EXTENDING HEALTH CARE TO AFDC RECIPIENTS WHO OBTAIN JOBS: RESULTS OF A DEMONSTRATION

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This study investigated the outcomes of a demonstration project that provided free medical coverage to former Aid to Families with Dependent Children (AFDC) recipients who were holding jobs with limited or no health benefits. Data were collected on the Medicaid expenditures of 54 eligible participants and their dependents for up to two years before they exited welfare; the expenditures averaged 56 percent less for adults and 45 percent less for children than the respective AFDC averages for the county. Because only 22 percent of the eligible participants took advantage of the program, telephone interviews also were conducted with 24 people who did not participate in or dropped out of the health plan. The main reasons cited for not enrolling were a misunderstanding of the program, a claim that no notification of the program was received, and a lack of interest. These results and their policy implications are presented in the context of the Family Support Act's mandate that states extend medical assistance coverage to AFDC recipients whose cases are closed because of employment.

The Final Regulations of the Family Support Act of 1988 (Family Support Administration, 1989) stipulated that on April 1, 1990, states must extend medical assistance coverage to Aid to Families with Dependent Children (AFDC) recipients who exit welfare because of increased income from employment. Families who received AFDC benefits in at least three of the six months preceding termination of their grants are now eligible for six months of additional insurance without having to reapply for medical assistance. Families that receive medical assistance during the entire initial six-month period and have average gross monthly earnings (less child care expenses) of 185 percent of the official poverty line may qualify for a second six months of extended benefits.

States have a variety of options for implementing the medical extension. They can continue straight Medicaid coverage, place recipients in designated private plans (such as health maintenance organizations), pay the premiums and

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deductibles of employer health insurance, or pay for all services under Medicaid that are not covered under the employer plan ("wrap-around" coverage). In assessing these alternatives, state administrators should consider such questions as cost and quality of care and whether a given choice will be understood and used by the target population. The selection of a health care strategy, therefore, becomes a major policy decision.

This study anticipates some of the issues in providing transitional medical insurance to former welfare families. The authors investigated a two-year health care demonstration program that was offered to AFDC recipients who had participated in the Wicomico County (Maryland) Basic Employment and Training (BET) program between 1987 and 1988 and had exited welfare because of employment. The authors attempted to understand why this plan, which provided needed coverage at no cost to the clients, was so underused. Of the 54 people who were eligible for health coverage, most of whom had limited or no coverage through their jobs, only 33 percent (n = 18) were enrolled in the health plan, and after six dropped out, only 22 percent participated. Focusing on the experience of a small county attempting to implement an innovative program, this inquiry also sought answers to several policy questions concerning the use of health insurance by former AFDC recipients:

- Would former AFDC recipients with jobs that offered limited or no health coverage take advantage of a free health insurance program? If they did not enroll in the health program, what were the reasons?
- Are former AFDC clients who become employed different in their use of Medicaid from recipients who remain on welfare?
- Would the lack of health insurance offered by the employer be a disincentive to remain on the job?

BET HEALTH CARE PLAN

The Wicomico/BET health care plan was funded under the Investment in Job Opportunities (IJO) Model Demonstration Projects program. Administered by the Office of Welfare Employment Policy of the Maryland Department of Human Resources, the IJO program provided seed money to counties willing to initiate new approaches to help overcome barriers to the self-sufficiency of welfare recipients.

Wicomico County officials chose to address the health care issue. The BET program, which provides training and employment services for AFDC recipients, sought to offer temporary health coverage to people who had made the successful transition from welfare to work. Once employed, these people were eligible for only four months of additional Medicaid, and most worked in jobs that offered no health insurance or limited coverage. BET's health care plan paid the difference between a person's existing benefits and full coverage. In cases where no benefits were available, BET contracted with a private insurance company for a nine-month temporary health plan, renewable at three-month intervals. The program would pay the premiums and the $100 deductible, as well as dental and optical services that were not covered by the policy. If a person had a health plan through his or her employer, BET would reimburse for premiums, deductibles, the percentage of costs not paid by the insurer, and noncovered services (for example, dental and optical care). When an individual could not pay for the services, BET would contact the provider and arrange to send the payment directly. At the end of the nine-month plan, enrollees still without employer health coverage were placed in a one-year plan offered by the same company, but they became responsible for deductibles and services not covered by the policy.

