

A Healthier Iowa Labor Market

Medicaid Expansions and the Impact On Incomes and Work Choices

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June 2009

The Iowa Policy Project

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Acknowledgements

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The Iowa Policy Project

Formed in 2001, the Iowa Policy Project is a nonpartisan, nonprofit organization based in Mount Vernon, with its principal office at 20 E. Market Street, Iowa City, IA 52245.

The Iowa Policy Project promotes public policy that fosters economic opportunity while safeguarding the health and well-being of Iowa's people and the environment. By providing a foundation of fact-based, objective research and engaging the public in an informed discussion of policy alternatives, IPP advances effective, accountable and fair government.

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By Beth Pearson, Lily French and Peter Fisher

Introduction

Access to quality, affordable health care is a necessity for all families, but the rising cost of health coverage makes meeting this basic need increasingly difficult. Low-income working families in particular struggle to afford health coverage. Many low-income workers work in jobs that do not offer employer-provided coverage, or where coverage is available some workers are increasingly unable to pay the employee share of premiums required by employer plans.

Recent efforts to expand access to health coverage have come at the state level, including programs in Maine, Massachusetts and Vermont that aim for or even mandate universal coverage for state residents. While varied in their approach, state reforms usually include a package of programs that provide different avenues to health coverage for different segments of the population. The goal of these reforms is to shore up the existing employer-based system of health insurance by helping employers obtain more affordable coverage and providing some level of means-tested premium assistance to individuals, while also expanding access to public health insurance for those who cannot access employer-based coverage.

This report focuses on the relationship between state investments in public health insurance programs and the labor market outcomes of low-income workers. In theory, access to health insurance improves labor market outcomes by positively impacting the health of workers and their dependents and allowing workers to be more productive and miss less work. Additionally, expansions of public health insurance programs that raise income eligibility limits would allow recipients to earn increased income from taking a higher-paying job or increasing hours worked. Often referred to as the Medicaid “notch,” the loss of health benefits due to increases in income that exceed eligibility thresholds can serve as a disincentive to increase earnings due to anticipation of losing valuable health insurance coverage.

Increasing access to health insurance might also reduce the uncompensated care costs incurred by hospitals, which must provide emergency care services to those in need, regardless of an ability to pay. When people are healthier, more productive, and earning more money, and when hospitals are losing less money in uncompensated costs, state personal income and economic output grows. Such growth leads to higher tax revenues collected by the state, which provides a return on investment in public health insurance programs.

Academic literature has investigated each of these relationships to varying degrees. Measuring the employment effects of public health insurance is a complex undertaking that will require further research and the development of new models that can use data on health insurance status, health status, changes in earnings and labor force participation, and policy expansions to better understand how the

labor market behavior of low-income adults is affected by health reform. Our analysis outlines the relationships that must be considered in this type of investigation and, to a limited extent, applies existing findings to estimate some effects of an expansion of Medicaid for uninsured adults in Iowa.

We find that an increase in income of between \$791 and \$1,050 a year for Medicaid recipients, as a result of raising income eligibility limits, could generate an aggregate \$71.9 million to \$95.4 million in additional income. Increased earnings generate additional tax revenue for state and local governments. If all workers receiving Medicaid benefits experienced a \$791 increase in their annual earnings, Iowa would receive an additional \$4.4 million in tax revenue. Additional tax revenue could be as high as \$5.8 million if those workers saw a \$1,050 increase in their annual incomes.

While the additional tax receipts generated by expanding Medicaid in Iowa amount to a small percentage of the total cost of such an expansion (estimated at between \$630 million and \$787 million), the positive return on a state investment in public health insurance nonetheless demonstrates that expansions in access to affordable health care produce more than just health benefits. Comprehensively measuring the costs of a status quo policy environment, in which low-income adults are particularly disadvantaged by gaps in health insurance coverage, means recognizing the multiple ways in which the current system distorts labor market incentives and strains government budgets. Iowa can work to extend important benefits to low-income workers by improving their access to Medicaid coverage through state reform initiatives and advocacy related to national health reform.

Working adults in Iowa make up bulk of uninsured

Most non-elderly Iowans are covered by employer-provided health insurance, either through their own job, the job of a spouse, or through a parent in the case of children. However, employer-provided health insurance coverage has decreased dramatically in Iowa during this decade as employers cease to offer health benefits or the costs of these benefits become unaffordable to workers. As employer-provided health coverage disappears, many Iowans have struggled to obtain other forms of coverage. The substantial cost of private, non-group insurance is out of reach for many families, and while public programs such as Medicaid and SCHIP (State Children’s Health Insurance Program) are meant to fill in gaps for low-income families who cannot afford coverage, eligibility restrictions result in many Iowa adults falling through the cracks and going without coverage.

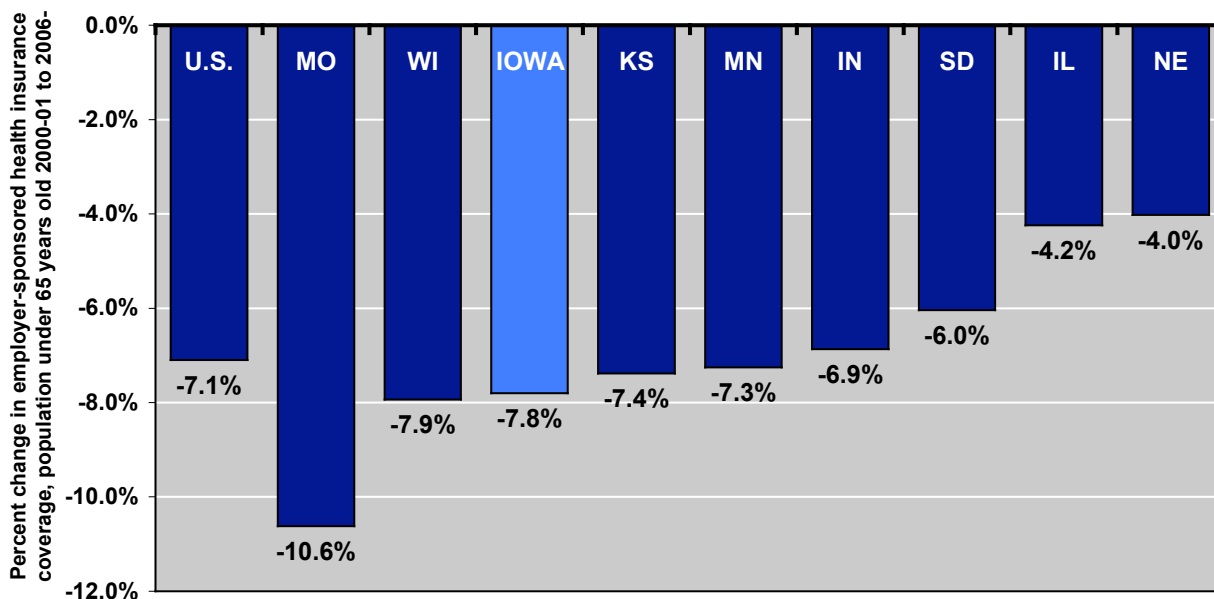
Table 1. Most Iowans Still Have Employer-Provided Insurance

	Source of Health Coverage					Total
	Employer	Individual	Medicaid	Other Public	Uninsured	
Iowa	67.9%	6.5%	13.1%	1.1%	11.4%	100%
U.S.	60.9%	5.5%	13.9%	2.5%	17.2%	100%

Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau’s March 2007 and 2008 Current Population Survey (CPS: Annual Social and Economic Supplements).

Iowa does well when compared to the nation in terms of the share of our population that has coverage; Iowa’s uninsurance rate is substantially lower than the national average, and Iowa also has a higher share of the population receiving employer-provided health coverage than the nation as a whole (Table 1). However, Iowa is also losing employer-provided health coverage at rate that exceeds the national average and is one of the highest in our nine-state region.¹ Figure 1 shows the percent decline in employer-provided coverage for the non-elderly population since the peak of the last business cycle, in 2000. By the end of this seven-year period, the share of the Iowa non-elderly population with employer-provided health coverage had decreased by almost 8 percent, compared to a 7.1 percent drop for the U.S. overall.

Figure 1. Iowa Loses Employer-Provided Health Care at Greater Rate than Nation, Much of Region



Source: Table 8 in Gould (2008), p. 16.

