilities, some of whom may require additional supports to work (which Medicaid often provides).

The truth is that health coverage can often be a prerequisite to finding and maintaining a job. In Ohio, 75% of unemployed Medicaid expansion enrollees looking for work reported that Medicaid made it easier to look for work, and 52% of those already working said coverage made it easier to continue working.[23] The same survey found that 39% of enrollees lived with a diagnosed chronic condition before they enrolled in Medicaid, and more than one in four enrollees had been diagnosed with a chronic condition *after* they enrolled in Medicaid, suggesting that coverage through Medicaid's new low-income adult category helps identify potential problems.[24] And Medicaid also helps people get and stay healthy. Ohio claims data suggested that for enrollees with medical records before and after Medicaid expansion, the percentage with high-risk blood pressure and cholesterol levels both dropped substantially after coverage began (from 34% to 22% for blood pressure, 10% to 3.3% for cholesterol).[25] Overall, nearly half of enrollees reported improved overall health status, while only 3.5% reported worse health.[26] Getting healthy makes it easier to be a productive employee.

### *Faces of Medicaid Expansion: Dewey*

Dewey from Michigan struggled without insurance for most of his adult life. Before the ACA, he could not afford individual insurance, and his employer did not offer any. He was in a terrible construction accident a number of years ago, and still suffers from related health problems. He had no insurance at the time and the medical bills were daunting.


Then Medicaid expansion came to Michigan, and Dewey got covered. Dewey says that Medicaid "has changed my life. I can work full time and live a much more positive life because I don't have to worry if I can make it to work or not." Dewey notes that "working with Medicaid has been surprisingly uncomplicated, no more burdensome that dealing with any insurance company."

## *Conclusion*

The adult Medicaid group is diverse and includes millions of people who have been left out for decades. They are parents, people with disabilities, low-income workers, and adults living with chronic conditions. These real stories reflect people who use Medicaid coverage as a springboard to succeed in other aspects of their life, including work, care giving, and being active members of their community. Nineteen states still have not accepted the adult expansion group, meaning millions more like Sandra, Amanda and Dewey are still facing those coverage gaps, still unable to afford health insurance and get the supports they need to succeed. Even worse, proposals to roll back the Medicaid adult expansion threaten to take away access for those who finally got the coverage they need.

---

[1] PENN. DEP'T HUMAN SERVS., *Medicaid Expansion* Report, 62 (Jan. 27, 2017), www.dhs.pa.gov/cs/groups/webcontent/documents/document/c_257436.pdf; Larisa Antonisse et al., KAISER FAM. FOUND., *The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review*, 4 (Feb. 2017), http://kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/.

[2] Katherine Baicker et al., *The Oregon Experiment – Effects of Medicaid on Clinical Outcomes*, 368 NEW ENG. J. MED. 1713 (2013); Larisa Antonisse et al., KAISER FAM. FOUND., *The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review*, (Feb. 2017), http://kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/.

[3] Benjamin D. Sommers et al., *Changes in Utilization and Health among Low-Income Adults After Medicaid Expansion or Expanded Private Insurance*, 176 JAMA INT. MED. 1501 (Oct. 2016); Katherine Baicker et al., *The Oregon Experiment – Effects of Medicaid on Clinical Outcomes*, 368 NEW ENG. J. MED. 1713 (2013).

[4] OHIO MEDICAID ASSESSMENT SURVEY, *The Changing Landscape of Healthcare Coverage Across Ohio: What Does It Mean for Our Health?*, 17 (Aug. 19, 2015), http://grc.osu.edu/sites/default/files/inline-files/OMASSLIDEDECK_FINAL%281%29_0.pdf.

[5] Kery Marakami, THE SALEM NEWS, *Coal Miners fight to Rescue Benefits*, (Mar. 2, 2017), http://www.salemnews.com/news/retired-coal-miners-fight-to-rescue-benefits/article_703c9d44-55de-5114-

a3b8-145b66e09b33.html; Margaret J. Krauss, NAT. PUBLIC RADIO, *Benefits in Jeopardy for Retired Coal Miners* (Feb. 25, 2017), http://www.npr.org/2017/02/25/517181428/benefits-in-jeopardy-for-retired-coal-miners.

[6] ASST. SEC. OF PLANNING & EVAL.U.S. DEPT. HEALTH & HUMAN SERVS., *Benefits of Medicaid Expansion for Behavioral Health*, 4 (Mar. 28, 2016).

[7] *Id.*

[8] PENN. DEP'T. HUMAN SERVS., *supra* note 1.

[9] *Id.* at 57.

[10] OHIO DEPT. OF MEDICAID, OHIO MEDICAID GROUP VIII ASSESSMENT: A REPORT TO THE OHIO GENERAL ASSEMBLY, 28, 35-37 (2016).

[11] $505 per month for a family of three was 31% FPL in 2013. KAISER FAM. FOUND., *Medicaid Income Eligibility Limits for Parents, 2002-2017*, (last visited May 17, 2017), kff.org/medicaid/state-indicator/medicaid-income-eligibility-limits-for-parents/.

[12] *Id*.

[13] U.S GOV'T ACCOUNTABILITY OFF., *Medicaid and CHIP: Given the Association between Parent and Child Insurance Status, New Expansions May Benefit Families*, (Feb. 2011).

[14] GEORGETOWN UNIVERSITY HEALTH POLICY INST. CTR. FOR CHILDREN & FAMILIES, *Medicaid Expansion: Good for Parents and Children*, (Jan. 2014), http://ccf.georgetown.edu/wp-content/uploads/2013/12/Expanding-Coverage-for-Parents-Helps-Children-2013.pdf.

[15] Karina Wagnerman, Alisa Chester and Joan Alker, GEORGETOWN UNIVERSITY HEALTH POL'Y INST.: CTR. FOR CHILDREN & FAMILIES, *Medicaid is a Smart Investment in Children*, 1 (March 2017).

[16] Abby Marquand, PARAPROFESSIONAL HEALTHCARE INSTITUTE, *Too Sick to Care: Direct-Care Workers, Medicaid Expansion, and the Coverage Gap*, 4 (July 2015), https://phinational.org/research-reports/too-sick-care-direct-care-workers-medicaid-expansion-and-coverage-gap.

[17] Abby Marquand, PARAPROFESSIONAL HEALTHCARE INSTITUTE, *Too Sick to Care: Direct-Care Workers, Medicaid Expansion, and the Coverage Gap*, 5 (July 2015), https://phinational.org/research-reports/too-sick-care-direct-care-workers-medicaid-expansion-and-coverage-gap.

[18] *Id.* at 8.

[19] Gregory ACS and Austin Nichols, URBAN INSTITUTE, *Low-Income Workers and Their Employers: Characteristics and Challenges*, 6 (2007), http://www.urban.org/sites/default/files/publication/46656/411532-Low-Income-Workers-and-Their-Employers.PDF.

[20] Based on nongovernmental employees with wages in the bottom quartile of all earners ($12/hr average). Bureau of Labor, at 7, (March 2016) https://www.bls.gov/news.release/pdf/ebs2.pdf.

[21] Rachel Garfield, Robin Rudowitz and Anthony Damico, KFF, *Understanding the Intersection of Medicaid and Work*,

[22] Id. at 2.

[23] *Id.* at 4.

[24] OHIO DEPT. OF MEDICAID, OHIO MEDICAID GROUP VIII ASSESSMENT: A REPORT TO THE OHIO GENERAL ASSEMBLY, 3 (2016).

[25] *Id.* at 31.

[26] *Id.* at 33.