



Cuts in Medicaid Eligibility Levels Would be Devastating To Thousands of Working Low-Income Families

by David Blatt, Community Action Project of Tulsa County
May 2002

In 1997, the Oklahoma Legislature responded to widespread alarm about the high rates of uninsured low-income children in Oklahoma by enacting one of the most significant pieces of social legislation of the last decade. SB 639, authored by Senator Angela Monson and Representative Billy Mitchell, increased eligibility for the state's Medicaid program for pregnant women and children to 185% of the federal poverty level (see Table 1). The expanded eligibility levels, coupled with aggressive outreach on the part of state agencies, health care providers, and advocacy groups, and the incentive of an enhanced federal matching rate under CHIP (the Children's Health Insurance Program), succeeded in greatly expanding health insurance coverage for children of working poor families. Medicaid coverage for low-income children has risen by over 175,000, an increase of 137%, *resulting in a 7% decline in the percentage of uninsured children.*

Today the important progress made by Oklahoma in covering low-income children is in grave jeopardy. Faced with a serious budget shortfall for the upcoming fiscal year, the Oklahoma Health Care Authority (OHCA) has proposed slashing Medicaid eligibility to the minimum levels required by federal law – 100% of poverty for children aged 6 to 18, and 133% of poverty for children from birth to age 5 as well as pregnant women. If this proposal is enacted by the Legislature or by OHCA's Board, at least 40,000 and perhaps tens of thousands more children will lose their Medicaid coverage. The consequences of this shortsighted, ill-timed action would be devastating for low-income working families, for our health care system, and for the state as a whole. Instead of cutting eligibility, the state should look to recoup available federal matching funds for the children at risk of losing coverage, as well as other less drastic options for balancing the budget.

Table 1

Medicaid Eligibility Levels (as % of federal poverty level)				
Age	Current Eligibility	Minimum Federal Eligibility	OK Pre-SB 639 Eligibility	Current Recipients At Risk *
Pregnant Women	185%	133%	150%	1,395
Infant (0-1)	185%	133%	150%	1,092
Age 1-5	185%	133%	133%	9,149
Age 6-13	185%	100%	100%	
Age 14-18*	185%	100%	35%	28,372
*According to OHCA Finance, "FY2003 Program Reduction Options", Revised 5/3/02 Note: Federal eligibility for children 14-18 has risen to 100% since 1997. Oklahoma expanded eligibility to 185% for children through age 14 in 1997, through age 17 in 1998, and through age 18 in 2001.				

Medicaid Is An Essential Source of Health Insurance Coverage for the “Near Poor”

In extending Medicaid eligibility to 185% of the federal poverty level, Oklahoma joined with some 42 other states that have set eligibility for public health insurance for children (either through Medicaid alone or through a combination of Medicaid and a stand-alone CHIP program) at a minimum of 185%. This translates to \$2,790 per month for a family of four, or a wage of \$8.04/hr. for two adults employed full-time. 38 states have established Medicaid or CHIP eligibility for children at 200% of poverty or higher.¹

Table 2

Federal Poverty Level, 2002 by Family Size

	1	2	3	4	5
100%	8,860	11,940	15,020	18,100	21,180
133%	11,784	15,880	19,977	24,073	28,169
150%	13,290	17,910	22,530	27,150	31,770
185%	16,391	22,089	27,787	33,485	39,183
200%	17,720	23,880	30,040	36,200	42,360

Medicaid Has Cut Uninsured Rates for ‘Near-Poor’ Children: While the number of uninsured adults continues to rise in America, the concerted efforts of national and state leaders to make a priority of extending health insurance coverage for children has paid off. As the Kaiser Commission on Medicaid and the Uninsured reports in its 2002 report on Health Insurance in America, “the percentage of children covered by public programs grew significantly among those from near-poor families (with incomes between 100%–199% of the poverty level) who qualify for CHIP, and accounted in large part for the decrease in children’s uninsured rates and numbers”.²

