# Health care Coverage Gaps Among the Working Poor: *Low-Wage Workers, Medicaid Eligibility and Employer Subsidized Plans*

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Health care coverage continues to be a topic of concern for policymakers, employers, academics, and anyone who gets sick in the United States. The perverse predicament low-wage workers, in particular, face when it comes to accessing affordable, quality health care warrants further scrutiny and discussion. Many low-income people are unable to afford private insurance, even through their employer, and rely on coverage through programs like Medicaid and the Children's Health Insurance Program (CHIP) to access the health care they need. Black, Latinx, and Indigenous people are concentrated in low-wage, largely service occupations and as a result are much more likely than their white counterparts to utilize Medicaid for their health coverage needs.[1]

The failure of large employers to provide living wages and robust benefits, along with policymakers ignoring the needs of their constituents, create a unique health care crisis for the working poor in this country - i.e., a coverage gap for people earning too much to qualify for Medicaid but too little to qualify for Affordable Care Act (ACA) marketplace subsidies or the out-of-pocket expenses associated with employer-sponsored plans (premiums, deductibles and copays).[2] The consequence of this coverage gap is that millions of working poor people do not qualify for or cannot afford any health care coverage at all.

Approximately, 2.2 million people fall into the coverage gap because they earn an income too high to qualify for Medicaid and too low to qualify for ACA marketplace subsidies.[3] Because of systemic racism, six in ten people in the coverage gap are Black and brown people.[4] Lawmakers can and must act to address the health care coverage disparities faced by the working poor by expanding Medicaid in the 11 states that currently have not done so.

In the states that have not expanded Medicaid eligibility, the working poor either forgo care altogether or accrue substantial medical debt after being forced to rely on emergency room (ER) care for basic health care needs. In states that have expanded eligibility, income thresholds require many low-wage workers to purchase coverage from the state or federal health insurance exchanges established by the Affordable Care Act (ACA) or obtain coverage through their employer. For many low-wage workers, out-of-pocket costs to cover premiums, co-pays, and deductibles can consume a huge percentage of their already

[1] https://www.kff.org/medicaid/issue-brief/medicaid-and-racial-health-equity/
[2] https://www.bls.gov/opub/reports/working-poor/2019/home.htm
[3] https://www.cbpp.org/research/health/federal-action-needed-to-close-medicaid-coverage-gap-extend-coverage-to-22-million
[4] https://www.cbpp.org/research/health/closing-medicaid-coverage-gap-would-help-diverse-group-and-narrow-racial

meager take home pay. Our current health care structures are premised on the American Dream, but the hurdles of accessing health care for the working poor puts that dream in jeopardy for millions of Americans.

*Former Walmart associate Jeana told us she is a 50-year-old woman who has worked in retail since the age of 18 and dedicated her life to exceptional customer service. She has worked at Walmart and other major retail stores being everything from a cashier to an overnight stocker. During the pandemic, she also took on the role of maintenance associate at Walmart making sure her store was sanitized and compliant with health and safety policies. Work-induced stress and anxiety, which increased during the pandemic, led Jeana to seek mental health attention. Unfortunately, Jeana soon realized that even with her health insurance provided by Walmart, copays were too high. On some occasions, her Walmart health coverage refused to cover the cost of her doctor visits, prescriptions, and treatments. Jeana decided to apply for Medicaid in hopes of a solution, but unfortunately, she was denied because she made "too much money" to qualify. This resulted in her current medical debt of thousands of dollars and the decision to completely stop seeking medical treatment. Jeana believes she falls into the Medicaid coverage gap, where she makes too much money to qualify for Medicaid but does not make enough money to afford her health care needs.*

As enacted, the ACA expanded Medicaid coverage to adults with incomes up to 138 percent of the federal poverty level (FPL), with subsidized marketplace coverage available to those individuals with higher incomes.[5] However, in a 2014 decision, the Supreme Court allowed states to choose whether to expand Medicaid. In states that chose to expand Medicaid eligibility, coverage is generally accessible for people up to the point of qualifying for subsidies for exchange plans.

