CENTER ON BUDGET AND POLICY PRIORITIES

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CONGRESS HAS A $28 BILLION OPPORTUNITY TO EXPAND COVERAGE FOR LOW-INCOME WORKING FAMILIES WITH CHILDREN

by Jocelyn Guyer

Senator Nickles, Oklahoma: *Everybody realizes when we have 42,500,000 uninsured people, that is too many. I think Democrats and Republicans, conservatives and liberals, agree with that. We ought to be working to reduce the number of uninsured as much as we possibly can.*

Senator Corzine, New Jersey: *"We ignore the issue of the uninsured at our peril and at a great cost to the quality of life C and to the very life C of our citizens."*

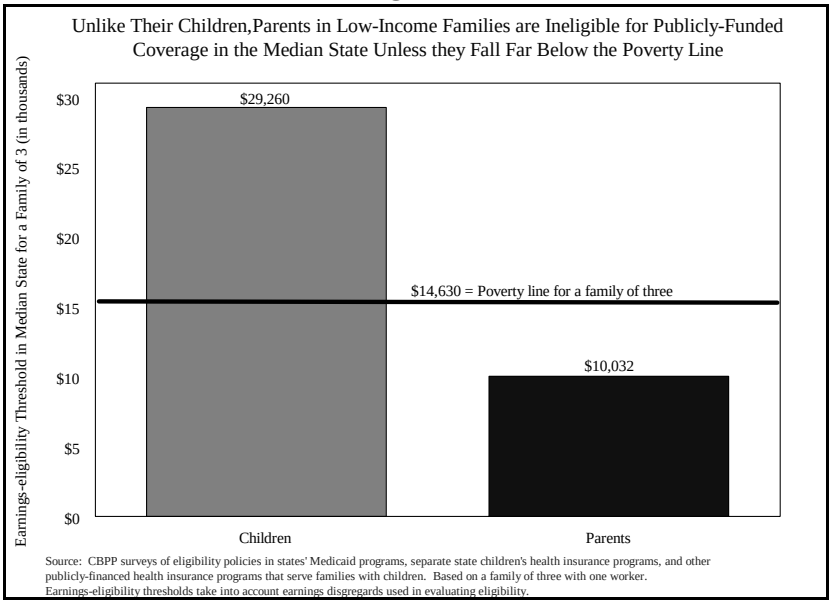
Senator Murkoswki, Alaska: *"Right now, there are 42.6 million Americans who are uninsured. These individuals lack even the most basic coverage and must continually worry about how they will pay for health care services. Will they become sick and fall into a situation where they fail to receive proper medical attention? Will they become hospitalized but have their hospital bills drive them into bankruptcy? Should they pay their doctor bills or pay their rent? Which is it?*"

Comments made on the Senate floor during recent debate over the Patients' Bill of Rights.

Overview

In the recent debate over the Patients' Bill of Rights on the Senate floor, a number of Senators raised the concern that the bill does not address the problems of the 42.6 million Americans without health insurance coverage. Senator Don Nickles of Oklahoma, for example, maintained that "we ought to be working to reduce the number of uninsured as much as we possibly can." Fortunately, Congress has an opportunity to take a significant step toward reducing the ranks of Americans without health insurance this year. The congressional budget resolution adopted in May set aside $28 billion for this purpose over the next ten

Figure 1



years — roughly one percent of the surplus that then existed outside of the Social Security and Medicare trust funds.

Although the $28 billion is not expected (or intended) to cover the cost of extending coverage to everyone who lacks health insurance, it can be used to make significant progress. As Secretary of Health and Human Services Tommy Thompson noted in a recent news interview, a promising strategy for using the $28 billion includes expanding coverage for parents. In recent years, states have adopted major expansions and improvements in coverage for children under Medicaid and the State Children's Health Insurance Program (SCHIP), enacted by Congress in August 1997. By providing states with new fiscal incentives to expand publicly-subsidized coverage to uninsured low-income parents — 90 percent of whom already have a child eligible for or enrolled in Medicaid or SCHIP — Congress can build upon the success of these child health initiatives.

