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When Done Right, Work Supports Work: Medicaid and Mothers' Employment and Wages

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Executive Summary

Welfare reform promised welfare mothers that if they went to work, they would receive the work supports and assistance necessary to help them find and keep employment. Congress has fulfilled some of that promise in that expenditures on work supports have increased since the early 1990s. However, work supports are generally time-limited and phase-out quickly as income rises. This limits the ability of mothers to stay employed because most do not easily transition off government work supports into private-sector work supports.

Because of time-limits and phase-outs, low-income and welfare mothers lose eligibility for Medicaid and other work supports as they move up the job ladder. Employer-provided health insurance is an option for those lucky enough to have found a job that provides it. However, few mothers make the transition from Medicaid to employer-provided health insurance. Between the beginning of 2002 and the end of 2003, 37.2 percent of those on Medicaid left the program, but fewer than a quarter of those had employer-provided health insurance.

The problem is not that Medicaid leavers lack employment, but that they do not find jobs offering employer-provided health insurance. Among those who left Medicaid in the late 1990s, the share moving from a job without employer-provided health insurance to one with insurance was just under one third. During the recession of the early 2000s, however, the share making this transition fell by 14.0 percentage points, down to 14.7 percent. There was not a comparably large decline in the share of mothers overall who moved from a job without employer-provided health insurance to one with. In the late 1990s, one-in-five (18.3 percent) of all mothers made this transition and in the early 2000s, this share only fell by 1.6 percentage points to 16.7 percent.

The transition from Medicaid to employer-provided health insurance is critical. Mothers who make this transition into employer-provided health insurance are nine times more likely to stay employed than mothers who leave Medicaid without this benefit. In fact, mothers leaving Medicaid with employer-provided health insurance are just as likely to stay employed as mothers who have employer-provided health insurance and are not Medicaid leavers. All Medicaid leavers suffer a wage penalty—that is, their wages are lower than those of comparable women, all else equal—however, compared to other mothers. This is true regardless of whether they left Medicaid with or without employer-provided health insurance.

What we know is that work supports matter. The private market does not step up quickly enough to allow the majority of women leaving Medicaid the opportunity to participate in an employer-based health insurance plan. The promise of work supports is only fulfilled, however, if they help mothers both find and maintain employment. Rapid phase-outs and relatively low earnings thresholds limit mothers' ability to stay employed, even if they had been successful at finding employment.

Introduction

Work supports are, in theory, supposed to help mothers stay employed by providing the supports that they need to work. This was the underlying logic of the "Work First" programs implemented in many states as a part of welfare reform. The faster the government could get women into employment, the sooner they would gain the kinds of on-the-job experience that would lead to higher wages. Research has indicated that access to work supports increases employment tenure, which then feeds back into higher wages (Boushey 2002; Lee 2004; Strawn and Martinson 2000). Lee (2004), for example, finds that all else equal, mothers with employer-provided health insurance are nearly three times as likely to stay on the job compared to mothers with other types of health insurance.

Welfare reform promised welfare mothers that work supports would ease their transition from welfare to employment. The passage of welfare reform accelerated a shift towards increased funding for work supports, as states began spending more on work supports, in particular Medicaid, other state public health programs, child care, and transportation, while spending relatively less on cash assistance. Funding was available for these supports because Congress pegged the amount of money that states received under welfare reform to caseload levels in the early 1990s. When caseloads plummeted in the late 1990s, the states had more welfare money per client to spend. Further, within a year of the passage of welfare reform, the federal government increased other forms of assistance to low-wage workers by increasing the minimum wage, expanding the Earned Income Tax Credit, and initiating the State Child Health Insurance Program, which extended Medicaid to the children of low-wage workers.

However, many of these work supports are time-limited or phase-out quickly as income rises. For example, although most women moving off welfare will find jobs without health insurance, federal law requires states to offer just six months of Medicaid coverage to families leaving welfare for work. Some states have waivers for the first full year or year and a half of employment, but this is rare. As states moved through the fiscal crises of the early 2000s, many of these work support programs were either reduced or eliminated. When that happened, those working were often the first to be cut from the programs. This creates a hole in the safety net for low-wage, working women, who are not likely to have access to employer-provided health insurance. Further, the phase-out of work supports reduces women's ability to become and remain self sufficient by limiting their ability to stay employed and, thus, move up the job ladder.