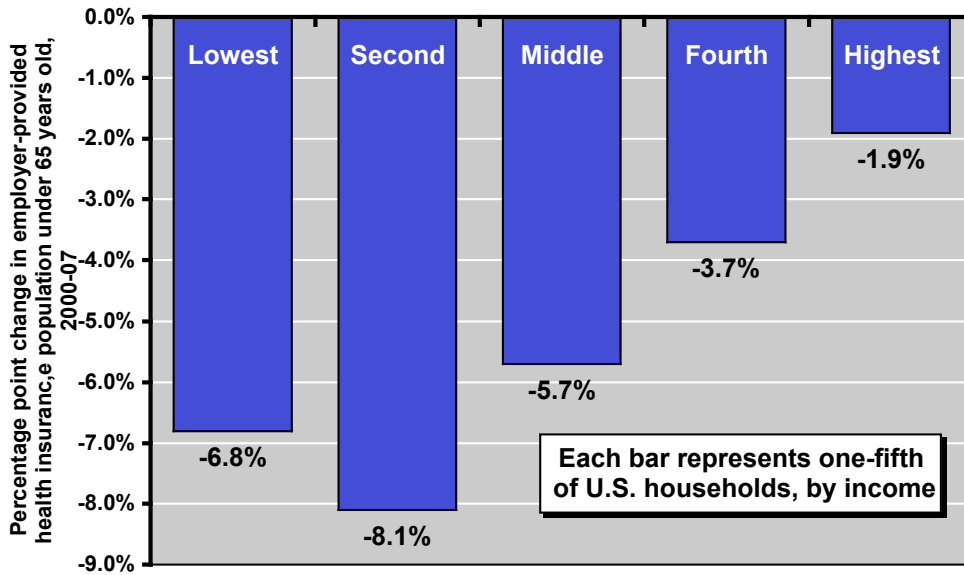
Across the country, the job growth between the 2001 recession and the beginning of the current recession in 2008 was not accompanied by a growth in employer-provided health coverage. Rather, this most recent business cycle was a period of dramatic loss for employer-provided health coverage. Data displayed in Table 2 and reported in the Iowa Policy Project’s *State of Working Iowa 2008* shows that all Iowa sectors (except education and health services) had lower rates of employer-provided health coverage in 2007 than in 1997.² In other words, although Iowa added 110,000 jobs to the economy over the past decade, it lost over 151,000 jobs with health coverage. Sectors such as manufacturing that had traditionally offered job-based benefits grew less quickly or shrank, while sectors such as leisure and hospitality that have low rates of employer-provided coverage grew more quickly.

Table 2. Iowa Grows Jobs But Loses Health Coverage, 1997-2007

	Jobs (thousands)		job-based health coverage		job growth, 97-07	covered job growth, 97-07
	1997	2007	1997	2007		
Total Nonfarm	1407	1517			110	-151.5
Leisure and Hospitality	121.5	136.8	64.7%	27.3%	15.3	-41.3
Manufacturing	239	229.5	82.7%	71.3%	-9.5	-34.0
Wholesale Trade	68.4	67.8	81.6%	49.4%	-0.6	-22.3
Retail Trade	182.1	178.8	59.7%	49.4%	-3.3	-20.4
Government	234.6	249.9	86.7%	74.2%	15.3	-18.0
Professional and Business Services	99.9	120.9	80.0%	54.6%	21	-13.9
Other Services	54.3	57.7	53.8%	35.6%	3.4	-8.7
Construction	60.1	72.5	60.4%	44.5%	12.4	-4.0
Transportation and Utilities	52.7	62.3	81.5%	62.9%	9.6	-3.8
Information	34.4	33.5	80.0%	71.1%	-0.9	-3.7
Financial Activities	81.4	102.7	85.2%	66.0%	21.3	-1.6
Natural Resources and Mining	2	2.1	80.9%	74.6%	0.1	-0.1
Education and Health Services	175.9	202.5	53.8%	56.7%	26.6	20.2

Source: Economic Policy Institute analysis of Current Employment Statistics survey data; HI coverage rates from Employee Benefit Research Institute

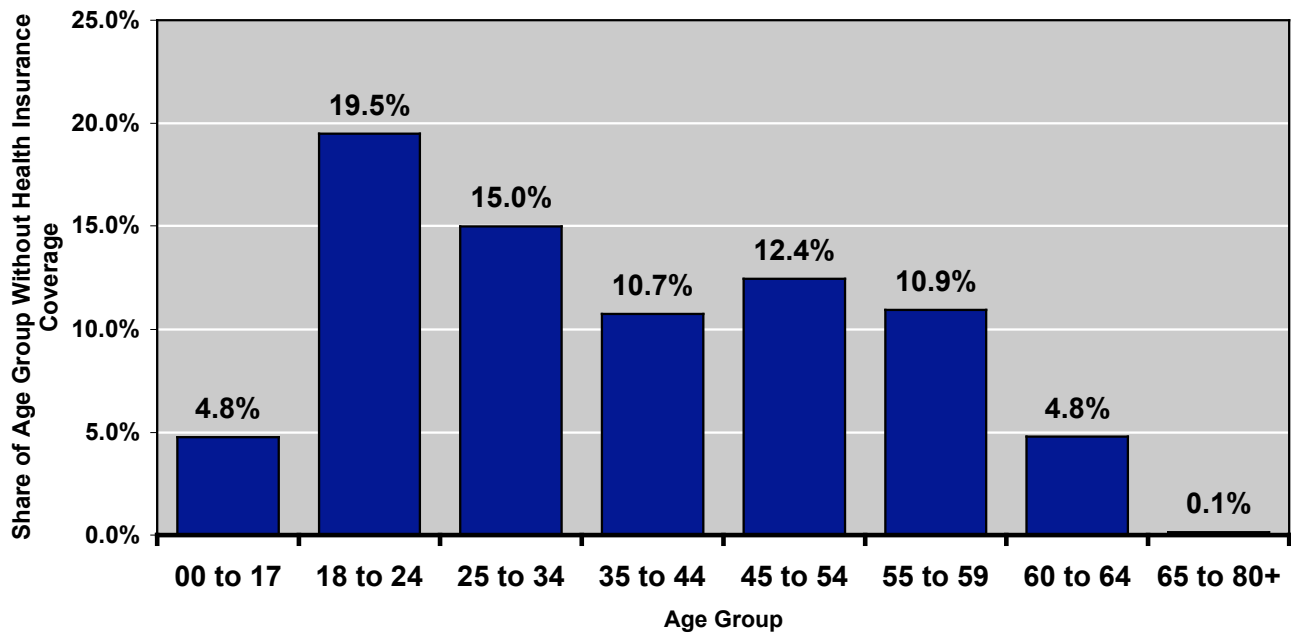
Figure 2. Low-Income Households See Greatest Decline in Employer-Provided Health Insurance, 2000-07



Source: EPI analysis of BLS (2008c) data in Gould (2009)

Nationwide, low-income, working adults have borne the brunt of this shift away from employer-provided health coverage (Figure 2).³ When employer-provided coverage evaporates, children can often be covered through public insurance (Medicaid and SCHIP). Likewise, the over-65 population receives health coverage through Medicare. As a result, children and the elderly have the lowest rates of uninsurance in Iowa (Figure 3).

Figure 3. Adults between 18 and 60 Most Likely to Be Uninsured in Iowa



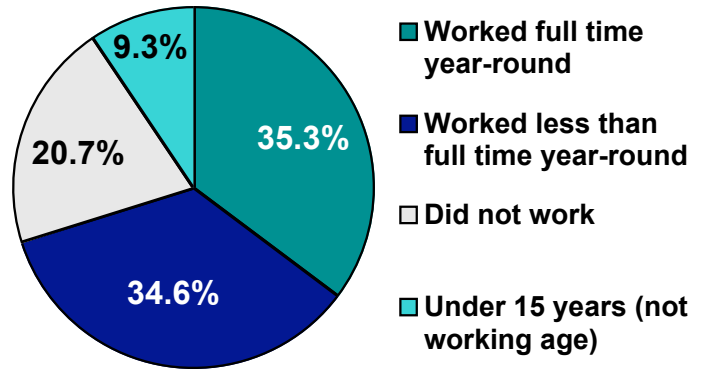
Source: Current Population Survey, Annual Social and Economic Supplement (2008)

The bulk of uninsured Iowans are adults between 18 and 60, the majority of whom are working. In 2007, 35 percent of the uninsured were full-time, year-round workers, while another 35 percent worked part time or for part of the year (Figure 4). Only about one in five of the uninsured did not work during 2007. Finally, low-income individuals in Iowa are more likely to be uninsured than individuals with higher incomes. About half of the uninsured in Iowa have incomes below 200 percent of poverty, or \$21,660

for an individual and \$36,620 for a family of three.⁴ Almost one-third of uninsured Iowans earn more than 300 percent of poverty, which is \$32,490 for an individual and \$54,930 for a family of three.