Qualifying for Medicaid in states that have not expanded eligibility is much more challenging. There are onerous rules and conditions imposed that limit the number of people who qualify. Those rules vary from state to state. Children and pregnant people generally qualify for Medicaid coverage, however it may not be comprehensive health coverage.  Seniors and people with disabilities will typically qualify, but childless adults do not qualify for Medicaid coverage in any non-expansion state. In fact, parents often do not qualify for any access to coverage, even when their children are eligible for Medicaid or CHIP, leaving many caregivers unable to visit a doctor or afford necessary medications and treatments.[6]

[5] https://www.congress.gov/111/plaws/publ148/PLAW-111publ148.pdf
[6] https://ccf.georgetown.edu/wp-content/uploads/2021/02/Kids-and-Medicaid-expansion_2-19.pdf

Over two million adults that live in non-expansion states fall in this coverage gap with incomes too high to qualify for Medicaid but too low to qualify for ACA marketplace subsidies.[7] These people will often be forced to rely on the Emergency Room (ER) to meet their health care needs. People with no health insurance coverage tend to use the ER for ailments that are not true emergencies or to delay seeking care until problems become an emergency.[8]

In four states that have not expanded Medicaid eligibility that hold some of the highest number of people who could benefit from Medicaid expansion, the income level for pregnant people, parents, and caretakers are as follows:

**Percentage of Federal Poverty Level (FPL)**

| State | Pregnant Women | Parent / Caretaker |
|---|---|---|
| Georgia | 225% | 33% |
| North Carolina | 201% | 39% |
| South Carolina | 199% | 67% |
| Texas | 207% | 16% |

Source: The Kaiser Family Foundation (KFF)

*CORRECTION: An earlier version of this report included inaccurate eligibility thresholds. We have updated all figures in the table based on thresholds provided by the Kaiser Family Foundation.*

## The Coverage Crisis for Low-Wage Workers

People who work for employers who pay low-wages certainly need access to health care but that access must be paired with other important policy changes, including fair scheduling and increased hourly wages, to ensure working people can be healthy and thrive.

The call to raise the hourly minimum wage to $15 is now a decade old, and while some employers have heeded the call to raise wages without being required by law to do so, it is imperative that we recognize $15 no longer constitutes a living wage in most places, including Southern states like Georgia, North Carolina, South Carolina, and Texas.[9] Additionally, many low-wage workers lack access to full-time hours which further reduces annual take home pay.

For example, a part-time worker earning $15 an hour, working approximately 23 hours a week would qualify for coverage in expansion states but would not qualify for coverage in states that have not expanded Medicaid eligibility as the

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[7] https://www.cbpp.org/research/health/federal-action-needed-to-close-medicaid-coverage-gap-extend-coverage-to-22-million

[8] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2793356

[9] https://livingwage.mit.edu/

median income limit in non-expansion states is 41% of FPL.[10] Once a person's annual income exceeds $8,905 their only option is to purchase a plan on the federal or state exchange or buy into whatever plan their employer offers, if they can afford to do so. ACA marketplace subsidies are based on income, up to 400% of FPL,[11] and annual premiums go up with any income increases. Premiums also vary by state and by age tier.

For a 28-year-old individual who earns enough to purchase a plan on the exchange in Georgia, Texas, North Carolina, or South Carolina, the premium costs are as follows:[12]

**Individual - Age 28**

Annual Premium in $

| Income | FPL | Georgia | Texas | North Carolina | South Carolina |
|---|---|---|---|---|---|
| $18,032 | 140% | $0.00 | $0.00 | $0.00 | $0.00 |
| $22,540 | 175% | $225.40 | $225.40 | $225.40 | $225.40 |
| $28,980 | 225% | $869.40 | $869.40 | $869.40 | $869.40 |
| $35,420 | 275% | $1,771.00 | $1,771.00 | $1,771.00 | $1,771.00 |
| $41,860 | 325% | $2,720.90 | $2,720.90 | $2,720.90 | $2,720.90 |
| $51,520 | 400% | $4,152.00 | $4,379.20 | $4,379.20 | $3,840.00 |