Few Mothers Make the Transition from Medicaid to Employer-Provided Health Insurance

Medicaid was established in 1967 by the federal government to provide public health insurance to the nation's poor. Currently, one-in-seven children (14.0 percent in 2002) and 5.8 percent of adults under age 65 are covered by Medicaid or the State Child Health Insurance Program (SCHIP) (Boushey and Wright 2004b). However, low income limits for eligibility for the program cause many working families to be excluded, even though they still may not be able to obtain health services through employer- or self-provided insurance. This is particularly

problematic because welfare reform aimed to push families receiving welfare into the workforce. If work means the loss of basic access to health care, this creates a substantial disincentive for mothers to choose employment over welfare receipt.

The underlying logic behind providing Medicaid as a work support is that this should help recent welfare leavers access health insurance until they either receive employer-provided health insurance or can afford to purchase private health insurance. However, many of those who left welfare during the late 1990s and early 2000s moved into low-wage, short-tenure jobs that did not offer employer-provided health insurance. In the late 1990s, the average wage in these jobs was between $6.00 to $8.00 per hour and only about one-quarter received health benefits (Loprest 2001). Thus, not only were few able to access health insurance through their employer, but wages were generally so low that they could not reasonably afford private health insurance on their own.

The low rate of transitions from Medicaid to employer-provided health insurance exemplifies the limited ability of former welfare recipients to find high quality jobs. Among those leaving Medicaid, over the two-year period from the beginning of 1997 through the end of 1998, just over one-in-ten (11.8 percent) moved from Medicaid into employer-provided health insurance (EPHI) (Table 1). There was a 2.0 percentage point drop in the share making this transition between the beginning of 2002 and the end of 2003. In reality, most mothers remained on Medicaid, with 58.4 percent staying over 1997 through 1998 and 62.8 percent staying from 2002 through 2003, but a not-insignificant share—about one-third in both time periods—moved off Medicaid without having employer-provided health insurance.

Therefore, among the 41.5 percent leaving Medicaid between the beginning of 1997 and the end of 1998, nearly one third of those (27.7 percent) moved from Medicaid into employer-provided health insurance. However, fewer left Medicaid for employer-provided health insurance in the early 2000s: of the 37.2 percent of those who left Medicaid between the beginning of 2002 and the end of 2003, fewer than a quarter (23.4 percent) had employer-provided health insurance. This 4.3 percentage point decline in the share of those who left Medicaid and moved to employer-provided health insurance is likely due to the fact that during the recession of the early 2000s, the rate of employer-provided coverage fell.

African Americans and whites were more likely than Hispanics to move from Medicaid into employer-provided health insurance. Over the two-year period from 1997 through 1998, 12.9 percent of both African Americans and whites moved from Medicaid to employer-provided health insurance, while only 7.8 percent of Hispanics made this transition. Hispanic's low transition rate from Medicaid to employer-provided health insurance is consistent with their low rate of employer-provided health insurance coverage overall (Boushey and Wright 2004a).

Although whites were just as likely as African Americans to transition from Medicaid to employer-provided health insurance, whites were more likely than African Americans to leave Medicaid without having employer-provided health insurance and less likely to stay on Medicaid. In the late 1990s, 34.2 percent of whites transitioned off Medicaid without employer-provided health insurance, compared to only 22.8 percent of African Americans. Only 52.9 percent of whites remained on Medicaid in the late 1990s, compared to 64.3 percent of African

Americans, an 11.4 percentage point gap. However, this gap shrunk to only 2.7 percentage points in the early 2000s, as 62.5 percent of whites and 65.2 percent of African Americans remained on Medicaid. Non-citizens were more likely than other groups to leave Medicaid without having employer-provided health insurance and also less likely to stay on Medicaid, compared to native-born and naturalized citizens.