Many low-income, working adults earn above the threshold level to qualify for most forms of public support, but often struggle to afford health insurance on the private market when it is not provided by an employer. Recent research from the Urban Institute notes that, absent national health reform that can address growing gaps in coverage for significant segments of the U.S. population, parents and non-custodial adults stand to experience the most substantial changes in coverage as they continue to lose employer-provided insurance and remain ineligible for Medicaid (discussed in greater detail below).⁵ It is clear that this group is falling through the cracks of our existing public health insurance system, especially as employer-provided health insurance continues to deteriorate as an affordable benefit.

Figure 4. Working Iowans Are 70 Percent of the Uninsured



Source: Current Population Survey, Annual Social and Economic Supplement (2008)

Medicaid in Iowa doesn't meet the needs of low-income, working adults

Low-income, working adults in Iowa who have lost their employer-provided coverage or who cannot afford health coverage are frequently ineligible for Medicaid because of its categorical and income eligibility restrictions. Medicaid was created by the federal government in 1965 to provide public health insurance services to low-income people who could not afford to purchase private insurance or who could not work to obtain employer-provided insurance. Medicaid works as a partnership between federal and state governments. In order to receive federal matching funds for Medicaid, states must meet federal guidelines in providing Medicaid services to particular low-income populations.

Importantly, it is not enough for someone to simply be low-income to qualify for Medicaid; recipients must also fit into one of the eligibility groups that the federal government calls “categorically needy.” When Medicaid was created, these low-income groups were identified as the aged, the disabled and families with dependent children. Eligibility for this third group — families with dependent children — was linked to participation in the Aid to Families with Dependent Children (AFDC) program, which provided cash assistance to low-income families.

Beginning in the mid- to late-1980s, Congress approved several expansions of Medicaid that let states establish more generous eligibility guidelines, so that families with dependent children but not eligible for AFDC could receive Medicaid benefits. These new guidelines quickly became mandatory for states receiving federal matching funds for Medicaid. The link between AFDC eligibility and Medicaid services was severed in 1996 with passage of federal welfare reform legislation. States still had to cover anyone at previous AFDC eligibility definitions, but higher eligibility thresholds were possible.

In 1997, Congress again expanded Medicaid eligibility by establishing the State Children's Health Insurance Program (SCHIP), which is designed to provide Medicaid services to children in low-income families whose income exceeds previous Medicaid eligibility thresholds. States that implement an

SCHIP program (which is not mandatory) can either expand their existing Medicaid programs or create a separate children’s health insurance program that provides similar services. As a result, Medicaid now requires states to provide public health insurance services to certain groups and also allows states the option of providing services to certain additional groups with matching federal funds.

Additionally, the Medicaid program allows states to apply for “waivers” to these guidelines so that they can, on an individual basis, provide Medicaid services to additional groups. States have used these waivers to provide coverage above existing income thresholds to parents, pregnant women and adults without children. They have also used them to provide some form of premium assistance whereby families or individuals purchase private insurance but Medicaid funds are used to subsidize the costs of that insurance. States may choose to provide Medicaid services to other groups that they identify as medically needy, but they will not receive federal matching Medicaid funds for these services.

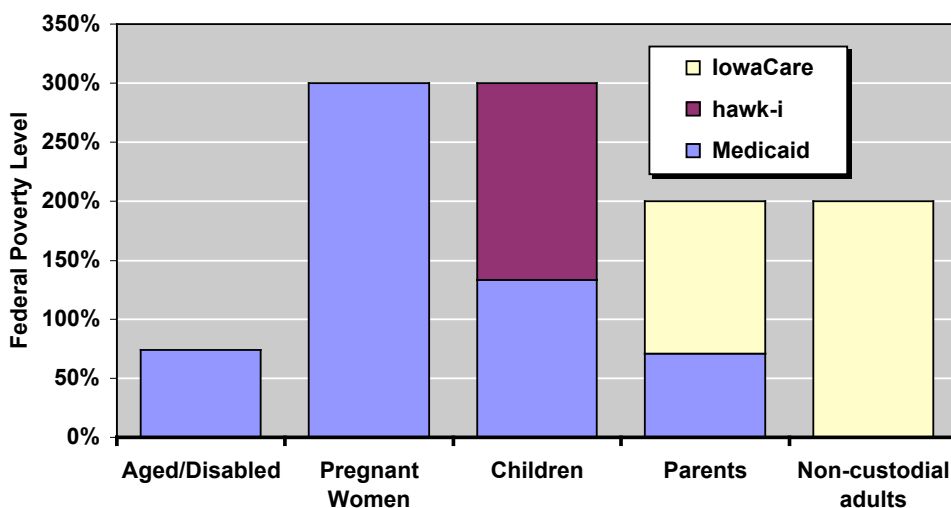
The categorical nature of Medicaid eligibility means that certain groups have less access to public health insurance than others. This is particularly true for adults in general and non-custodial adults (single adults and childless couples) specifically. While Medicaid eligibility has been expanded dramatically to cover more and more children, adult coverage has lagged. Figure 5, below, shows eligibility thresholds for different groups of potential Medicaid recipients in Iowa.⁶ Iowa’s Medicaid program covers pregnant women up to 300 percent of the FPL (as of July 1, 2009), and covers children up to 133 percent of the FPL. Children are covered by Iowa’s SCHIP program (called *hawk-i*, for Healthy and Well Kids in Iowa) if their family income falls between 133 percent and 300 percent of the FPL. Supplemental Security Income (SSI) recipients (aged, blind or disabled persons with little income who receive federal cash assistance to help meet basic needs) with incomes below 74 percent of the FPL receive Medicaid services per federal requirements.

Parents with dependent children and incomes below 71 percent of the FPL are covered by Medicaid, but non-custodial adults are not eligible for Medicaid in Iowa unless they are SSI recipients. Iowa does provide some health coverage services to non-custodial adults and parents of children in the *hawk-i* program through a Medicaid waiver program called IowaCare. Established in 2005, IowaCare provides a limited benefits package and, depending on eligibility, also requires some level of cost-sharing by participants.

A major drawback of the IowaCare program is the limited provider pool, which includes only Broadlawns Medical Center in Des Moines, the University of Iowa Hospitals and Clinics in Iowa City, and the state’s four mental health institutes.

During the 2008 legislative session, the Iowa Legislature acknowledged the need for state health reform

Figure 5. Current Eligibility for Medicaid Programs in Iowa



Source: The Lewin Group (2008)

efforts targeted to working adults with approval of House File (HF) 2539. Among other provisions, this bill called for a comprehensive plan to provide access to affordable insurance for all children and adults

in Iowa, whether through Medicaid or *hawk-i* or through private insurance plans. Legislation passed in 2009 increased income eligibility limits for children and pregnant women. It also directed a new commission to develop a health care reform strategic plan with options for access to affordable coverage for uninsured adults.⁷ The commission will deliver its final report to the Legislature in January 2011.

Increasing access to affordable health coverage for uninsured adults is essential to improving the economic security of low-income families in Iowa, particularly as job-based coverage accelerates its decline. One way of increasing access to health care and improving economic security is expanding Iowa’s Medicaid program to cover adults below 150 percent of the federal poverty level. Making these investments in comprehensive health reform will induce changes in the labor market. The following section examines existing research on possible labor market effects as a way of estimating the state’s return on investment from expanding Medicaid.

Health coverage and labor market outcomes

This section of the analysis examines existing literature on how state investments in public health insurance could positively affect the labor market outcomes of low-income workers. It focuses in particular on two issues. First, if state public health investments increased the number of low-income Iowans with health coverage, they could lead to better health outcomes and associated increases in worker productivity. Second, if access to public health insurance was expanded by increasing income eligibility thresholds, a state investment might also produce returns by encouraging increased earnings by current Medicaid recipients. In addition to these labor market effects, increased access to health coverage might reduce public costs associated with poor health and uncompensated care.

Health coverage, health and earnings

The idea that uninsurance carries societal costs is largely uncontroversial. It is more difficult, however, to quantify those costs and then go a step further to estimate the savings or return that might result from investing in access to insurance. A 2003 analysis by the Institute of Medicine Committee on the Consequences of Uninsurance concludes that 40 million uninsured Americans experience a loss of \$65-\$130 billion a year in the value of forgone health.⁸ The authors emphasize that even this figure does not include spillover costs associated with the poorer health and shorter lives of the uninsured, which can include costs related to diminished workforce productivity and forgone public revenues and which are even more difficult to measure (see Table 3).