METHOD

The health plan was limited to AFDC recipients who had participated in BET, were holding jobs, and no longer qualified for Medicaid. In the study population (n = 54), there were 52 women and 2 men; 33 were black and 21 were white. The mean was 11.5 years of education. Thirty-one were long-term AFDC recipients (three years or more); 30 had been employed within the past two years of entry into the BET program. For comparison, the 54 eligible program participants were divided into

three groups. *Nonparticipants* (n = 36) were subdivided into people who expressed an interest in the plan (n = 8) and people who did not respond to the letter that explained the BET health care program (n = 28). *Participants* (n = 12) were either enrolled in the nine-month temporary private health plan (n = 9) or received supplementary health care payments (that is, premiums or uncovered services) from BET (n = 3). *Dropouts* (n = 6) failed to renew their health insurance policies (n = 5) or no longer participated in the supplemental payment phase (n = 1).

Medicaid Data

The Office of Program and Administrative Support Services of the Maryland Department of Health and Mental Hygiene provided Medicaid data for 54 people and their dependent children for the period prior to their finding employment. Through computerized records, individual medical costs were tracked from April 25, 1987, through April 27, 1989, which was termed the medical assistance (MA) study period. Because the length of time varied that people were on medical assistance, monthly and yearly averages were computed. The number of months in the MA study period was divided by the total Medicaid costs to calculate the monthly average, and the monthly average was multiplied by 12 to calculate the yearly average.

The average adult and child medical assistance payment also was obtained for fiscal years 1987 and 1988. This average was based on the total Medicaid expenditures for a given year divided by the average monthly caseload number. Therefore, the two averages are not equivalent: The client mean is a monthly rate projected over a year's time, whereas the county and state mean is the total yearly costs divided by an average monthly caseload size.

Telephone Interviews

The telephone interview format was designed to be open-ended and interactive to elicit information in five areas: (1) present health care coverage, (2) child care and transportation needs, (3) knowledge of the BET health plan, (4) valuation of one's experience in the BET program, and (5) thoughts on being employed rather than on AFDC. The interview also was framed as an intervention to determine whether people would use the BET health plan if given another opportunity.

Calls were made to the 42 people in the nonparticipant and dropout groups. Of this number, 24 (57 percent), were interviewed. Eight could not be reached because the person was no longer working with the employer of record and the home telephone was disconnected. In eight cases, messages were left with the employers, but the calls were not returned. In two instances, clients had left the state.

FINDINGS

There were five major findings in this study. First, most nonparticipants in the BET health plan continued to work with limited or no health coverage. Of the 24 people interviewed, 11 (46 percent) had no health insurance and six had partial coverage. Only six people had health insurance that included optical and dental care, and one had reapplied for and was receiving medical assistance. Five of the six who dropped out of the BET health plan continued to lack health insurance, and one had partial coverage through her employer.

Second, most nonparticipants sought health care services only in emergencies. Eleven telephone interviewees sought health care when there was a crisis, whereas four used services for themselves in emergencies but sent their children for regular medical and dental checkups. Only six people had routine health care for themselves and their children, but in two instances identified medical problems (for example, high blood pressure or thyroid condition) were the reasons care was sought.

Third, misunderstanding, disinterest, and lack of notification were the main reasons cited for nonenrollment in the BET health plan. Eight of the 24 people interviewed said misunderstanding or confusion about the program was the primary reason for not participating. For example, two dropped out of the health plan because they believed the temporary policy excluded dental and optical care; one dropped out because she could not meet the $100 deductible,

not realizing that BET would directly pay the deductibles and all uncovered costs. Another interviewer believed that she did not meet the requirements of the health plan because her earnings were too high; in effect, she mistook eligibility for BET coverage for that of AFDC or food stamps.