Table 1. Transitions from Medicaid into Employer-Provided Health Insurance (EPHI)

	Among those on Medicaid in January 1997, health insurance status in December 1998			Among those on Medicaid in January 2002, health insurance status in December 2003		
	Medicaid	EPHI	Neither	Medicaid	EPHI	Neither
All	58.5%	11.5%	30.0%	62.8%	8.7%	28.5%
White	52.9	12.9	34.2	62.5	9.2	28.3
African American	64.3	12.9	22.8	65.2	12.3	22.6
Hispanic	58.1	7.8	34.1	57.1	6.1	36.8
Other	73.2	8.9	17.9	77.8	2.2	20.0
Native	59.0	12.0	29.0	64.5	9.7	25.8
Naturalized	76.0	12.0	12.0	58.3	8.3	33.3
Non-citizen	54.6	8.6	36.8	57.0	3.2	39.8
Children infants to age 5 only	47.3	17.6	35.2	61.4	5.3	33.3
Children 6 to 17 only	60.1	11.9	28.0	64.2	8.7	27.1
Children infants to age 5 & children 6 to 17	56.9	10.5	32.5	57.8	11.2	31.1

Source: Author's analysis of the 1996 and 2001 panels of the Survey of Income and Program Participation.
Notes: Sample includes mothers ages 25 to 54. Transitions are measured from the first to the last month of the period and will not include transitions that occur within the two-year period. Thus, a person moving from Medicaid to employer-provided health insurance then back to Medicaid within the period will be counted as staying on Medicaid.

Mothers with young children were less likely to stay on Medicaid and more likely to leave Medicaid without having employer-provided health insurance, compared to mothers who only had children from age six to 17. In the early 2000s, mothers with only pre-school age children were very unlikely to move to employer-provided health insurance, with only 5.3 percent moving from Medicaid to employer-provided health insurance, while one-third (33.3 percent) moved off Medicaid without having employer-provided health insurance.

Longer Employment Tenure Increases Probability of Having Employer-Provided Health Insurance

Mothers do not quickly transition from Medicaid into employer-provided health insurance. However, the longer a mother is off welfare and on the job, the greater her probability of acquiring employer-provided health insurance, at least in the late 1990s (Table 2). Compared to mothers who left welfare within the past six months, the probability of having employer-provided health insurance in the late 1990s is 16.5 percentage points greater for those who left welfare over two years earlier and 14.3 percent greater for those who had been working for more than two years. This is nearly three times as large a probability than for those who left welfare and had been employed for the past seven to 12 months.

However, length of time since leaving welfare was not a factor in predicting whether a low-wage working mother had access to employer-provided health insurance in the early 2000s. Compared to the late 1990s, the effect of employment tenure on the likelihood of receiving employer-provided health insurance was also smaller in the early 2000s.

The differences across the late 1990s and early 2000s may be due to changes in the how firms offer health insurance. For the past three years, there have been double-digit increases in health insurance costs, far higher than overall inflation (Kaiser Commission on Medicaid and the Uninsured 2003). Employers are increasingly passing these higher costs on to their employees in the form of higher premiums or co-payments (Bureau of Labor Statistics 2003). In the early 2000s, it may have been more difficult for former welfare recipients to find jobs with health insurance or to afford the higher premiums many employers were requiring employees to pay, compared to the late 1990s.

Table 2. Probability of Receiving Employer-Provided Health Insurance Among Low-wage Working Mothers

	Late 1990s	Early 2000s
Relative to those exiting welfare within past six months:		
Welfare recipient	-2.3	5.0
Months since welfare exit:		
7 to 12 months	5.0***	-2.7
13 to 18 months	10.4***	-1.3
19 to 24 months	15.5***	2.8
25 months or more	16.5***	3.2
Relative to those working continuously six months or less:		
Continuous months of employment:		
7 to 12 months	5.2***	3.9***
13 to 18 months	8.5***	6.5***
19 to 24 months	11.3***	8.6***
25 months or more	14.3***	10.3***

Source: Author's analysis of the 1996 and 2001 panels of the Survey of Income and Program Participation.
Notes: Sample includes mothers ages 25 to 54. Low-wage workers are those earning at or less than $10.00 per hour in December 1999 constant dollars. Marginal effects are calculated from a logit estimation of the probability of receiving employer-provided health insurance. For full model results, see (Boushey 2005). The marginal effects are calculated assuming that months off welfare and months employed are equal and all other values are set at their means.
* significant at 10%; ** significant at 5%; *** significant at 1%

Transitioning from Medicaid into a job with employer-provided health insurance became less likely between the late 1990s and the early 2000s (Table 3). Among those who left Medicaid in the late 1990s, the share moving from a job without employer-provided health insurance to one with employer-provided health insurance was 28.7 percent, 14.0 percentage points higher than in the early 2000s when only 14.7 made this transition. The strong labor market of the late 1990s may be part of the reason. At that time, individuals could job-switch to find better wages or benefits and the labor market was especially good for low-wage workers, who saw their first significant inflation-adjusted wage gains in decades. However, in the early 2000s, the recession made finding a good job more difficult. The low rate of transition into employer-provided health insurance may also be due to the rapid increases in health insurance costs during the past few years and the greater likelihood of employers asking workers to pay a larger share of the premiums.