Table 3. Types of Cost Related to Uninsurance

Internal or private costs (for individuals, families and firms)	External or spillover costs
Greater morbidity and premature mortality Developmental losses for children Family financial uncertainty and stress, depletion of assets (resource and transfer costs) Lost income of uninsured breadwinner in ill health Workplace productivity losses (absenteeism, reduced efficiency on the job) Diminished sense of social equality and self-respect	Diminished quality and availability of personal health services Diminished public health system capacity Diminished population health (such as higher rates of vaccine-preventable disease) Higher taxes, budget cuts, loss of other uses for public revenues diverted to uncompensated care (primarily transfer costs, except administrative costs) Higher public program costs connected with worse health (Medicare, disability payments)(primarily transfer costs) Diminished workforce productivity Diminished social capital; unfulfilled social norms of caring, equal opportunity, and mutual respect

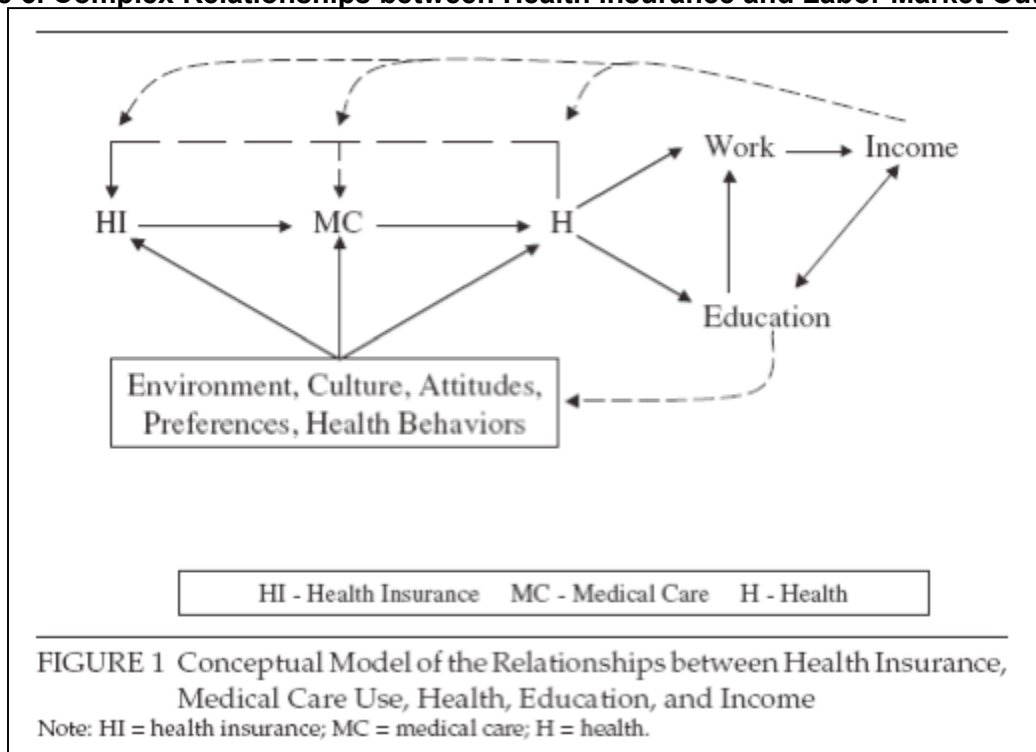
Source: Miller, Vigdor, and Manning (2004); adapted from Institute of Medicine Committee on the Consequences of Uninsurance, Hidden Costs, Value Lost: Uninsurance in America (Washington, National Academics Press, 2003), 31, Figure 2.2.

Access to health insurance could improve health outcomes and therefore positively affect productivity and income, meaning that people with health insurance might work and earn more because they are healthier. In a widely cited piece titled *Sicker and Poorer — The Consequences of Being Uninsured*, Jack Hadley of the Urban Institute compiles a comprehensive analysis of research on the relationship among health coverage, health, and associated effects on income and earnings.⁹ Hadley opens his discussion of evidence on the links between health coverage and health and labor market outcomes by noting the potential for this relationship to impact state revenues and spending:

Presumably, people value improved health, longer life and a reduction in pain and discomfort, as a good in and of itself. From a more pragmatic perspective, good health is an important element of human capital, leading to improved educational attainment, improved productivity, and greater labor force participation. As such, improved health can potentially increase incomes, increase tax revenues, and reduce government spending for disability and other health-related transfer programs.¹⁰

Hadley offers a conceptual model for understanding the relationships among health insurance, medical care, health and labor market outcomes (see Figure 6), while acknowledging that investigating these relationships is difficult. Health insurance, health and labor market outcomes are all factors that influence each other in multiple ways, making it difficult to isolate causality and determine the independent effect of health insurance. For instance, while health insurance can lead to better health through increased use of medical care, it is also the case that poor health and higher need for medical care can mean that individuals place a higher value on securing health insurance than those already in good health. Similarly, the American system of job-based health coverage means that access to health care is often determined by employment and income, rather than health care and better health creating the context for possible employment and earnings. These multidirectional relationships complicate the task of drawing conclusions about how health insurance itself affects health, employment or income.

Figure 6. Complex Relationships between Health Insurance and Labor Market Outcomes



Source: Hadley (2003), p. 7S

Despite these difficulties, Hadley's review of existing research, covering 54 separate studies, concludes there are identifiable positive relationships between health insurance and health outcomes, as well as health and labor market outcomes. Whether studies examine the relationship between insurance coverage and outcomes of specific diseases (for instance, hypertension and heart attacks, cancer or pneumonia) or between insurance coverage and general mortality rates, results indicate that insurance coverage has a significant positive effect on health outcomes. For instance, a 2000 study of heart attack patients found that uninsured patients had significantly higher in-hospital mortality rates than patients who were privately insured.¹¹ Another study, in 1993, examined differences between uninsured and insured women with breast cancer and found that uninsured women were significantly more likely to be diagnosed at a later stage of the disease and to have higher mortality rates than insured women.¹²

Collating the results of all studies that looked at the relationship between insurance and disease-specific mortality, Hadley concludes that, "for people with particular illnesses or conditions, the mortality rate for the uninsured was 37 percent higher than for the insured."¹³ The relationship between insurance and general mortality is less dramatic, but still significant; Hadley's review of the evidence that insurance reduces general mortality anywhere from 4-5 percent to 20 percent for the adult population.¹⁴

Hadley also investigates the associated relationship between improved health outcomes and increased income. Health might affect labor force participation (whether someone works at all as well as how much he or she works) or productivity (how much that work is worth, measured in wage rates). Ample evidence does in fact exist to suggest that poor health reduces earnings, as well as to suggest that people in good health have higher earnings than people in poor health. For instance, Hadley cites a 1993 study examining the link between alcoholism and income that finds people in good physical health have annual earnings that are almost 40 percent higher than people with health problems.¹⁵ In another study, Fronstin and Holtmann find that annual average earnings increase as a result of employment-based health insurance.¹⁶ Depending on firm size, men gain between \$97 and \$381 a year, and women gain between \$47 and \$469 a year. Hadley concludes his review of this research by estimating that poorer health status "is associated with a 15 percent to 20 percent reduction in annual earnings."¹⁷

Since Hadley's work was published in 2003, a growing body of occupational health literature has continued attempts to measure the impacts and cost of health on productivity within an evolving methodological framework.¹⁸ For instance, in a review of research concerning the relationship between health and labor market outcomes, O'Brien examines many of the same studies included in Hadley's review from the perspective of a business case for health insurance.¹⁹ She cites a number of studies drawing links between health status and worker absenteeism, as well as health status and workplace productivity and agrees that existing literature supports the conclusion that access to health insurance leads to improved health, which can positively affect income.* More recently, using data from the Commonwealth Fund Biennial Health Insurance Survey, Davis et al. find that the economic cost of labor time lost to health problems amounts to \$260 billion per year.²⁰ Included in this estimate is the value of lost days of work associated with workers taking sick days, being less productive on the job, or not working due to health reasons.

Some literature is also beginning to emerge on the links between health and labor market effects in the context of state health reform efforts of the past several years. For instance, Dube applies literature on the "job lock" hypothesis, which holds that workers may forgo seeking better employment out of the fear that they will lose employment-based health insurance by leaving their current job, in the context of

* Some research has also indicated that provision of health insurance can cause a substitution between absenteeism due to illness and absenteeism due to medical care visits since insured workers can access the health system for regular checkups and visits to the doctor when they are ill, which is not possible without insurance. See Thomas Buchmueller, *The Business Case for Employer-Provided Health Benefits: A Review of the Relevant Literature* (California HealthCare Foundation, 2000).

evaluating health reform proposals in California.²¹ Dube notes that, while the literature on job lock is extensive and generally concludes that it reduces mobility between 20 percent and 40 percent, academic research is scarce on how job lock translates into productivity loss. Dube's analysis of March CPS data from 1998 to 2002 finds that insurance coverage increases the probability that a person stays or becomes healthy from one year to the next. He further concludes that changes in health status from one year to the next affect labor force participation; a transition from "not healthy" to "healthy" is associated with a 5.6 percentage point increase in the labor force participation rate. Applying this analysis to California, Dube estimates that 179,000 workers are not switching jobs because of job lock. By analyzing changes in wages among workers who do switch jobs, Dube finds that a voluntary job change is associated with a 9 percent increase in income and, as a result, that job lock related to inconsistent access to employer-provided health insurance is costing California \$773 million annually.