Four other interviewees gave reasons that can be categorized as lack of interest. One person dropped out of the temporary insurance because she did not want to deal with all the changes in procedure, such as having to send in receipts and renew the policy every three months. Another was interrupted while reading the BET health care letter and never finished it. A third person received an orientation and letter about the health plan. He expressed an interest in the coverage, but was in the process of moving and never contacted BET.

Four other interviewees claimed that they never received letters announcing the health plan; however, no letters were returned by the post office or to the BET office. One person did not renew and one did not follow up because of conflicts in job schedules, and a third client misplaced the renewal letter and found it only after her policy had lapsed. Another client contacted BET and stated that she did not need health insurance because the hospital was obligated to provide services. Lastly, one woman did not use the plan because she believed that BET had helped her enough and she wanted to be self-sufficient.

The fourth finding was that clients who were eligible for the BET health plan had significantly lower Medicaid expenditures than the AFDC population as a whole (Table 1). For fiscal year (FY) 1988, the study population had Medicaid expenses that on average were 49 percent less than for AFDC recipients in Wicomico County and 41 percent less than the state adult mean. The children of eligible study participants averaged 30 percent less than the AFDC child recipients in Wicomico County and 25 percent less than the overall state mean for children. In all groups, adults used more health care services than did children.

When the study population is subdivided, these results are more clearly differentiated (Table 2). For FY 1988, the study's nonparticipants averaged 56 percent fewer Medicaid expenses than the Wicomico County adult AFDC recipients and 49 percent less than the state average. The average Medicaid cost for an AFDC child in Wicomico County and the state compared with a child in the nonparticipant study group was 45 percent and 41 percent higher, respectively.

Conversely, the Medicaid costs of adult participants were 35 percent higher than those of nonparticipants. Also, the children of participants had medical expenses that were nearly double those of their nonparticipant counterparts and higher than the county and state groups. This may be a result of the small group size, in which several large expenditures artificially inflate the mean. For example, one person had 11 inpatient days, and one child had psychotherapy that would have cost $5,000 over a year's time.

Table 1. Average Yearly Medicaid Expenditures for Adults and Children (in dollars)

Sample	Adult	Child
Study population	789	550
Wicomico County AFDC		
Fiscal year 1988	1,544	780
Fiscal year 1987	1,251	734
Maryland AFDC Average		
Fiscal year 1988	1,338	729
Fiscal year 1987	1,056	713

NOTE: AFDC = Aid to Families with Dependent Children.

Table 2. Average Projected Yearly Medicaid Expenditures for Study Population Subgroups

Subgroup	Adult ($)	Child ($)
Participants	1,050	855
Dropouts	926	649
Nonparticipants	679	432
Wicomico AFDC (fiscal year 1988)	1,544	780
Maryland AFDC (fiscal year 1988)	1,338	729

NOTE: AFDC = Aid to Families with Dependent Children.

Finally, all interviewees preferred employment to AFDC. With an average hourly wage of $4.39, most of these former AFDC recipients were at best marginally better off economically than when they were receiving welfare benefits. Most worked in the secondary labor market with few fringe benefits, while their AFDC, food stamps, and Medicaid entitlements were cut off or sharply reduced. Nevertheless, all interviewees preferred being employed to remaining on public assistance. With one exception, all stated a preference to continue to work even if AFDC paid the same amount as their current jobs.

Furthermore, in 11 instances, interviewees associated holding a job with feelings of self-worth, which was expressed as self-esteem, a sense of confidence and self-assurance, working toward a future, and standing on one's own two feet. Six gave another closely related reason for working as the satisfaction of earning money through their own efforts rather than receiving a handout from the state. Six mentioned that they enjoyed the work itself. Three people saw the welfare system as a hassle and a personal humiliation, and three preferred to be paid weekly or biweekly rather than wait for a monthly AFDC check. Transportation and child care generally were not problems that interfered with employment.