It may also be that those who left Medicaid in the late 1990s were more advantaged than those in the early 2000s, given the large decreases in the welfare rolls over the past decade. As the better skilled mothers have moved off welfare, those left on welfare are more disadvantaged

and less equipped to find the kinds of jobs that offered employer-provided health insurance (Boushey and Wenger 2003).

While the probability of transitioning from a job without employer-provided health insurance to a job with insurance fell sharply for Medicaid leavers between the late nineties and the early 2000s, it did not change for other mothers. During the late 1990s, among those who started with a job, but did not have employer-provided health insurance, one-in-five (18.3 percent) had a job with employer-provided health insurance two years later. During the early 2000s, the share gaining employer-provided health insurance fell by 1.6 percentage points, down to 16.7 percent.

Over this time period, because of the recession, mothers—both all mothers and Medicaid leavers—became more likely to stay without a job and less likely to move from no job into a job with or without employer-provided health insurance. However, mothers leaving Medicaid saw a 15.2 percentage point increase in their likelihood of staying unemployed, from 64.1 percent in the late 1990s up to 79.3 percent in the early 2000s, while mothers overall only saw a 6.1 percentage point increase over the same time period, from 70.0 to 76.1 percent.

Table 3. Transitions into Jobs with Employer-Provided Health Insurance (EPHI)

	Status at end of period					
	January 1997 to December 1998			January 2002 to December 2003		
Status at beginning of period	No job, no EPHI	Job, no EPHI	Job, EPHI	No job, no EPHI	Job, no EPHI	Job, EPHI
No job, no EPHI	70.0%	23.4%	6.6%	76.1%	18.3%	5.7%
Job, no EPHI	16.9	64.7	18.3	19.1	64.3	16.7
Job, EPHI	6.6	14.3	79.1	7.4	14.8	77.8
Medicaid Leavers						
No job, no EPHI	64.1	28.3	7.6	79.3	15.9	4.9
Job, no EPHI	19.4	51.9	28.7	20.0	65.3	14.7
Job, EPHI	3.5	13.8	82.8	3.9	13.7	82.4

Source: Author's analysis of the 1996 and 2001 panels of the Survey of Income and Program Participation.
Notes: Sample includes mothers ages 25 to 54. See notes to Table 1.

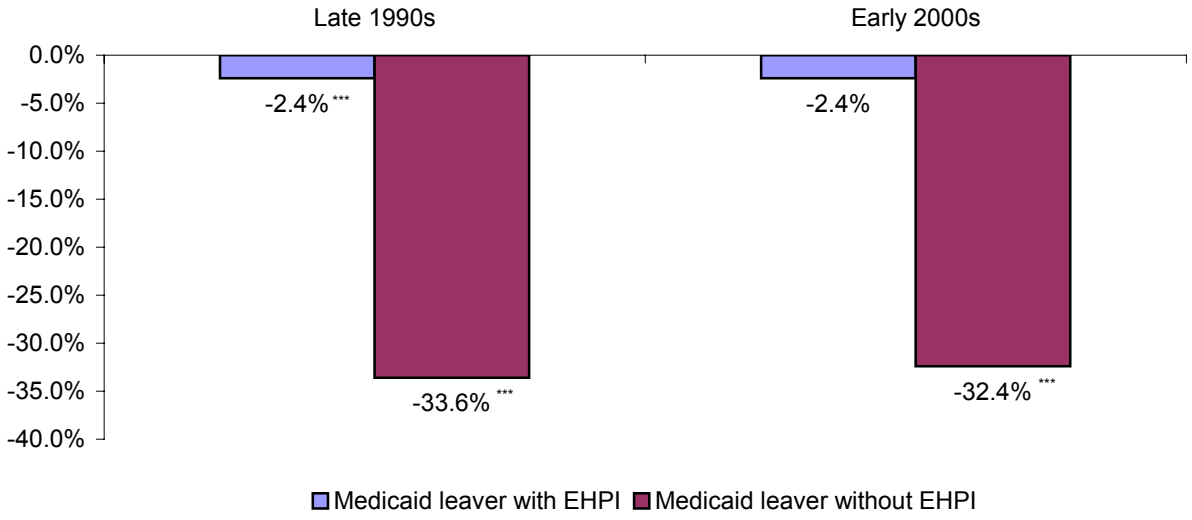
Moving Off Medicaid without Employer-Provided Health Insurance Increases Probability of Leaving Employment and Creates Wage Penalty