Decades of research therefore demonstrate strong evidence both for health insurance improving health status, and for health and health insurance status affecting labor market outcomes, including earnings. However, the extent to which these relationships between insurance, health status and income hold true for low-income recipients of Medicaid is less clear, making it difficult to assume that expansions of public health insurance would produce returns to state investment through increased earnings.

Complications with Medicaid

In many studies, evidence that health coverage improves health outcomes is weaker for Medicaid coverage than for private coverage. For instance, the same 1993 study that found uninsured women were more likely than insured women to have late diagnoses and high mortality rates from breast cancer also found that women on Medicaid had outcomes more similar to those of uninsured women than those of privately insured women. Hadley explains that there are several factors that could be producing these effects. For one thing, health insurance alone may not be sufficient to overcome the health effects of the socio-economic deficits of many Medicaid recipients. In addition, poor health itself may be one reason that an individual is receiving Medicaid, whether because they meet state definitions of "medically needy" or have been unable to work and earn an income because of health problems.

Finally, Hadley points out that many people enrolled in Medicaid may have become enrolled at their time of contact with medical care since providers have an incentive to enroll eligible uninsured patients in Medicaid to receive some reimbursement for medical services. Although an individual shows up in surveys and administrative records as receiving Medicaid coverage, this may not reflect continuous access to medical care or health coverage and, in fact, the individual shares more characteristics with the uninsured population than with the privately insured.

Hadley contends the findings related to the effect of Medicaid on health do not contradict conclusions that uninsured individuals have worse health outcomes than privately insured individuals.²² Indeed, evidence of the positive health effects of health insurance is strong; however, Medicaid cannot be assumed to mirror private health insurance in terms of producing these positive health outcomes. Health is a function of various factors, including income, educational attainment and living situation, as well as one's insurance status. Work support programs that address only health coverage are more likely to produce positive health outcomes when programs also exist to support the other factors contributing to health status.

Eligibility thresholds and labor market incentives

Although research is less convincing that incomes may increase for Medicaid recipients as a result of greater access to public health insurance leading to improved health outcomes, another body of academic literature has examined whether incomes might increase as a result of changing Medicaid

eligibility thresholds. Means-tested public health insurance programs target medical assistance to low-income populations, but their structure sets up a disincentive to increase earnings by removing health benefits if incomes exceed the eligibility threshold.

If increased earnings guaranteed a family would be able to take up private insurance, their loss of Medicaid benefits would be negligible. However, low-wage jobs that may render an adult ineligible for Medicaid may not provide health insurance or even an income sufficient to purchase insurance on the private market. In addition, rising health care costs and the decline of job-based coverage over the past decade have reduced access to affordable private insurance for families transitioning off work support programs.

As discussed above, employer-provided health insurance in Iowa has declined over the past decade, and national data shows that the largest declines in coverage have occurred for low-income workers (see Figure 2). Boushey's research on single mothers leaving Medicaid shows, for instance, that while these women find employment, few of them move into jobs with employer-provided health insurance.²³ Boushey finds that about 28 percent of women leaving Medicaid between 1997 and 1998 obtained job-based coverage, but this share declined to about 23 percent during the period between 2002 and 2003. As a result, it can be more cost-effective for a family to maintain a level of income that allows them to continue to access Medicaid coverage, rather than increase their hours worked or pursue a job with a higher wage rate and lose their health insurance.

Researchers have therefore hypothesized that expanding Medicaid by raising eligibility thresholds might induce increases in income by allowing recipients to earn more without fear of losing their Medicaid coverage. As with the relationship between health insurance, health status, and income, the relationship between Medicaid expansions and labor market decisions is difficult to measure. Individuals may value Medicaid benefits differently, depending on their individual health situation, and their labor market decisions take into account economic conditions as well as a whole host of state-specific eligibility rules. These complications are significant and have contributed to a lack of consensus around whether and how Medicaid expansions affect labor market decisions.

In a 2002 review of existing research that examined 16 studies, Gruber and Madrian discuss the variety of methodologies that have been employed to try to understand the relationship between Medicaid and labor market participation.²⁴ Early studies took place in the context of the AFDC program, which placed less emphasis on transitioning to work than did the post-reform TANF program. In this policy environment, some researchers tried to use expected medical expenditures as a way of measuring the level of demand for health insurance coverage and determining how that demand affected labor market decisions.

For instance, Moffitt and Wolfe find a significant and negative relationship between Medicaid benefits and the likelihood of employment, meaning that Medicaid recipients who assign a high value to their medical benefits are less likely to work.²⁵ However, they also note that only a minority of households — those with high expected medical expenditures — alter their AFDC participation or employment decisions in response to Medicaid availability or levels. Moffitt and Wolfe estimate a guarantee of Medicaid-equivalent private insurance coverage for all female workers would increase the probability of employment for this group by 32 percent. While stressing the difficulty of determining exit rates from welfare if people faced no worries about medical expenses, Ellwood and Adams likewise posit that such exit rates would increase by 10 percent to 20 percent with the provision of employment-based insurance equivalent to Medicaid.²⁶ The exit rate for those leaving welfare due to increased earnings could be even higher.

Other studies attempted to determine whether the generosity of different state Medicaid programs — measured in terms of per capita Medicaid spending — affects labor market participation. Using data from the early and mid-1980s, these studies found weak or insignificant links between Medicaid participation and AFDC or labor market participation. For instance, Blank concludes that the value of Medicaid coverage does not appear to add significantly to the value of AFDC participation.²⁷ Blank also finds no relationship between Medicaid benefits and number of hours worked. Winkler describes a small but significant negative relationship between Medicaid’s market value and the probability that a female head of household would be employed.²⁸ In other words, as the value of Medicaid increases, the likelihood that a recipient will be employed decreases.

Gruber and Madrian explain that more recent research on the effect of Medicaid benefits on the labor market has examined the various expansions of the Medicaid program that took place starting in the late 1980s. Because these expansions weakened and then severed the link between AFDC and Medicaid, they allow researchers to determine whether low-income Medicaid recipients will seek work when their health coverage is no longer threatened by an increased income. This research produced mixed results. The most widely-cited use of this approach is Yelowitz’s research, which finds that a 26.8 percent increase in Medicaid eligibility due to program expansions reduced AFDC participation by 6.3 percent, increased labor force participation by 1.58 percentage points, and increased hours worked per week by 1.5 percent.²⁹ Increases in eligibility also reduced by 1.8 percent the amount of a family’s income coming from public assistance.

Although Yelowitz’s analysis supports the hypothesis that expansions of Medicaid can incentivize work, the effects are relatively small. In addition, Yelowitz’s conclusions have been critiqued by other researchers, including Ham and Shore-Sheppard, who replicate Yelowitz’s use of CPS data after correcting for what they contend are miscalculations in his assumptions and find that there is no evidence for expansions of Medicaid eligibility resulting in decreased welfare participation or increased labor force participation.³⁰

Ultimately, Gruber and Madrian’s review concludes that the availability of Medicaid has “either no or a very small effect on the labor force participation of low-income single mothers.”³¹ However, they acknowledge that this conclusion is somewhat surprising and call for ongoing research investigating the relationship between Medicaid and labor supply. Subsequent research has continued to return mixed results. For instance, Tomohara and Lee find that Medicaid expansions have no effect on women’s labor supply after controlling for the effect of other changes in welfare policy between 1996 and 2000.³² Conversely, Wolfe et al. examines the effect of public health insurance expansions on women’s employment in Wisconsin, and their analysis (discussed in greater detail below) finds that the introduction of expanded Medicaid-equivalent health coverage for single mothers increased employment and earnings.³³

Meara et al. use 2005 CPS data to model how three different policy options for health care reform (refundable tax credits, Medicaid expansions, and employer mandates) would affect coverage and labor market outcomes for low-income workers.³⁴ Rather than focusing on the “Medicaid notch” effect, they rely on economic theory on the relationship between health benefits and wages, which holds that employers will pass on the entire cost of mandated benefits in the form of lower wages. Medicaid expansions could increase wages by removing the employer cost of providing health insurance to low-income workers. Meara et al. estimate a \$6.9 billion increase in annual wages would result from expanding Medicaid eligibility to 300 percent of the federal poverty level. They also refer to research by Baicker and Chandra that concludes employment and hours worked fall as insurance premiums rise and employers must lower wage costs.³⁵ However, Meara et al. caution that it may not be possible to assume

an opposite, symmetrical effect by which employment and hours worked rise as employer insurance premium costs fall under Medicaid expansions.