Annual Premium (% of Income)

| Income | FPL | Georgia | Texas | North Carolina | South Carolina |
|---|---|---|---|---|---|
| $18,032 | 140% | 0.0% | 0.0% | 0.0% | 0.0% |
| $22,540 | 175% | 1.0% | 1.0% | 1.0% | 1.0% |
| $28,980 | 225% | 3.0% | 3.0% | 3.0% | 3.0% |
| $35,420 | 275% | 5.0% | 5.0% | 5.0% | 5.0% |
| $41,860 | 325% | 6.5% | 6.5% | 6.5% | 6.5% |
| $51,520 | 400% | 8.1% | 8.5% | 8.5% | 7.5% |

[10] https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines and https://www.kff.org/health-reform/state-indicator/medicaid-income-eligibility-limits-for-adults-as-a-percent-of-the-federal-poverty-level/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[11] https://www.kff.org/report-section/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid-issue-brief-8659-10/#endnote_link_508791-1

[12] Because these four states have not expanded Medicaid, we are relying on data from their exchange plans.

For a family of four – ages 40, 38, 10, and 8 in those states, the premiums are as follows:

**Annual Premium in $**

| Income | FPL | Georgia | Texas | North Carolina | South Carolina |
|---|---|---|---|---|---|
| $37,100 | 140% | $0 | $0 | $0 | $0 |
| $46,375 | 175% | $464 | $464 | $464 | $464 |
| $59,625 | 225% | $1,789 | $1,789 | $1,789 | $1,789 |
| $72,875 | 275% | $3,644 | $3,644 | $3,644 | $3,644 |
| $86,125 | 325% | $5,598 | $5,598 | $5,598 | $5,598 |
| $106,000 | 400% | $9,010 | $9,010 | $9,010 | $9,010 |

**Annual Premium (% of Income)**

| Income | FPL | Georgia | Texas | North Carolina | South Carolina |
|---|---|---|---|---|---|
| $37,100 | 140% | 0.0% | 0.0% | 0.0% | 0.0% |
| $46,375 | 175% | 1.0% | 1.0% | 1.0% | 1.0% |
| $59,625 | 225% | 3.0% | 3.0% | 3.0% | 3.0% |
| $72,875 | 275% | 5.0% | 5.0% | 5.0% | 5.0% |
| $86,125 | 325% | 6.5% | 6.5% | 6.5% | 6.5% |
| $106,000 | 400% | 8.5% | 8.5% | 8.5% | 8.5% |

This cost is only to get access to health insurance. When people seek services, they will also need to pay deductibles and copays – along with the premium, these are commonly referred to as Out-of-Pocket costs (OOP).

*Nicole told us she has been working at Walmart for almost five years, and because she is a full-time employee, she has access to the Walmart-provided health insurance. Nonetheless, the out-of-pocket costs have become a burden for Nicole. Every time she visits a doctor, she must pay a $35 copay, and if she visits a specialist, it is $75, which is more than she makes in one day of work. Having to visit a specialist has become a financial decision, based on whether she can afford to take the day off and pay the cost, or has to struggle through the pain and earn her wages. Recently, Nicole has delayed seeking medical attention and even canceled scheduled specialist doctor visits to avoid medical debt.*

## Pregnant People in the Coverage Gap May Accrue Substantial Medical Debt

For a woman who has an uncomplicated pregnancy and delivery, the total costs are as follows:

| | | Premium + OOP Cost (baby) in $ | | | |
|---|---|---|---|---|---|
| Income | FPL | Georgia | Texas | North Carolina | South Carolina |
| $18,032 | 140% | $860 | $1,560 | $1,060 | $835 |
| $22,540 | 175% | $2,985 | $3,135 | $3,185 | $1,585 |
| $28,980 | 225% | $6,429 | $7,929 | $7,139 | $5,429 |
| $35,420 | 275% | $8,631 | $9,931 | $9,241 | $7,981 |
| $41,860 | 325% | $9,581 | $10,881 | $10,191 | $8,931 |
| $51,520 | 400% | $11,012 | $12,539 | $11,849 | $10,050 |