One in every three low-income parents — some 6.9 million parents — lacks health insurance coverage. ("Low-income" is defined as having income that falls at or below 200 percent of the poverty line, or $29,260 for a family of three).[1] Nearly nine of every ten of these uninsured parents are members of working families.

Low-income working parents are at potentially high risk of being uninsured because they often lack access to affordable employer-based coverage and also are ineligible for publicly-funded coverage in most states, unless they have income far below the poverty line. Although states have made enormous strides in expanding coverage for *children* through Medicaid and other programs since enactment of SCHIP, the *parents* in low-income families often can qualify for coverage only if their income falls below the welfare income eligibility limits that their state used prior to enactment of the 1996 federal welfare law.

- Half of all states provide coverage to a working parent with two children only if the parent's earnings fall below roughly $10,000 a year, an amount that leaves the family nearly $5,000 below the poverty line. In the typical (or median) state, a working parent with two children becomes ineligible for coverage when her earnings reach 69 percent of the poverty line.

- In some states, the eligibility cutoff for parents is lower than this. In Alabama, a parent with two children is ineligible for Medicaid if the parent's earnings exceed $3,048 a year, an amount that leaves the family more than $11,500 below the poverty line.

- By contrast, 39 states (including the District of Columbia) now provide coverage to children in families with income up to at least 200 percent of the poverty line.

In most states, low-income parents thus face the prospect that if they or other family members earn enough to lift their family to the poverty line, they must forego health insurance

coverage. As a result of the low income eligibility limits for publicly-subsidized coverage that apply to parents in many states and the limited availability of employer-based coverage at low-wage jobs, working poor parents are more likely to be uninsured than their counterparts. In 1999, for example, nearly half of poor parents (49 percent) who secured a majority of their income from earnings were uninsured. In comparison, a little more than one in five poor parents (21 percent) who derived a majority of their income from sources other than earnings were uninsured.

By using a share of the $28 billion to give states more resources with which to expand affordable coverage for parents, Congress can help states extend Medicaid and SCHIP to millions of uninsured low- and moderate-income working parents. Furthermore, a growing body of evidence indicates that there is a strong, positive relationship between extending coverage to parents and increasing the enrollment of eligible children in publicly-funded coverage. This suggests that an initiative to extend health insurance to more low-income working families will bolster the effectiveness of initiatives underway in many states to enroll more of the eligible-but-uninsured children.

Congressional Budget Resolution Includes $28 Billion for the Uninsured

When Congress crafted its budget resolution this spring, it decided to invest $28 billion — roughly one percent of the surplus that exists outside of the Social Security and Medicare trust funds — in a reserve fund that can be used to provide health insurance to the uninsured. This $28 billion has been "set aside" and can be released by the Chairman of the Budget Committee (in the Senate or the House, as appropriate) to cover the cost of a bill that extends health insurance to the uninsured.[2] The reserve fund makes $8 billion available in 2002, $10 billion in 2003, and $10 billion in 2004, but the Chairman of the Budget Committee can allow the funds to be used over a period of up to ten years in any stream or configuration. Hence, it is commonly said that the $28 billion reserve fund can be used over a period of up to 10 years.

One caveat associated with the $28 billion reserve fund is that it cannot be used unless a surplus would still remain outside the Social Security and Medicare Hospital Insurance Trust Funds. This caveat is important because the recently enacted $1.35 trillion tax cut has used up a large share of the available surplus over the next few years.[3] Although a sufficient amount of the surplus remains at present to allow Congress to use the $28 billion reserve fund, the remaining surplus could disappear over the next few months if Congress adopts significant tax cuts or program increases not allowed for in the congressional budget resolution. For example, some members of Congress are pushing for substantial additional tax cuts beyond those in the recently enacted $1.35 trillion tax cut.