Table 3

Health Insurance Coverage in 1995 and 2000 – United States

	Parents		Children	
	1995	2000	1995	2000
Between 100 and 200 Percent of Poverty				
Uninsured	27.9%	28.6%	22.2%	18.5%
Employer Coverage	47.8%	52.4%	39.5%	41.4%
Other Private Insurance	5.3%	4.1%	8.3%	7.2%
Other Public Insurance	5.8%	4.3%	4.3%	2.9%
Medicaid	13.2%	10.6%	25.7%	30.0%
TOTAL	100.0%	100.0%	100.0%	100.0%
Below 200 Percent of Poverty				
Uninsured	31.5%	33.4%	22.4%	21.2%
Employer Coverage	33.0%	39.0%	24.0%	27.8%
Other Private Insurance	4.5%	4.1%	6.3%	6.6%
Other Public Insurance	4.4%	3.8%	2.9%	2.5%
Medicaid	26.6%	19.7%	44.4%	41.9%
TOTAL	100.0%	100.0%	100.0%	100.0%

Source: Center on Budget and Policy Priorities analyses of Current Population Surveys for March 1996 and March 2001, based on pre-verification responses

The importance of expanded Medicaid eligibility in providing health insurance coverage for children between 100% to 200% can be seen from the data presented in Table 3. Slightly less than one-fifth (18.5%) of children in this income range were uninsured in 2000, compared to more than one-quarter (28.6%) of adults. The fact that less children than adults are uninsured, as well as the progress made between 1996 and 2000 in reducing the number of uninsured “near poor” children, are attributable almost entirely to the greater availability of Medicaid coverage for children. Since overall coverage of children has risen without a decrease in private coverage, we can fairly conclude that expanding Medicaid eligibility has succeeded in significantly reducing the number of uninsured (rather than substituting for, or ‘crowding out’, private coverage).

The national trend in insurance coverage has been even more dramatic in Oklahoma. Table 4 reveals that rates of uninsurance remained virtually unchanged in Oklahoma for low-income adults (below 200% of poverty) between the mid-1990s (1994-96) and late-1990s (1999-2000), while there was a 7% decline in the percentage of uninsured children during the same period, from 24.2% to 17.2%. The decline in the uninsured rate was even greater for children in low-income families (-8.2%). *Yet Oklahoma is still shown as having substantially greater numbers of uninsured low-income children than the national average (28.0% compared to 22.2% in 1999-2000).* And while Oklahoma has made greater progress than many states, Oklahoma still has the 8th highest rate of uninsured children in the nation. **The need is to take further steps forward in reducing the number of uninsured in Oklahoma, not massive leaps back.**

Table 4
Percentage of Children and Adults Without Health Insurance
Oklahoma and National, Mid vs. Late 1990's

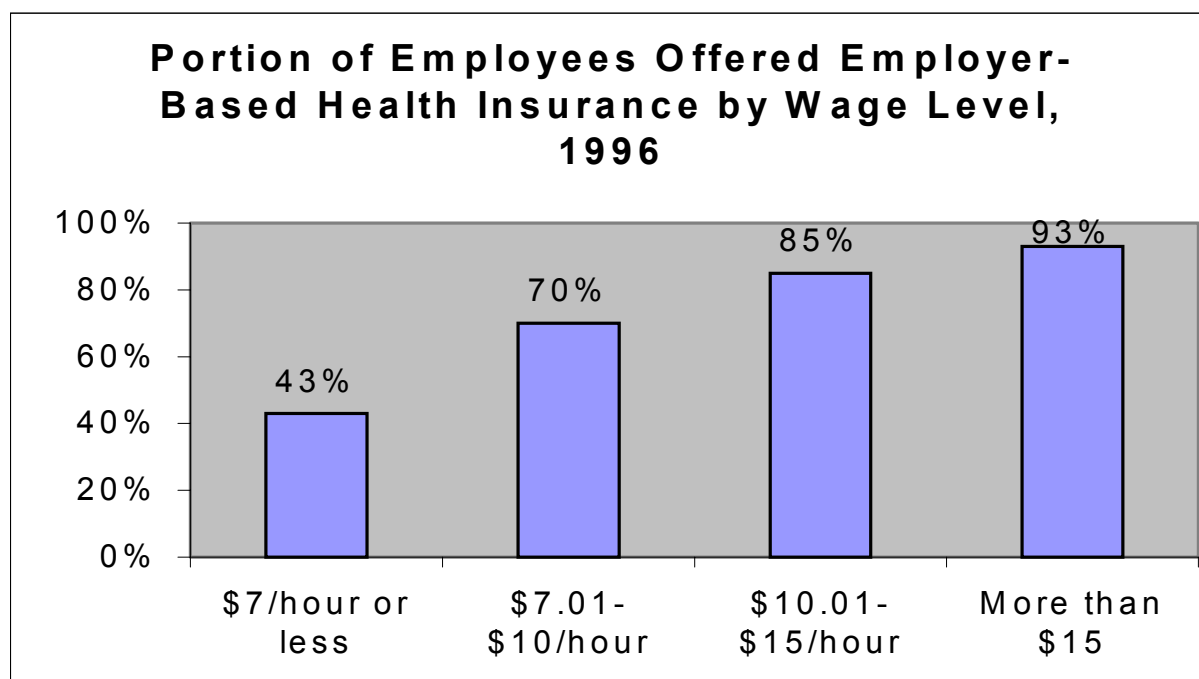
	Oklahoma			National		
	1994-1996	1999-2000	Change	1994-1996	1999-2000	Change
All Children	24.2	17.2	-7.0	14.6	12.4	-2.2
Low-Income Children (below 200% poverty)	36.2	28.0	-8.2	24.0	22.2	-1.8
All Adults (18-64)	23.4	22.6	-0.8	18.9	17.7	-1.2
Low-Income Adults (below 200% poverty)	41.8	42.5	0.7	32.5	37.6	5.1