Low-wage mothers who left Medicaid and had employer-provided health insurance (EPHI) were nine times more likely to stay employed, compared to those who left Medicaid without having EPHI. Figure 1 shows the probability of staying employed for low-wage mothers based on whether they left Medicaid with or without EPHI. Compared to low-wage mothers who did not leave Medicaid, but had EPHI, mothers who left Medicaid without EPHI were about one-

third less likely to stay employed over a year, compared to mothers who left Medicaid with EPHI.

Mothers who left Medicaid with EPHI had employment durations similar to mothers who had EPHI. In the late 1990s, Medicaid leavers were 3.6 percent less likely to stay employed and in the early 2000s, they were a statistically insignificant 1.2 percent less likely to stay employed.

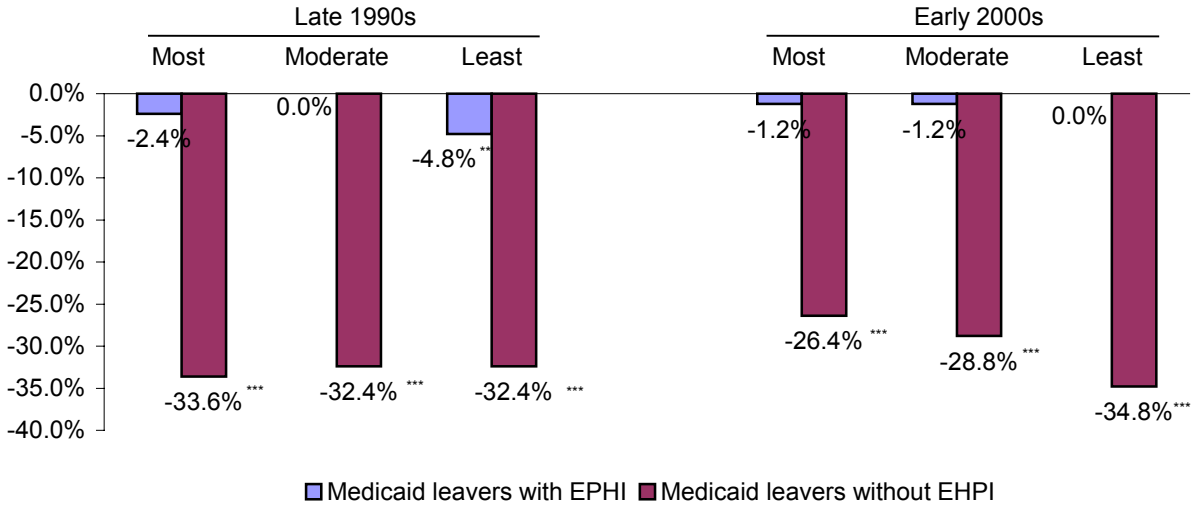
Figure 1. Annualized probability that low-wage mothers stay employed: Medicaid leavers compared to mothers with EPHI



Source: Author's analysis of the 1996 and 2001 panels of the Survey of Income and Program Participation.
Notes: Sample includes mothers ages 25 to 54. See notes to Table 2.
significant at 10%; ** significant at 5%; *** significant at 1%

The level of state Medicaid generosity affected mothers' probability of staying employed, more so in the early 2000s than the late 1990s (Figure 2). In the early 2000s, low-wage mothers living in the least generous states who left Medicaid without EPHI were 34.8 percent less likely to stay employed relative to low-wage mothers not on Medicaid who had EPHI. However, there is an 8.4 percentage point gap between mothers in the least and most generous states as low-wage mothers who left Medicaid without EPHI in the most generous states were only 26.4 percent less likely to stay employed.