| | | Premium + OOP Cost (baby) (% of Income) | | | |
|---|---|---|---|---|---|
| Income | FPL | Georgia | Texas | North Carolina | South Carolina |
| $18,032 | 140% | 4.8% | 8.7% | 5.9% | 4.6% |
| $22,540 | 175% | 13.2% | 13.9% | 14.1% | 7.0% |
| $28,980 | 225% | 22.2% | 27.4% | 24.6% | 18.7% |
| $35,420 | 275% | 24.4% | 28.0% | 26.1% | 22.5% |
| $41,860 | 325% | 22.9% | 26.0% | 24.3% | 21.3% |
| $51,520 | 400% | 21.4% | 24.3% | 23.0% | 19.5% |

For a 28-year woman in Texas earning $29,000 a year, the annual cost of her premiums to purchase individual coverage will be $869. If she becomes pregnant and has an uncomplicated natural birth, she will incur an additional $7,060 in OOP costs to pay for deductibles, copays, and prenatal vitamins that are not covered by insurance. Combined with her premiums, she will need to pay $7,929 (27% of her pre-tax income) out-of-pocket. While plans have an out-of-pocket maximum, the premiums do not count toward that OOP maximum. A person in this income category has access to a plan with an OOP maximum of $6,950, but the scenario includes costs that are not covered by the benefit (like prenatal vitamins).

As people's income goes up, their OOP maximum also goes up. For example, if the woman in Texas earned $35,420 (275% of FPL), she could spend up to $10,471 or 30% of her income on health care.

The annual premium plus the OOP Max is as follows:

| | | Premium + OOP Maximum in $ | | | |
|---|---|---|---|---|---|
| Income | FPL | Georgia | Texas | North Carolina | South Carolina |
| $18,032 | 140% | $1,000 | $1,500 | $1,000 | $775 |
| $22,540 | 175% | $3,125 | $3,125 | $3,125 | $2,425 |
| $28,980 | 225% | $7,369 | $7,819 | $7,819 | $5,444 |
| $35,420 | 275% | $10,271 | $10,471 | $10,471 | $8,221 |
| $41,860 | 325% | $11,221 | $11,421 | $11,421 | $9,171 |
| $51,520 | 400% | $12,652 | $13,079 | $13,079 | $10,290 |

| | | Premium + OOP Maximum (% of Income) | | | |
|---|---|---|---|---|---|
| Income | FPL | Georgia | Texas | North Carolina | South Carolina |
| $18,032 | 140% | 5.5% | 8.3% | 5.5% | 4.3% |
| $22,540 | 175% | 13.9% | 13.9% | 13.9% | 10.8% |
| $28,980 | 225% | 25.4% | 27.0% | 27.0% | 18.8% |
| $35,420 | 275% | 29.0% | 29.6% | 29.6% | 23.2% |
| $41,860 | 325% | 26.8% | 27.3% | 27.3% | 21.9% |
| $51,520 | 400% | 24.6% | 25.4% | 25.4% | 20.0% |

The same pattern holds for a family of four.

## Employer-Sponsored Coverage at Amazon and Walmart: A Double Edged Sword for Workers

The situation may improve if a worker qualifies for employer-sponsored health insurance, but not in all cases. By looking at plans offered by the two largest private sector employers in the United States - Walmart and Amazon - we can see the difficult decisions workers face as they consider their health care options. If we assume the same woman works 40 hours a week at $15/hr, she will earn $31,200/yr pretax – or 242% FPL. As an individual she can purchase a plan ranging from $396/yr (1.27% of income) with Amazon or up to $2,308.80/year (7.4% of income) with the most expensive Walmart premium. If she is a smoker, the cost for the Walmart plan goes up to $4,617.60/yr (14.8% of income). Employee contributions (premiums) are based on electing individual, individual +1, or family coverage rather than demographics and income level like the ACA plans. For this analysis, we assume if there are 2 adults on the plan, both are working $15/hour, 40 hour/week jobs.