Source: Kaiser Commission on Medicaid and the Uninsured, Health Insurance Coverage in America, 1999 and 2000 Data Updates

Private Insurance for Many Near-Poor Families is Neither Available Nor Affordable: There are very important reasons why virtually every state in the nation has enacted policies to extend coverage to families in the “near poor” or “working poor” range of 100% to 200% of poverty. In order to cover children through employer-based insurance, coverage must be both *available* and *affordable*. The reality is that both availability and affordability present significant challenges for families in the 100% to 200% of poverty range.

The majority of all insured Americans, including children, are insured through employer-based coverage. In Oklahoma, 74% of all those insured under age 65, and 64% of insured children, were covered through employer-based insurance in 1999-2000.³ However, access to employer-based coverage is not uniformly available across the income spectrum. As can be seen from Figure 1, low-wage jobs frequently do not provide access

Figure 1



SOURCE: Cindy Mann and Jocelyn Guyer, "Next Steps", Center on Budget and Policy Priorities, 1988

to health insurance coverage. Only 70% of workers in jobs earning at \$7-\$10/hr (the wage range most closely associated with the "near poor" population) were offered employer-based health insurance. And even when employees are offered health insurance, their dependents often are not.

In addition, the 'refusal rate', or the rate at which workers decline health insurance coverage, usually due to high cost, has been rising for low-wage workers. Data analyzed by the Kaiser Commission showed that of workers making \$7-\$10/hr, 14% refused employer-based coverage in 1996, compared to only 6% in this wage group who refused coverage in 1988.⁴ When it comes to paying for family coverage, affordability becomes an even greater obstacle for low-income households. Data from the Henry J. Kaiser Foundation shows that in Oklahoma in 1998, employees on average paid 12% of the cost of the insurance premium for themselves, but 26% of the cost of the premium for family coverage.⁵ These percentages have increased significantly in the past few years as health care costs have skyrocketed and many employers have reacted by shifting more of the burden for dependents in particular on to employees.

The burden that health insurance expenses can have on families between 100% and 200% of poverty can be well illustrated by examining findings from the recently released *Self-Sufficiency Standard for Oklahoma* report. The report looks at the actual cost for families of various types and sizes to meet their basic necessities. *Nowhere in the state would a family with children and income below 150% of the federal poverty level even come close to being able to afford all its basic needs without private or public subsidies.* Table 5 helps illustrate the point for sample counties and families. For a typical single-parent family with two children (one preschooler and one elementary) in Tulsa County, the self-sufficiency income without public health care coverage is \$33,233, or 221% of the federal poverty level. For the same family in

Sequoyah County (where 30% of children live below the poverty level), the self-sufficiency income is less, but at \$27,141 is still 181% of the federal poverty level. With an income at 150% of poverty (\$22,530), the 3-person family in Tulsa County falls \$10,700 short of being able to afford its basic needs if the parent pays for children's health insurance through her employer. If, however, the children are covered for free through Medicaid, then the self-sufficiency standard falls to \$29,558, just \$7,028 over the family income for a family at 150% of poverty. In Sequoyah County, Medicaid coverage can close the income gap for a family at 150% of poverty from a deficit of \$4,611 to a deficit of just \$1,434.