Figure 2. Annualized probability that low-wage mothers stay employed by generosity of state Medicaid: Medicaid leavers compared to mothers with EPHI

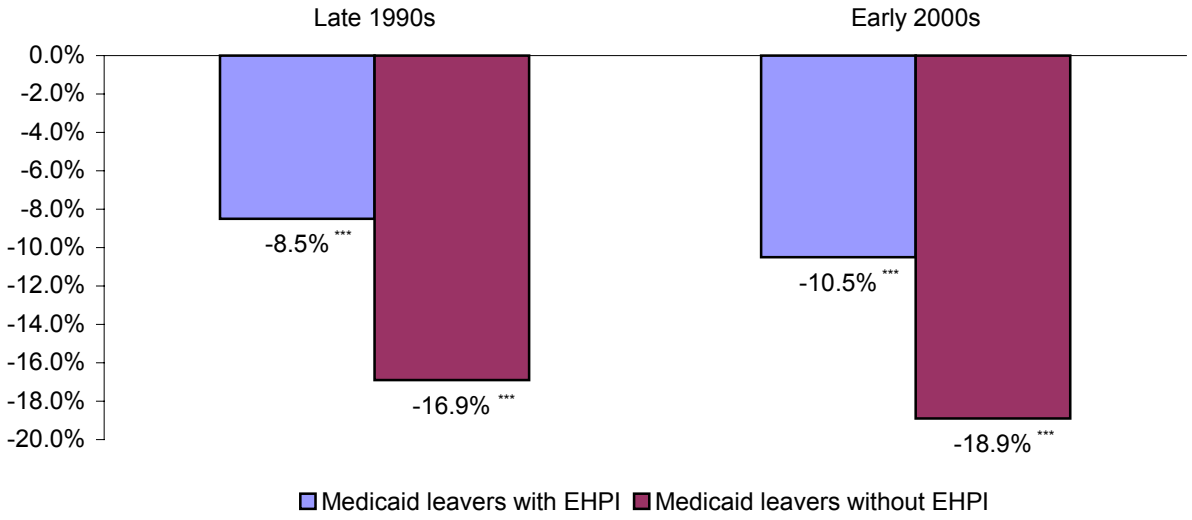


Source: Author's analysis of the 1996 and 2001 panels of the Survey of Income and Program Participation.
Notes: Sample includes mothers ages 25 to 54. See notes to Table 2.
significant at 10%; ** significant at 5%; *** significant at 1%

Moving from Medicaid to EPHI increases the probability of staying employed, so much so that mothers leaving Medicaid look like mothers who have EPHI and are not Medicaid leavers. However, mothers leaving Medicaid have lower wages than non-Medicaid mothers with EPHI, regardless of whether they left Medicaid with or without EPHI (Figure 3). Mothers leaving Medicaid for EPHI have a wage penalty that is half as large as mothers leaving Medicaid without EPHI. In the early 2000s, compared to non-Medicaid low-wage mothers with EPHI, the wages of low-wage mothers who left Medicaid were 18.9 percent lower for those that did not move into EPHI and only 10.5 percent lower for those that did.

The lower wages for all Medicaid leavers may indicate systemic differences in these mothers compared to mothers overall. Mothers leaving Medicaid have often also been on welfare and there may be a wage penalty associated with the stigma of being a former welfare recipient. It may also be that these mothers are willing (and able) to trade off higher wages for health insurance. Given two job offers, one with EPHI and one with higher wages, they may choose the lower-paying job with health insurance. However, in reality, it is more likely that high-paying jobs offer health insurance and mothers may not have the opportunity to trade-off higher wages for health insurance coverage.