These recent results do not settle the debate over whether — and to what extent — the increased availability of Medicaid benefits positively affects the labor market participation of low-income individuals. Rather, they point to the need for ongoing evaluations and research of the labor market effects of attempts to increase access to public medical insurance, particularly related to recent state reform plans that have expanded insurance coverage to low-income working families. Perhaps most importantly, the entire body of research on the relationship between Medicaid and labor supply helps emphasize the fact that changes to Medicaid alone will not fundamentally alter the barriers to labor market participation faced by low-income individuals. The potential loss of health insurance benefits is one disincentive for low-income workers to increase their income or their hours worked, but other factors also have a powerful influence on this decision. Lack of access to affordable and quality child care, low levels of education and training, inadequate transportation options, and multiple other factors affect the labor market participation of low-income individuals.

Estimating the Results of Medicaid Expansions in Iowa

This review of academic literature on the relationship between health insurance, health, employment and earnings indicates that several different labor market outcomes for adults could result from expanding Iowa’s income eligibility limits for Medicaid to 150 percent of the federal poverty level. Table 4 lists and categorizes these potential labor market outcomes and their consequences for a state return on investment in public health insurance.

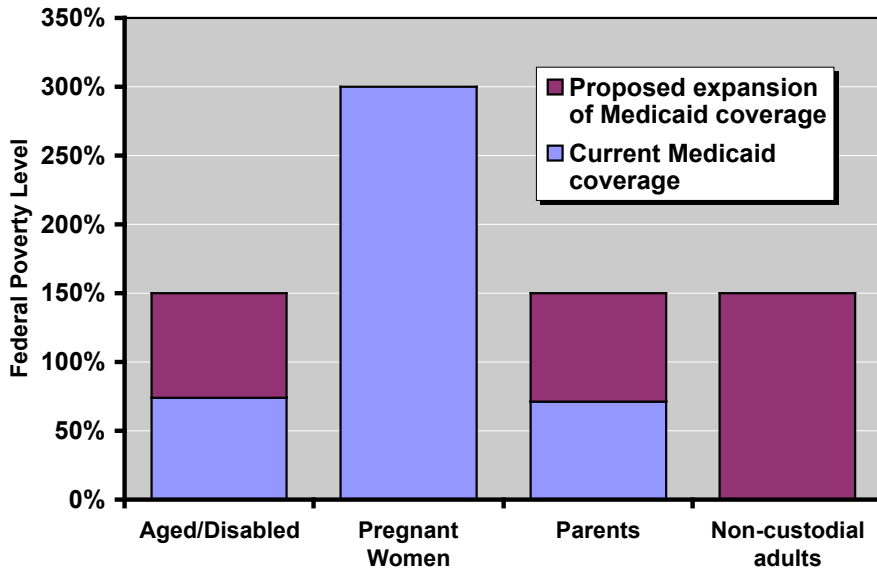
Table 4. Potential Labor Market Effects of Expanded Eligibility for Medicaid in Iowa

Category	Current insurance status	Currently employed?	Labor market effect of eligibility expansion	State return
1	Medicaid	Yes	Able to earn more without losing benefits	Positive
2	Medicaid	No	Able to take a job and earn without losing benefits	Positive
3	Uninsured	Yes	Access to Medicaid results in better health, which leads to increased productivity and earnings	Positive
4	Uninsured	No	Access to Medicaid results in better health and ability to take a job	Positive
5	Employer-provided	Yes	Able to switch to a higher-paying job without fear of losing health coverage	Positive
6	Employer-provided or private	Yes	Able to reduce earnings by switching to a lower-paying job, working fewer hours, or ceasing employment without fear of losing health coverage	Negative

We do not attempt to model the effects of all these scenarios in this analysis. Rather, we focus on the case of adults who may be constrained by the cliff effects inherent to the current structure of Medicaid eligibility, in which increased income above 71 percent or 74 percent of the federal poverty level eliminates eligibility for health benefits. Under the current system, adults in category 1, category 2, and category 5 (from Table 4) are constrained from entering the workforce, earning more or taking a better-paying job out of fear that doing so will result in the loss of their health insurance coverage. We focus only on those adults who fall into category 1.

Figure 7 shows how expanding income eligibility would increase access to Medicaid, either by raising income eligibility levels for those categories of adults currently eligible for Medicaid (aged and disabled adults currently receiving SSI benefits and parents) or by making access newly available (for non-custodial adults not receiving SSI benefits).

Figure 7. Expanding Medicaid for Adults in Iowa



Source: Lewin Group, *Cost and Coverage Impacts of Options for Expanding Health Insurance Coverage in Iowa, August 2008*

The bulk of new enrollees in an expanded Medicaid program would be non-custodial adults. According to Lewin Group analyses of various policy scenarios for implementing this expansion, between 76 percent and 81 percent of new enrollees would be non-custodial adults while the remainder would be parents.³⁶ The Lewin Group estimates that between 149,000 and 253,000 Iowa adults would be enrolled in expanded Medicaid coverage.

Raising the Medicaid income eligibility threshold to 150 percent of the federal poverty level theoretically means that

some adults who currently have access to employer-provided health insurance may choose to drop that coverage and take up Medicaid. This substitution of public insurance for private coverage can be minimized through features of policy design — for instance, requiring a waiting period before taking up public health insurance — and by making use of innovative programs such as Iowa’s Health Insurance Premium Payment (HIPP) program. The HIPP program pays for the cost of employer-provided health insurance premiums, copayments and deductibles when it would be more cost-effective than replacing private coverage with Medicaid.³⁷ If a low-wage worker has access to an employer-sponsored health plan but cannot afford to take up the coverage, the HIPP program can save the state money while providing equivalent or better health coverage than is available through Medicaid.

Increasing incomes

In order to estimate how the incomes of adults would change as a result of Medicaid expansions, we only want to examine a subset of total Medicaid recipients — those currently receiving Medicaid who would now have an incentive to increase their incomes or take a job because they no longer fear a loss of benefits. In developing this estimate, we rely on Wolfe et al.’s evaluation of how a similar expansion of Medicaid eligibility affected labor market outcomes in Wisconsin. Wolfe et al.’s research studies the effects of the introduction of a public health insurance program called BadgerCare on the employment and earnings of low-income working mothers who are welfare leavers. BadgerCare, which began to operate in July 1999, provides Medicaid-equivalent health care coverage for children and adults with incomes below 185 percent of the poverty line (200 percent for those already enrolled in Medicaid at the time of introduction).[†] The introduction of BadgerCare substantially increased the population eligible for

[†] Although BadgerCare has now been extended to childless adults, Wolfe et al.’s research evaluates the program when eligibility was restricted to parents of minor children.

public health insurance in Wisconsin; the Wisconsin Works (W-2) program that had replaced AFDC in 1997 provided coverage only for parents and children below 115 percent of poverty.

The lack of a standard methodology — let alone a common result — in the academic studies discussed above makes it impossible to simply apply an accepted model to simulate the results of a Medicaid expansion in Iowa. Unlike many of the existing studies on this topic, Wolfe et al.'s sample is composed of women leaving welfare programs after federal reform had taken place; therefore, their results are not complicated by the link between AFDC and Medicaid that existed in some form prior to 1996. In addition, the analysis is restricted to analyzing the results of one state reform. Although this shrinks the sample size for the analysis, it does not have to be adjusted for the variations among states in Medicaid policy that have plagued previous studies. Ultimately, even if using Wolfe et al.'s analysis as a framework for our own calculations does not amount to the final word on the effects of Medicaid expansion in Iowa, it can provide us with an idea of the kind of return that the state could generate from expanding access to public insurance for adult workers.

Wolfe et al. hypothesize that BadgerCare will positively affect earnings and employment for low-income working mothers for two reasons. First, women who were employed but earning below the Medicaid eligibility level no longer had to fear the loss of health insurance because of increased work or earnings. Additionally, women earning above the Medicaid income eligibility limit who are newly eligible for BadgerCare can seek employment without the constraint of needing to find an employer offering health benefits, which could lead to higher employment and earnings.