Table 5

Self-Sufficiency Standard for One Adult with PreSchool and Schoolage Children in Select Counties, 2002

Monthly Costs	Self-Sufficiency Standard Tulsa County	Self Sufficiency Standard Tulsa County (w/CHIP)	Self Sufficiency Standard Sequoyah County	Self Sufficiency Standard Sequoyah County w/CHIP
Housing	626	626	502	502
Child Care	655	655	559	559
Food	396	396	396	396
Transportation	223	223	212	212
Health Care - OK	262	91	246	90
Miscellaneous	216	216	191	191
Taxes	572	483	431	368
Earned Income Tax Credit (-)	0	-47	-92	-135
Child Care Tax Credit (-)	-80	-80	-84	-88
Child Tax Credit (-)	-100	-100	-100	-100
Child Support	0	0	0	0
Self-Sufficiency Wage				
- Hourly	\$15.74	\$14.01	\$12.85	\$11.34
- Monthly	\$2,769.48	\$2,463.23	\$2,261.79	\$1,997.00
- Annual	\$33,233.80	\$29,558.76	\$27,141.42	\$23,964.00

Source: Adapted from The Self-Sufficiency Standard for Oklahoma by Diana Pearce and Jennifer Brooks, February 2002

In conclusion, the expansion in Medicaid eligibility above the federal poverty level in recent years has been crucial in providing health insurance coverage for children of low-income working families. Rolling back eligibility during a time of rapidly increasing health care costs and an economic downturn will unquestionably result in increased strain on vulnerable families. Some families with children with special health needs may react to restricted eligibility by deciding that they are better off taking lower paying jobs, even going on public assistance, so as to qualify for continued benefits. Some will do whatever it takes to adjust their household budgets by going without other basic necessities or going deeper into debt in order to obtain private insurance. The likeliest impact, however, will be increased numbers of children joining the ranks of the uninsured.

The Consequences of Increasing the Number of Uninsured

While community-based health clinics play an essential role in serving the uninsured, nearly 25% of uninsured children nationally have no regular source of health care.⁶ This percentage is likely even higher in Oklahoma, with its much smaller network of community-based health clinics than other states to pick up the burden of caring for those without insurance.⁷

Studies have identified various consequences of lacking health insurance:

- Uninsured children are 70% more likely than insured children not to have received medical care for common conditions such as ear conditions, and 30% less likely to receive medical attention when they are injured;

- Uninsured children are less likely to receive preventive care. A third of uninsured children did not see a doctor in the past year;
- The uninsured are more than 70% likelier to report having a family member experience difficulty obtaining care. 87.5% of those who have had difficulty obtaining care say that the main problem was that they could not afford care;
- Having health insurance would reduce mortality for the uninsured by 10-15 per cent⁸

We must also remember that Medicaid eligibility for pregnant women is also threatened, which will impact the ability of women to get full and timely prenatal care and increase the possibility of unhealthy birth outcomes. Oklahoma already lags slightly below the national average in percentage of pregnant women receiving first trimester care.⁹

Health insurance is by itself no guarantee of prompt access to quality care. For the privately insured, co-pays and deductibles may serve as obstacles to needed care. For those covered by Medicaid, the shortage of participating providers in Oklahoma creates particularly serious barriers. However, both access and cost become especially acute problems for low-income families without insurance.

Along with the impact on families, increasing the ranks of the uninsured will place an additional burden on Oklahoma's already overburdened safety net providers – community health clinics, mental health centers, and hospitals. As much as Medicaid reimbursement rates are a source of perpetual dissatisfaction, shifting more of the patient base from Medicaid to the uninsured will be yet another straw on the backs of those who take care of the poor. As the Oklahoma Health Care Authority Task Force concluded in its May, 2002 report, *“decreasing recipients through tighter eligibility creates more uninsured, which translates to bad debt for providers, with no federal participation”*

Cutting Children's Eligibility is Fiscally Inefficient

Enhanced CHIP/Title XXI Federal Matching Rate: Of all the budget cuts that the state could consider to help address its impending shortfall, rolling back Medicaid eligibility for children is the least efficient. The federal match for Medicaid services multiplies the impact of all cuts in Medicaid spending. Yet under the federal CHIP program, the federal government pays states an enhanced match for covering children who were ineligible for Medicaid prior to 1997. In Oklahoma, *this means a federal match of close to \$4 for every \$1 state spent on the expansion population*, which comprises more than three-quarters of those targeted for disenrollment.¹⁰ The State would have to cut Medicaid spending by \$50 million – and forsake \$40 million of federal funds – to realize \$10 million in state savings. The proposed cuts in Medicaid eligibility would essentially shift a \$40 million burden from the federal government to Oklahoma families, communities and taxpayers.