**Premium Only in $**

| | Income | AMAZON SHARED DEDUCTIBLE PLAN | Walmart Premier Plan - National | Walmart Saver Plan - National | Walmart Contribution Plan - Nationa |
|---|---|---|---|---|---|
| Individual (no tobacco) | $31,200 | $396.00 | $816.40 | $910.00 | $2,308.80 |
| Individual (tobacco user) | $31,200 | $396.00 | $1,632.80 | $1,820.00 | $4,617.60 |
| Individual + child(ren) (no tobacco) | $31,200 | $2,208.00 | $1,307.80 | $1,430.00 | $3,255.20 |
| individual + child(ren) (tobacco user) | $31,200 | $2,208.00 | $2,124.20 | $2,340.00 | $5,564.00 |
| Individual + Adult (no tobacco) | $62,400 | $2,700.00 | $4,131.40 | $4,323.80 | $7,807.80 |
| Individual + Adult (1 tobacco user) | $62,400 | $2,700.00 | $4,947.80 | $5,233.80 | $10,116.60 |
| Individual + Adult (2 tobacco users) | $62,400 | $2,700.00 | $5,764.20 | $6,143.80 | $12,425.40 |
| Family (no tobacco) | $62,400 | $4,488.00 | $4,846.40 | $4,992.00 | $8,361.60 |
| Family (1 tobacco user) | $62,400 | $4,488.00 | $5,662.80 | $5,902.00 | $10,670.40 |
| Family (2 tobacco users) | $62,400 | $4,488.00 | $6,479.20 | $6,812.00 | $12,979.20 |

**Premiums as % of Income**

| | | | | | |
|---|---|---|---|---|---|
| Individual (no tobacco) | $31,200 | 1.3% | 2.6% | 2.9% | 7.4% |
| Individual (tobacco user) | $31,200 | 1.3% | 5.2% | 5.8% | 14.8% |
| Individual + child(ren) (no tobacco) | $31,200 | 7.1% | 4.2% | 4.6% | 10.4% |
| individual + child(ren) (tobacco user) | $31,200 | 7.1% | 6.8% | 7.5% | 17.8% |
| Individual + Adult (no tobacco) | $62,400 | 4.3% | 6.6% | 6.9% | 12.5% |
| Individual + Adult (one tobacco user) | $62,400 | 4.3% | 7.9% | 8.4% | 16.2% |
| Individual + Adult (two tobacco users) | $62,400 | 4.3% | 9.2% | 9.8% | 19.9% |
| Family (no tobacco) | $62,400 | 7.2% | 7.8% | 8.0% | 13.4% |
| Family (one tobacco user) | $62,400 | 7.2% | 9.1% | 9.5% | 17.1% |
| Family (two tobacco users) | $62,400 | 7.2% | 10.4% | 10.9% | 20.8% |

*Mark, who currently works at Walmart, said, "I qualify for the health plan but I cannot afford it. Without access to health care, I can't see a doctor or go to a hospital when I need it. I just try to fix myself, but I have arthritis in my legs and hips. If I'm in too much pain, I'm forced to miss work. I usually have to wear shoes with a lot of padding or occasionally use a cane just to make it through my shift. I'm only 55, I should be able to work fine until retirement but now it feels like I'm fighting just to make it there. Last February I contracted COVID but I couldn't go to the hospital. It caused my arthritis to flare up, and it felt like someone beat me up with a baseball bat. Sometimes I'm in so much pain I just have to go to bed. I've used my limit of PPTO (Protected Paid Time Off) and it won't reset until next February. I have really bad days where I just have to push through the pain."*

Adding in the OOP cost share for an uncomplicated pregnancy and delivery brings up the costs to $2,456 (7.87% of income) with Amazon, or $6,828.80 with Walmart if she is a non-smoker, or 21.89% of income. Once she accesses benefits, given her income level, the plans become comparable to ACA plans, sometimes slightly better or worse depending on the state.