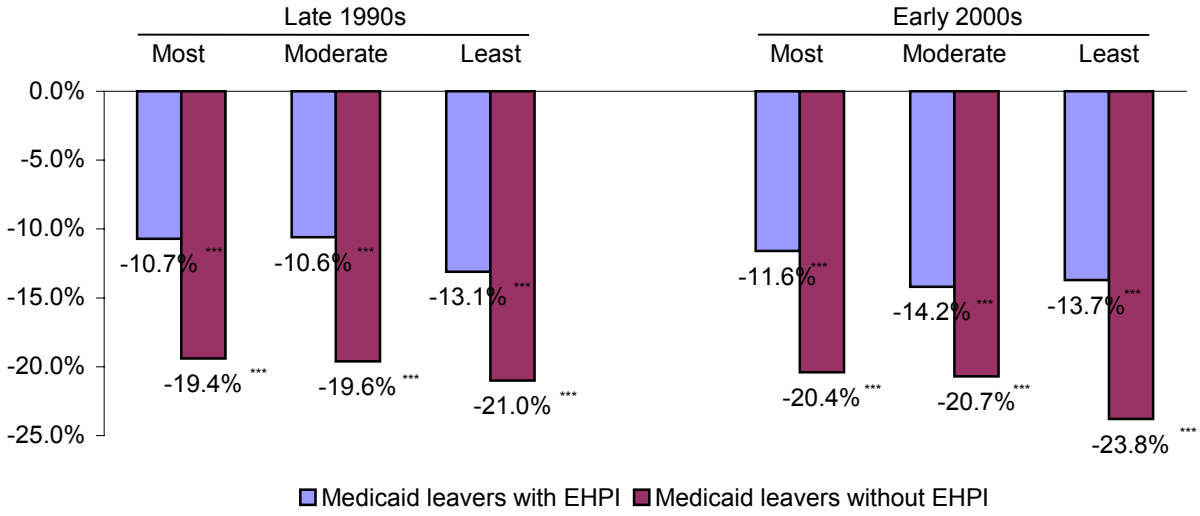
Figure 3. Effect of losing Medicaid on wages: Medicaid leavers compared to mothers with EPHI



Source: Author's analysis of the 1996 and 2001 panels of the Survey of Income and Program Participation. \
Notes: Sample includes mothers ages 25 to 54. See notes to Table 2.
* significant at 10%; ** significant at 5%; *** significant at 1%

The wage penalty for moving from Medicaid to no EPHI was greatest in states with the least generous Medicaid policies (Figure 4). In the late 1990s, low-wage mothers living in the least generous states and had left Medicaid without EPHI had wages that were 21.0 percent lower than low-wage mothers who had not been on Medicaid and had EPHI; in the early 2000s, the wage penalty was even higher, at 23.8 percent. In both the late 1990s and early 2000s, the wage penalty is higher in the least generous states, compared to the most generous states.

Figure 4. Effect of losing Medicaid on wages by state Medicaid generosity: Medicaid leavers compared to mothers with EPHI



Source: Author's analysis of the 1996 and 2001 panels of the Survey of Income and Program Participation.
Notes: Sample includes mothers ages 25 to 54. See notes to Table 2.
All estimates significant at 1%

Conclusions

This study finds that it is not enough for states to offer work supports for a few months; to fulfill their promise, they need to be offered until the woman is self-sufficient. Mothers on welfare and other low-income mothers are often eligible for Medicaid. However, as they move up the job ladder, most become ineligible, even if they do not have private-sector support. Some do move onto employer-provided health insurance, but most do not.

Losing Medicaid before gaining access to an employer-based health insurance plan limits a mother's ability to stay employed. Work supports only fulfill their mission if they help mothers both find and maintain employment. Rapid phase-outs and relatively low earnings thresholds limit mothers' ability to stay employed, even if they had been successful at finding employment. Yet, the private market does not step up quickly enough to allow the majority of women leaving Medicaid the opportunity to participate in an employer-based health insurance plan.

Our social policy system is two-tiered and this hurts low-income working families. While the social safety net provides work supports to the very poor and employers provide them for the upper and middle classes, neither provides for the working poor. In short, the way our social policy system works, low-wage workers are too rich for public supports, but too poor to afford these goods and services on their wages. The lack of an adequate safety for low-wage, working parents threatens their ability to stay employed and move up the job ladder.

In order to create an adequate safety net for all working families, policymakers should move away from policies aimed only at the non-working poor or recent labor market entrants and focus on meeting the needs of working families more generally. Universal health insurance would remove the link between having a good job and having access to health care. Further, it is likely that a universal system could not only save money in administrative costs, but also provide real incentives to keep people healthy, rather than waiting until people are very ill.

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