Under the national rules that are established for CHIP funding, if Oklahoma does not spend its SCHIP grant, federal funds are taken away from the state and either redistributed to more generous states like New York or returned to the U.S. Treasury. That is, if Oklahoma does not use its CHIP funds, not only does it lose \$4 federal dollars for every state dollar, it loses access to those funds on a permanent basis. As it stands now, it looks like Oklahoma will give up more than \$40 million in federal SCHIP funds at the end of federal fiscal year 2002. If Oklahoma cuts its eligibility greatly and essentially terminates its SCHIP program, it would give up over \$100 million more in federal grant funds at the end of FY 2003. At a time when the state has such economic hardship, it is tragic for the state to be turning back so much money that could be used to help cover uninsured children.

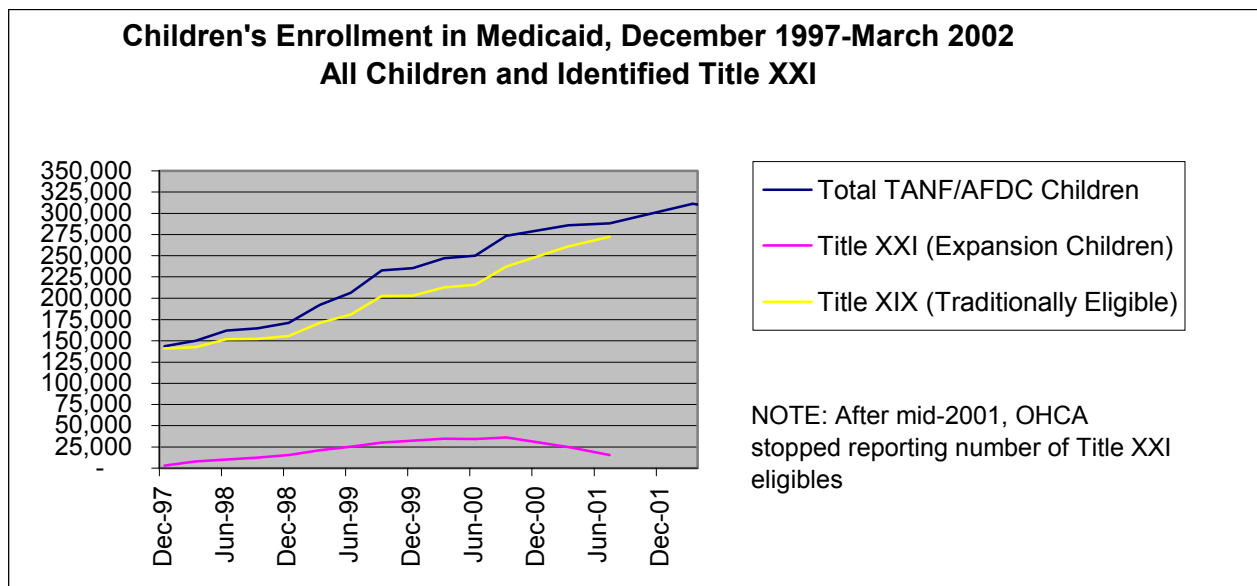
Rolling Back Eligibility Puts Federal Relief At Risk: On May 16, 2002, important bipartisan legislation was introduced in Congress by Senators Nelson (D-Nebraska) and Collins (R-Maine) to provide fiscal relief to the states for health care expenditures. Unlike earlier, unsuccessful efforts at federal assistance, the Nelson/Collins bill, which would divide funding between enhanced federal match and block grant funding, enjoys the active backing of the National Governor's Association. Observers give the Nelson-Collins bill a good chance of passing the Senate, which will put additional pressure on the House and the Administration to support assistance to the states. For Oklahoma, the bill would provide an additional X million in FFY '02, Y in FY '03 and Z in FY '04. However, in order to be eligible for relief under Nelson-Collins, *states must maintain Medicaid eligibility at least at the same levels as they were in October 2001.* By reducing eligibility levels, Oklahoma would be jeopardizing its best opportunity for a solution to the immediate fiscal crisis.