| | | **Premium + OOP (Baby)** | | | |
|---|---|---|---|---|---|
| | Income | AMAZON SHARED DEDUCTIBLE PLAN | Walmart Premier Plan - National | Walmart Saver Plan - National | Walmart Contribution Plan - National |
| Individual (no tobacco) | $31,200 | $2,456.00 | $6,136.40 | $6,380.00 | $6,828.80 |
| Individual (tobacco user) | $31,200 | $2,456.00 | $6,952.80 | $7,290.00 | $9,137.60 |
| Individual (no tobacco) | $31,200 | 7.9% | 19.7% | 20.4% | 21.9% |
| Individual (tobacco user) | $31,200 | 7.9% | 22.3% | 23.4% | 29.3% |

As discussed above, if a person seeks other services, they are likely to hit their OOP Max. The Premium plus OOP Max is as follows:

**Premium + OOP Max in $**

| | Income | AMAZON SHARED DEDUCTIBLE PLAN | Walmart Premier Plan - National | Walmart Saver Plan - National | Walmart Contribution Plan - National |
|---|---|---|---|---|---|
| Individual (no tobacco) | $31,200 | $2,396.00 | $7,666.40 | $7,560.00 | $9,158.80 |
| Individual (tobacco user) | $31,200 | $2,396.00 | $8,482.80 | $8,470.00 | $11,467.60 |
| Individual + child(ren) (no tobacco) | $31,200 | $8,208.00 | $15,007.80 | $14,730.00 | $16,955.20 |
| individual + child(ren) (tobacco user) | $31,200 | $8,208.00 | $15,824.20 | $15,640.00 | $19,264.00 |
| Individual + Adult (no tobacco) | $62,400 | $6,700.00 | $17,831.40 | $17,623.80 | $21,507.80 |
| Individual + Adult (one tobacco user) | $62,400 | $6,700.00 | $18,647.80 | $18,533.80 | $23,816.60 |
| Individual + Adult (two tobacco users) | $62,400 | $6,700.00 | $19,464.20 | $19,443.80 | $26,125.40 |
| Family (no tobacco) | $62,400 | $10,488.00 | $18,546.40 | $18,292.00 | $22,061.60 |
| Family (1 tobacco user) | $62,400 | $10,488.00 | $19,362.80 | $19,202.00 | $24,370.40 |
| Family (2 tobacco users) | $62,400 | $10,488.00 | $20,179.20 | $20,112.00 | $26,679.20 |

**Premium + OOP Max as % of Income**

| | | | | | |
|---|---|---|---|---|---|
| Individual (no tobacco) | $31,200 | 7.7% | 24.6% | 24.2% | 29.4% |
| Individual (tobacco user) | $31,200 | 7.7% | 27.2% | 27.1% | 36.8% |
| Individual + child(ren) (no tobacco) | $31,200 | 26.3% | 48.1% | 47.2% | 54.3% |
| individual + child(ren) (tobacco user) | $31,200 | 26.3% | 50.7% | 50.1% | 61.7% |
| Individual + Adult (no tobacco) | $62,400 | 10.7% | 28.6% | 28.2% | 34.5% |
| Individual + Adult (one tobacco user) | $62,400 | 10.7% | 29.9% | 29.7% | 38.2% |
| Individual + Adult (two tobacco users) | $62,400 | 10.7% | 31.2% | 31.2% | 41.9% |

| | | | | | |
|---|---|---|---|---|---|
| Family (no tobacco) | $62,400 | 16.8% | 29.7% | 29.3% | 35.4% |
| Family (one tobacco user) | $62,400 | 16.8% | 31.0% | 30.8% | 39.1% |
| Family (two tobacco users) | $62,400 | 16.8% | 32.3% | 32.2% | 42.8% |

Note that we assumed for these calculations that if there were 2 adults in the family, there would be 2 incomes totaling $62,400/yr combined. However, there are many families that are not fortunate enough to have 2 full-time steady income earners. If one person is laid off, the percentage of family income that goes toward health insurance could double. A family of 4 with only 1 income earner, with no tobacco users, could spend between 34%-70% of the household income on health care on a company plan. At that point, the ACA plans become the better option.