Wolfe et al.'s sample is composed of women who were receiving assistance under the AFDC-Regular or W-2 programs in September of 1995, 1997 and 1999. The authors note that they expect women receiving benefits in 1997 and 1999 to have greater barriers to independence than those in 1995, due to earlier reforms and reductions in case load. In this analysis, we use figures from the 1997 cohort in order to produce conservative estimates. Wolfe et al. find that the introduction of BadgerCare increases the quarterly earnings of the 1997 cohort by \$153, from \$2,200 to \$2,353. This 7 percent increase translates to an annual increase in earnings of \$612.

In order to apply this figure to an analysis of labor market outcomes and return to state investment in Iowa, we must first estimate how many working-age Medicaid recipients could be expected to earn more as a result of expanding Medicaid in Iowa. We are focusing on adults who, in the status quo, have the incentive to keep their earnings below Medicaid income eligibility thresholds in order to maintain public health insurance coverage. Wolfe et al.'s sample only included women who were working, with the justification that non-working welfare leavers face more fundamental barriers to employment than the lack of health insurance. Thus, our analysis of income increases as a result of Medicaid expansion only includes working Medicaid recipients.

Although this model can help estimate the labor market effects of a Medicaid expansion, it does have important limitations. Our calculations do not account for individuals currently earning just above 150 percent of poverty who may now have an incentive to reduce their income in order to qualify for Medicaid. In addition, while Wolfe et al.'s study analyzed the effect of raising the income eligibility threshold from 115 percent of the federal poverty level to 185 percent, we are studying the effects of moving the threshold from 71 percent to 150 percent. We assume for the purposes of this analysis that the effects would be similar, which may not be the case.

According to CPS data, 90,888 working Iowans received Medicaid benefits during 2007.[‡] There are two potential ways of using Wolfe et al.'s data to estimate an aggregate increase in income for Medicaid

[‡] Discrepancies between administrative records and CPS data on the number of Medicaid recipients per state have led to a widespread consensus among researchers that the CPS undercounts the number of Medicaid recipients. Because we do not

recipients as a result of expanded eligibility. Adjusted for inflation, the yearly effect of BadgerCare’s introduction is a \$791 increase in income (2007 dollars), so we can apply that dollar amount to the number of working Medicaid recipients in Iowa. Or, we can calculate a 7 percent increase in the median income of working Medicaid recipients and use that income figure. CPS data indicates that the median income of this population is approximately \$15,000, meaning that a 7 percent increase would be equivalent to about \$1,050.

Table 5 shows that an increase in income of between \$791 and \$1,050 a year for Medicaid recipients in Iowa who are currently working could generate an aggregate \$71.9 million to \$95.4 million in additional annual income.

Table 5. Expansion of Medicaid Could Generate \$72 Million to \$95 Million in Additional Annual Income for Iowans

Adult workers receiving Medicaid benefits in Iowa	90,888
Average annual income increase	\$791-\$1,050
Aggregate annual income increase	\$71.9 million - \$95.4 million
State taxes as share of income	6.1%
Additional annual state tax revenue	\$4.4 million - \$5.8 million

Increased earnings generate additional tax revenue for state and local governments. Adults receiving Medicaid in Iowa are earning below about 75 percent of the federal poverty level. Poverty levels are based on family size and income; a single parent with one, two, or three children earning at 75 percent of the poverty level would be earning less than \$16,000 a year. The Institute on Taxation and Economic Policy (ITEP) calculates that Iowa taxpayers earning less than \$16,000 a year pay 6.1 percent of their income in direct state taxes (including state sales and excise taxes and state income tax).³⁸ If all workers (both full- and part-time) receiving Medicaid benefits experienced a \$791 increase in their annual earnings, Iowa would receive an additional \$4.4 million in tax revenue. Additional tax revenue could be as high as \$5.8 million if those workers saw a \$1,050 increase in their annual incomes.

Increasing the income eligibility threshold for Medicaid may also result in potential workers deciding to take a job. Academic literature has found that Medicaid expansions could be associated with a small, positive labor force participation effect. For example, Wolfe et al.’s research found that expanding BadgerCare increased the labor force participation rate of single mothers by 1.33 percentage points. Their results are similar to Yelowitz’s research, which found that the expansions of Medicaid he studied increased labor force participation by 1.58 percentage points.

We do not model potential increases in the labor force participation rate as a result of expanding Medicaid eligibility in Iowa. Although there are likely similarities between the demographic characteristics of current Medicaid recipients and the populations studied by Wolfe et al. and Yelowitz before and shortly following after welfare reform in the mid-1990s, additional analysis is needed of the employment outcomes associated with more recent expansions of health care to low-income adults for us to draw reliable conclusions related to changes in Iowa’s labor force participation rates.

Public health coverage expansions and uncompensated care

In addition to labor market effects, expanding access to affordable health insurance could produce a fiscal return by reducing status quo costs associated with uncompensated care. Uninsured individuals

attempt to adjust the CPS numbers for this analysis, this likely contributes to a conservative estimate of the size of the fiscal return we estimate.

often rely on free medical care provided by hospitals as a substitute for insurance coverage. This uncompensated care can be a major cost for hospitals and comes in two forms: charity care (for which no payment is expected) and bad debt care (for which payment is expected but not recovered). Both components of uncompensated care theoretically would be eliminated under universal public health insurance. The American Hospital Association’s Annual Survey of Hospitals indicates Iowa hospitals used 4.7 percent (\$612.8 million) of gross patient revenue to provide uncompensated care during 2007.³⁹

Unfortunately, little statistical analysis exists regarding the relationship between public insurance expansions and uncompensated care costs. Results from the few studies conducted (Table 6) suggest that

Table 6. Research on Effects of Public Health Expansions on Uncompensated Care Costs

Study	Results
APS Healthcare, <i>The Impact of BadgerCare on Hospital Uncompensated Care in Wisconsin</i> (Wisconsin Department of Human Services State Planning Grant, 2006).	A 1 percent increase in BadgerCare enrollment results in \$3.67 decrease in uncompensated care expenditures per capita. 6-year savings (1999-2004) from BadgerCare = estimated 9.5 percent reduction in uncompensated care costs
Lynn A. Blewett, Gestur Davidson, Margaret E. Brown, and Roland Maude-Griffen, “Hospital Provision of Uncompensated Care and Public Program Enrollment,” <i>Medical Care Research and Review</i> 60, no. 4 (2003): 509-527.	5-year savings in uncompensated care costs from increased enrollment in MinnesotaCare are equivalent to an estimated 11.8 percent reduction in uncompensated care costs.
Amy J. Davidoff, Anthony T. LoSasso, Gloria J. Bazzoli, and Stephen Zuckerman, “The Effect of Changing State Health Policy on Hospital Uncompensated Care,” <i>Inquiry</i> 37 (2000): 253-267.	Only public hospitals (as compared to non-profit and for-profit hospitals) experience reductions in uncompensated care costs as a result of Medicaid expansions between 1990 and 1995. These reductions were small.
Anthony T. LoSasso and Dorian G. Seamster, “How Federal and State Policies Affected Hospital Uncompensated Care Provision in the 1990s” <i>Medical Care Research and Review</i> 64, no 6 (2007): 731-744.	A 50 percent increase in adult Medicaid eligibility would produce an estimated 1 percent decline in uncompensated care costs.
Debra Lipson et al., <i>Leading the Way? Maine’s Initial Experience in Expanding Coverage Through Dirigo Health Reforms</i> (Mathematica Policy Research, 2007).	Implementation of Dirigo health reforms (childless adults under 100% FPL, premium subsidies for up to 300% FPL) resulted in estimated \$2.7 million savings to health care providers in 2006 and 2007, less than 1 percent of paid claims for those years.
Massachusetts Division of Health Care Finance and Policy, <i>Uncompensated Care Pool Quarterly Report, PFY07 Q3</i> (February 2008).	Implementation of Massachusetts’ Commonwealth Care (no premiums under 100% FPL, subsidized premiums up to 300% FPL) corresponded with an 8.2 percent decline in allowable uncompensated care costs billed to the state’s Uncompensated Care Pool in first three quarters after reforms took effect.
Bowen Garrett et al., <i>The Coverage and Cost Impacts of Expanding Medicaid</i> (The Kaiser Commission on Medicaid and the Uninsured, 2009).	Expanding Medicaid to cover adults with incomes below 150% FPL would result in an \$11.1 billion reduction in uncompensated care costs, which amounts to 25 percent of the cost of this expansion.

expansions in eligibility for public health coverage produce reductions in uncompensated care costs, although these reductions may be small or even negligible. Studies examining aggregate effects across various state policy environments and several years of change have generally found little to no change in

uncompensated care costs as a result of Medicaid expansions.⁴¹ However, single-state studies evaluating the effects of specific public health coverage expansions have tended to find larger effects. For instance, in a study conducted for the Wisconsin Department of Health and Family Services, APS Healthcare estimated that the introduction of BadgerCare saved hospitals 9.5 percent of their uncompensated care costs over the five years the program had been in existence.