Alternatives to Cutting Eligibility Levels

While there are no simple, obvious, and painless solutions to the budget situation, there are a few alternatives that are worthy of consideration:

First, Oklahoma has failed to identify properly the full population that is eligible for enhanced federal matching funds under CHIP. Despite the fact that total children's Medicaid enrollment has continued to rise steadily during the past two years, the number of children identified as CHIP peaked at some 35,000 in 2000 and then fell precipitously to under 15,000 (Figure 2). The most plausible explanation for this mysterious drop, based on discussions with state and legislative officials, is that OHCA and DHS, which administers the eligibility process, have lost track of a sizable portion of the CHIP population. Assuming that 20,000 CHIP-eligible children are going unidentified, and the average child costs the Medicaid program \$125 per month, then Oklahoma stands to recoup some \$2.5 to \$3 million a year in additional federal matching funds. Oklahoma must at least make a serious effort to fix its administrative problems and do a better job of claiming our fair share of federal matching funds before slashing eligibility.

Figure 2



While Oklahoma's budget shortfall is no greater than many other states, so far only Oklahoma seems to be contemplating lowering eligibility levels to the federal minimum. Faced with similar challenges, other states have actively explored a range of options to rein in Medicaid expenditures.¹¹ Among the action that states have taken or considered include:

- Increasing taxes on tobacco;
- Targeting skyrocketing pharmaceutical costs by negotiating deep discounts with pharmacy manufacturers in return for being placed on preferred product lists;
- Setting up prescription drug management programs that work with providers and heavy consumers of services to better manage consumption;
- Maximizing federal contributions by shifting state-only expenditures to Medicaid and shifting administrative expenditures to higher-matched service costs;
- Establishing stand-alone CHIP programs for children above the poverty level to take advantage of opportunities to levy premiums and co-pays on participating families;
- Enacting enrollment freezes for their CHIP population in the face of budgetary squeezes.

These options are not necessarily desirable for Oklahoma and are not intended as recommended courses of action. They do represent, however, efforts to cut expenditures short of the draconian threat of simply disenrolling tens of thousands of kids from the program.

Conclusion

There is no question that the decline in state revenues during the current and upcoming fiscal years have created severe budgetary challenges and have forced decision-makers to choose between unpalatable options. It is also an unfortunate fact that the Medicaid program has been an especially severe source of budgetary strain in recent years. However, of all the options under consideration for balancing the state budget, eliminating Medicaid coverage for low-income working families up to 185% of poverty would be among the most painful, shortsighted and counterproductive.

ENDNOTES

My thanks to Leighton Ku of the Center on Budget and Policy Priorities and Cindy Mann of the Kaiser Family Foundation for invaluable assistance with this paper

¹ Kaiser Commission on Medicaid and the Uninsured, "CHIP Program Enrollment: December 2000", September 2001, p. 17

² Kaiser Commission on Medicaid and the Uninsured, "Health Insurance Coverage in America, 2000 Data Update", February 2002.

³ Ibid

⁴ Ellen O'Brien and Judith Feder, "How Well Does the Employment-Based Health Insurance System Work for Low-Income Families", Kaiser Commission on Medicaid and the Uninsured, September 1998.

⁵ The Henry J. Kaiser Family Foundation, State Health Facts Online, Oklahoma: Average Annual Total Employment-Based Premiums, 1998 <http://statehealthfacts.kff.org>

⁶ Kaiser Commission on Medicaid and the Uninsured, "The Uninsured and their Access to Health Care", February 2002.

⁷ Oklahoma in 1999 had 10 community health center sites, compared to 41 in Arkansas, 81 in New Mexico and 147 in Texas.

⁸ Kaiser Commission on Medicaid and the Uninsured, "The Uninsured and their Access to Health Care", February 2002; Kaiser Commission on Medicaid and the Uninsured, "Sicker and Poorer: The Consequences of Being Uninsured", May 2002; and Families USA, Getting Less Care: The Uninsured With Chronic Health Conditions, February 2001.

⁹ Oklahoma State Department of Health, State of the State's Health, 2001.

¹⁰ Oklahoma had optionally expanded eligibility for infants to 150%, so infants between 133% and 150% are not entitled to CHIP matching funds. Also, the state does not receive enhanced match for pregnant women or for children who had been privately insured within 3 months of applying for Medicaid.

¹¹ See National Conference of State Legislatures, Managing Medicaid Costs: A Legislator's Tool Kit, December 2001.