*Dawn, a Walmart worker in North Carolina, told us, "I qualify for the Wal-Mart health plan but it costs $500 a month and I only make $1600. I can't afford to pay a quarter of my monthly income for health care. Because of this, my husband and I are skipping medications that we need. On top of that, my two kids haven't seen a doctor in years. If one of us gets sick or injured, all we can do is hope for the best."*

The preceding analysis only takes into consideration a person's gross income and does not factor in other costs families face like rent, utilities, food, transportation, childcare, entertainment, etc. Additionally, once a person crosses the Medicaid threshold into the ACA marketplace subsidized plans or employer-sponsored plans, deductibles, copays and network limitations must also be taken into consideration. Employer-sponsored plans may include a Health Reimbursement Agreement (HRA), Health Savings Account (HSA), or Flexible Spending Account (FSA) account to offset these costs, but they also create an additional administrative burden for the worker and their family. It is difficult to navigate the complicated cost structures of the health care system, and even more time consuming and confusing if someone makes a mistake. All of this has a cost that is difficult to calculate.

## Addressing the Low-Wage Worker Coverage Crisis Requires Public and Private Action

When it comes to affordable health care coverage, there are simply no good options for the working poor. The reality for most low-wage workers is that the

American Dream remains out of reach, even when one is employed by the largest corporations in the world. Given the inequitable health care outcomes outlined above, it is imperative that our nation's public and private leaders take immediate steps to close these gaps.

An effective multi-pronged approach to mitigate these gaps would, at minimum, include:

1. Lawmakers expanding medicaid eligibility in the states that have not yet done so.
2. Policymakers working with insurance companies to lower the cost of ACA marketplace plans.
3. Large corporate employers like Amazon and Walmart must increase eligibility and participation in employer-sponsored plans while leveraging their market power to lower costs and improve the quality of those plans.

In the 11 states that have not expanded Medicaid, policymakers can immediately take action to address some of the concerns that workers who fall into the coverage gap face by expanding Medicaid. Expanding Medicaid is even more critical now given the end of the COVID-19 Public Health Emergency next month. On April 1, 2023, states will resume reviewing all Medicaid enrollees' eligibility, also known as "unwinding," ending coverage for those found ineligible.[13] Millions of eligible individuals and families, particularly people of color and children, are at risk of losing coverage during the unwinding process due to administrative hurdles they must overcome to maintain their coverage.[14] According to Center on Budget and Policy Priorities, "Leaders in these states should prioritize expanding Medicaid to protect people's coverage, and to take advantage of a well-timed boost in federal incentive funding available to states that newly expand."

This policy, which 39 states and the District of Columbia have enacted, will also help low-wage workers get the care they need without going into medical debt. Paired with other critical policy changes, including increasing the minimum wage and full-timing the hours worked, expanding Medicaid is a necessary step to take for low wage workers to access the care they need.

Another critical step for policymakers is to use whatever power they have to lower the out-of-pockets costs associated with the ACA marketplace plans. As

[13] https://www.cbpp.org/research/health/last-11-states-should-expand-medicaid-to-maximize-coverage-and-protect-against

[14] https://www.cbpp.org/research/health/states-must-act-to-preserve-medicaid-coverage-as-end-of-continuous-coverage

shown above, these costs can be substantial and present a burden to low-wage workers already struggling to make ends meet.

Finally, large private employers like Walmart and Amazon must leverage their purchasing power in the market to lower the cost of employer-sponsored plans while expanding the services those plans cover. Increasing participation in employer-sponsored plans can help mitigate the Medicaid eligibility cliffs that come with wage increases, but employers must recognize that an individual's decision to participate in those plans will be determined by the wages an employee earns and an assessment of the cost and quality of the plan offered by the employer.