A 10 percent reduction in uncompensated care costs for Iowa hospitals would amount to hospitals savings of over \$61 million, but this would amount to less than half of 1 percent of hospital gross revenue. Because most hospitals — especially those with large amounts of low-income or uninsured patients — are nonprofit or public and do not pay corporate income tax, the state return on investment from reducing uncompensated care costs is not significant. Reductions in uncompensated care costs should ultimately be regarded as a positive side effect of public health coverage expansions, rather than as a major factor motivating the adoption of an expansion.

Comparing state returns to cost of investing in health care expansion

Evidence suggests that expanding access to Medicaid for adults in Iowa would have a positive effect on their earnings and employment, as well as on state revenues generated from income and sales taxes. In addition to estimating the number of adults who would be covered under various policy expansion scenarios, the Lewin Group provides some estimates of state costs for each option. Their analysis finds that average per-month enrollee costs for adults amount to about \$430. Because non-custodial adults are not a categorical eligibility group under current Medicaid rules, states must bear the entire cost of expanding services to this group. The Lewin Group estimates that expanding access to Medicaid to adults under 150 percent of the federal poverty level would cost the state of Iowa between \$630 million to \$787 million, depending on specifics of policy design.

The additional tax receipts generated by expanding Medicaid in Iowa amount to a small percentage of the total cost of such an expansion. The additional \$4.4 million to \$5.8 million in income and sales tax revenues the state could see as a result of increased earnings by Medicaid recipients who are no longer limited by low-income eligibility thresholds amounts to only about 0.7 percent of the state cost of implementing various scenarios for an expanded Medicaid program for adults up to 150 percent of the federal poverty level.

Indeed, it would be unrealistic to expect that tax revenues from the increased incomes of only 90,888 workers would offset a substantial portion of the costs of providing medical care to as many as 177,000 new enrollees. Nonetheless, the positive return on a state investment in public health insurance demonstrates that expansions in access to affordable health care produce more than just health benefits. The economic security of Iowa families is closely related to access to health care, and raising income eligibility limits for adults can mean that more Iowans are able to go to work and earn more when they are not constrained by the limits of the current health care system.

It is also important to remember that status quo health insurance structures generate substantial costs to state governments as well as employers and individuals. As employer-provided health coverage continues to decline in the context of an ongoing recession, Medicaid spending rises due to growth in enrollment and in per-enrollee costs. States share the cost of Medicaid with the federal government, meaning that failure to enact meaningful health reform will put greater future strain on state budgets. Urban Institute researchers who have modeled various scenarios find that, absent reform, Medicaid/SCHIP spending could increase between 28 percent and 46 percent from 2009 to 2014, depending on factors such as levels of economic growth and health cost increases during those years.⁴² They also project a corresponding \$18.9 billion to \$30.2 billion increase in uncompensated care costs during those years (a jump of between 30 percent and 49 percent) if reform does not take place.

Comprehensively measuring the costs of a status quo policy environment, in which low-income adults are particularly disadvantaged by gaps in health insurance coverage, means recognizing the multiple ways in which the current system distorts labor market incentives and strains government budgets. Additional tax revenue from the increased incomes of Medicaid recipients no longer subject to eligibility thresholds that discourage work is one component of the returns that state governments will experience as a result of expanding coverage to low-income adults.

Conclusion and Policy Recommendations

The interactions among labor market behavior, health status and insurance coverage are complex, particularly in the context of a health system where work and access to health benefits are structurally linked. Public health benefits in the form of the Medicaid program play a key role in supporting the employment of low-income workers. These workers are often have low-wage employment and lack access to employer-provided health insurance or may not be able to afford the coverage that is offered.

Research shows that good health is integral to improved earnings and work performance, and there is also strong evidence that health insurance improves health status. At the same time, existing research on the relationship between expansions of state Medicaid programs and labor market outcomes is inconclusive. While increasing income eligibility thresholds may incent higher earnings, given that individuals no longer have to fear losing health coverage if they work more and increase their incomes, it is also the case that low-wage workers face multiple barriers to success in the labor market. Improving labor market outcomes requires attention to the multiple and intersecting factors affecting productivity and earnings.

Expanding access to health insurance coverage for low-income adults in Iowa will require action at both the state and federal levels. The following policy recommendations suggest ways that state and national health reform efforts could support positive labor market outcomes for low-income Iowans by increasing eligibility limits for Medicaid.

■ Expand Iowa's Medicaid program to cover all adults with incomes below 150 percent of the federal poverty level.

Iowa can take action at the state level to provide coverage to low-income adults who are currently excluded from the Medicaid program. Health reform efforts in Iowa have produced legislation during both the 2008 and 2009 legislative sessions that calls for expansion of access to affordable healthcare for all Iowans. As policymakers move forward with developing recommendations for state health reform, current gaps in coverage of low-income adults should be a primary target for expansions of state programs.

■ Provide federal matching funds for states to expand eligibility beyond current federal minimums, particularly with regard to low-income adults.

Federal funding support is a key variable in supporting state expansions of Medicaid programs. Strengthening Medicaid by providing federal matching funds for coverage of low-income adults should be a central feature of national health reform initiatives.

■ Remove categorical eligibility criteria for Medicaid and set minimum federal eligibility standards based on income alone.

Medicaid's historical ties to cash assistance programs mean that it remains restricted to certain groups of low-income recipients. This structure creates gaps that leave low-income adults — particularly non-custodial adults — without access to affordable coverage. Eliminating categorical eligibility criteria and simply creating a new federal minimum eligibility standard based on income alone would close these gaps and benefit low-income adults.

This section of a larger analysis on the return to a state investment in work support programs estimates the results of expanding Medicaid eligibility for adults in Iowa to 150 percent of the federal poverty level. While acknowledging that research on the relationship between Medicaid and increased earnings is ongoing, we applied recent results from Wolfe et al.'s examination of the labor market effects of Wisconsin's BadgerCare program. We find that expanding Medicaid eligibility to 150 percent of the federal poverty level would result in a conservatively estimated \$791 to \$1,050 increase in annual incomes for adult workers currently receiving Medicaid in Iowa. This translates to a \$71.9 million to \$95.4 million aggregate increase in worker income and generates between \$4.4 million and \$5.8 million in state tax revenue. Although research also supports a relationship between expanded eligibility limits for Medicaid and increased labor force participation as recipients become newly employed, we do not estimate the size of this effect in Iowa.

While this return is small in comparison to the costs of expanding eligibility to between 137,000 and 177,000 adults in Iowa, it is important to remember that improved labor market outcomes is one benefit among many that result from expanding essential work support programs. We also find that Iowa hospitals could expect a reduction in their uncompensated care costs, although again this reduction would not substantially affect the total costs of uninsurance and underinsurance that are born by hospitals in Iowa.

While more research is needed on the labor market effects of increasing income eligibility thresholds for public health insurance programs, especially in the context of recent state reform efforts, it is clear that access to affordable health insurance is a necessity for all families. Health coverage improves the health status of workers, which can in turn improve their productivity and incomes and generate state fiscal returns. Iowa can work to extend these benefits to low-income workers by improving their access to Medicaid coverage through state reform initiatives and advocacy related to national health reform.

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² Colin Gordon and Beth Pearson, *The State of Working Iowa 2008* (Iowa Policy Project, 2008). Available from: http://www.iowapolicyproject.org/SOWI_2008.html.

³ Elise Gould, "Health: Life Expectancy Gap Grows As Coverage Declines," in *State of Working America 2008/2009* L. Mishel, J. Bernstein, and H. Shierholz (Cornell University Press, 2009).

⁴ Current Population Survey, Annual Social and Economic Supplement (2008).

⁵ John Holohan et al., *Health Reform: The Cost of Failure*, (Urban Institute, 2009).

⁶ The Lewin Group, *Cost and Coverage Impacts of Options for Expanding Health Insurance Coverage in Iowa: Final Report* (August 2008).

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⁹ Jack Hadley, "Sicker and Poorer—The Consequences of Being Uninsured: A Review of the Research on the Relationship between Health Insurance, Medical Care Use, Health, Work, and Income," *Medical Care Research and Review* 60, no.2 (Supplement to June 2003): 3S-75S. See also an earlier version of Hadley's research, published in May 2002 by the Kaiser Commission on Medicaid and the Uninsured.

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¹⁴ Hadley (2003), p. 62S.

¹⁵ John Mullahy and Jody Sindelar, "Alcoholism, Work, and Income," *Journal of Labor Economics* 1, no. 3 (1993): 494-520. Cited in Hadley (2003), p. 59S.

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