DISCUSSION

Analyzing Costs

The first consideration for policy is the need to more critically analyze health care costs by differentiating AFDC recipients who find and retain jobs from recipients who remain on welfare. The study focused on eligible clients who obtained jobs and then dropped out or failed to participate in the BET health care demonstration. What emerged was a picture of individuals who perceived themselves to be reasonably healthy and who were motivated to work. As a group, their Medicaid expenditures for the year before leaving the welfare system were less than one-half of the average medical cost for an AFDC adult in both Wicomico County and the state as a whole. Because they had perceived little need for health coverage, they did not consider securing health insurance to be a high priority.

It is not clear whether the strong work motivation was a function of better health or whether the desire to hold a job overrode all but the most serious health problems. The low health care use of this population is consistent with medical studies that have identified "perceived health status" as a key indicator of number of physician visits and costs (Buczko, 1986; Evashwick, Rowe, Diehr, & Branch, 1984). Connelly, Philbrick, Smith, Kaiser, and Wymer (1989) found that patients with the lowest health perception scores had significant levels of anxiety, depression, and health-related worry. Not surprisingly, these people had the highest levels of ambulatory health care use.

In this study, the low Medicaid costs of the nonparticipants were associated with a crisis orientation toward health care. As one woman expressed it, "I wait until I can't stand it any longer." Only emergencies warranted intervention, and these clients were reluctant to avail themselves and their children of needed services. Anderson, Buck, Danaher, and Fry (1977) reached the same conclusion: Although nonusers of primary care physicians perceived themselves to be healthier, were more likely to treat themselves, and scored higher in self-sufficiency, they also were less inclined to obtain medical care for potentially serious symptoms and found a greater number of practical obstacles for not visiting a physician. Therefore, the authors of this study are concerned that these tendencies can lead to an underuse of necessary services and that self-care should be encouraged through a doctor-patient relationship that fosters health education.

The findings also suggest that a more critical assessment be made of the health care costs for the AFDC population. Specifically, the distinction should be sharpened between job-ready clients and clients less likely to hold jobs. Clients who are able and willing to work may more closely resemble the marginally employed than the long-term welfare recipient in attitudes toward work and health care use. Indeed, a cursory look at the expenditures of the study groups showed that the costs were for routine

procedures and that there was a conspicuous absence of services for drug and alcohol dependency, AIDS, and psychotherapy. Thus, job-ready recipients may represent no higher risk to private health insurers than other workers.

There are a number of reasons why AFDC recipients who become employed may have lower health care expenditures on average than non-AFDC employees. Former AFDC recipients are more likely to lack information about health care and to experience transportation difficulties. They have less time to use health care services when they are employed. The latter reason was confirmed by Levey, MacDowell, and Levey (1986), who found that nonpoor children in Iowa had fewer routine physician visits than AFDC children, because both parents were usually working.

These findings have implications for the medical assistance extension options that states may choose to pursue under the Family Support Act. Because job-ready AFDC recipients have lower health care expenditures, the most cost effective alternative for states may be simply to continue Medicaid coverage. The primary alternative to extending regular Medicaid, "buying-in" to employer coverage, would be very complex and costly to administer. Most states do not possess a computer system designed to handle these particular claims—that is, to coordinate the numerous policies and to track deductibles, coinsurance, and noncovered services. Because the extended coverage must be equivalent to what was available under Medicaid, clients would continue to use Medicaid to pay for health care that is not included in a given employer policy. Additionally, the premiums for the "buy-in" would probably be more costly than the actual Medicaid expenditures incurred, even if states promoted the importance of preventive health care.

However, the selection of straight Medicaid may be more cost-effective for the state, but it may not be the most convenient policy for clients to use. Although Medicaid provides a wider range of coverage than other health insurance plans, services may not be as readily available because of the lack of providers who are willing to accept Medicaid.

Need for Education

The second consideration for policy is a need to incorporate an educational component in the Job Opportunities in the Business Sector (JOBS) program to enable AFDC recipients to better understand and access medical services. The BET health care demonstration project touches on some basic issues about the place of health care in a welfare-to-work strategy. If health is considered a significant factor in obtaining and maintaining employment, then more thought should be given to the kinds of programs that would make health care better understood and appreciated. The experience of this demonstration indicates that programs that provide needed services may be underused if their underlying assumptions are not shared by the targeted client group. The programmatic question is the extent to which client values must be shaped and services aggressively promoted to increase participation.

Among the clients contacted who had minimal or no coverage, almost all lacked the middle-class perspective that health insurance was protection against unanticipated illnesses or injuries and that its importance was having rather than necessarily using it. These clients articulated more of a present-need orientation toward health care. Generally, they sought services for themselves and their children when there were pressing needs. Concomitantly, there was little emphasis on preventive care. In the absence of emergencies, the urgency of obtaining health insurance was minimized. This attitude was best exemplified by one person who did not renew her health policy because she had not used it for three months. If the insurance was never used because she and her children were healthy, she reasoned, why spend the time and bear the inconvenience of renewing the policy? Judging from their Medicaid expenditures in the year before they left the welfare rolls, these clients may in fact have been in good health and thus more willing to risk the probability that this well-being would continue.

The low-priority explanation, however, is not entirely correct. Telephone interviews also indicated that many of these clients were not knowledgeable about how to access the health

care system. A number of people had little understanding of how the health program operated; some confused the plan with eligibility for food stamps or AFDC. Some people were not aware that BET would pay for services not covered by their present policies. Similar results were found by Reis and Olson (1987), who reported that inner-city Chicago residents did not know about the operational features of Medicaid prepaid plans and were reluctant to enroll.

A common obstacle to use of the health plan was client passivity. For example, when BET mailed announcements of the program and stipulated the cutoff date for Medicaid or insurance renewal, people who delayed calling assumed that they were no longer eligible for services. It did not occur to them to call the BET office and appeal for a reconsideration of their cases. Similarly, most clients never called to ask for clarification of the plan or to make other arrangements for missed appointments. If job hours or transportation difficulties interfered with their coming in person to the BET office, few considered mailing receipts and other documentation.

As part of the study's telephone interview, people were given the opportunity to reapply for BET health benefits. The BET program was clarified and presented with reference to the person's situation. In a number of cases, individuals had pressing treatment needs, which they either postponed or paid from personal funds. All of the interviewees said at the time of the interview that they understood the health plan. Most said that they would use the coverage while it was available, yet only two of the 14 telephone interviewees with limited or no insurance followed up by contacting the BET office. Providing information and marketing the program did not lead to increased participation.

CONCLUSION

This study raises important issues about health care for AFDC recipients. Given the small number of subjects, however, these findings should be interpreted with caution. More research is needed to better identify the differential patterns of health care awareness and use in this population. Nevertheless, states must make choices and deliver services in the absence of definitive knowledge, and this demonstration signals some of the problems in providing transitional health coverage.

The interview data clearly indicate that health care awareness must be cultivated. It cannot be assumed that health services are understood, appreciated, or valued by former AFDC recipients. In the words of the BET counselor who worked closely with the health plan, "One hour of orientation does not compensate for years of handling problems and approaching health care in familiar ways."

Social workers can enable AFDC clients to use the health care system with confidence by nurturing attitudes and teaching clients health insurance operations and medical care access skills. This goal might be accomplished by incorporating a health education curriculum into the JOBS program. The state of Maryland has developed such a classroom training module in its Project Independence (JOBS) program.

Unfortunately, limited federal and state funding means that only a small percentage of AFDC recipients will participate in JOBS. In fact, the Family Support Act only requires that states serve 7 percent of their mandatory caseload. A much larger percentage of people in each state's caseload will obtain jobs on their own, and many may not be aware of their extended medical assistance options.

If a national policy goal is the enhancement of health, then people who are most vulnerable and least knowledgeable must become informed consumers of health care. Human services organizations involved in welfare-to-work programs should emphasize the development of a health ethic in conjunction with a work ethic. As direct service workers, supervisors, and administrators in both income maintenance and employment and training programs, social workers should be advocates for this approach. They should recognize that good health in their clients is a basis for self-determination as well as self-sufficiency.

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