In addition, the Congressional Budget Office will be releasing a revised estimate of the surplus later this summer. The revised estimate is expected to reduce the size of the projected surplus.

Other Proposals to Use the $28 Billion

The strategy of using the $28 billion to expand coverage for parents is not the only option under consideration. Members of Congress also have put forth a number of promising proposals to expand Medicaid and SCHIP for pregnant women, to give states the option to cover some of the legal immigrants excluded from coverage by the 1996 federal welfare law, and to help states enroll more eligible children in coverage. Along with expanding parent coverage, these proposals could help the states make progress toward reducing the number of uninsured.

Some proposals for using the $28 billion, however, would do little or nothing to help the uninsured and may actually expand their ranks. Conservative activists may press to use part of the $28 billion to expand the use of Medical Savings Accounts (MSAs), tax-advantaged personal savings accounts that may be used by persons covered by high-deductible insurance policies. Analysis shows that by making MSAs more available and more attractive as a tax shelter to affluent, healthy people with low medical bills, "adverse selection" is likely to result; those remaining in conventional insurance could, on average, be less healthy because some healthier individuals would have opted for MSAs. This drives up health insurance premiums for conventional health insurance, which can make it unaffordable for some firms and their employees.

Others may press to establish a new tax deduction for the purchase of health insurance. Such a deduction is a poorly targeted and costly way to help a very small fraction of the uninsured obtain coverage. The vast majority of the benefit from such a deduction would go to high-income taxpayers who are likely already to have insurance, while low to moderate-income individuals, who constitute more than 90 percent of the uninsured, would receive no or little benefit from the deduction. In addition, the deduction could encourage firms not to offer coverage or reduce their contribution to the cost of health insurance premiums.

In contrast to MSAs and individual tax deductions, refundable health tax credits can be used by low-income people with limited income tax liability and, thus, are better targeted at the uninsured. Unfortunately, the proposed tax credits are typically of inadequate size to make insurance affordable for low- and moderate-income families. They also generally require people to purchase coverage in the individual insurance market where older people and people with health problems often cannot readily obtain health insurance, sometimes regardless of the amount they are willing to pay. Finally, individual tax credits present a host of administrative problems, including the problems of the mismatch between the time that health insurance premiums must be paid and the time that the reimbursement is available through a tax credit.

For a more detailed discussion of the shortcomings of tax-based approaches to reducing the number of uninsured, see the following reports on the Center's web site at www.cbpp.org: "Possible Health Insurance Deduction Amendment To the Patients' Bill of Rights Offers Little Help to the Uninsured;" "Likely Medical Savings Account Amendment to Patients' Bill of Rights Could Drive up the Price of Health Insurance Premiums and Increase the Number of Uninsured;" and, "Tax Credits for Individuals to Buy Health Insurance Won't Help Many Uninsured Families."

The $28 billion reserve fund represents a relatively modest investment in addressing the problems of the uninsured. The $1.35 trillion tax cut that Congress recently enacted costs roughly 50 times as much. Nevertheless, if Congress defers action on the $28 billion until late in the congressional session, there is a risk that the size of the remaining surplus will not be sufficient to enable the $28 billion to be used. If the opportunity to use the $28 billion disappears, Congress could encounter difficulty in finding resources to address the problems of the uninsured for the foreseeable future.

Nearly 7 Million Low-Income Parents Lack Health Insurance Coverage

While the budget resolution does not provide specific instructions on how the $28 billion reserve fund should be used to help the uninsured,[4] one of the most promising strategies is to build on the success of the child health initiatives adopted in recent years and extend coverage to low-income working parents through Medicaid and SCHIP. Indeed, Secretary Tommy Thompson observed in a recent interview that the $28 billion should be used to expand SCHIP to cover uninsured parents.[5] (As Governor of Wisconsin, Secretary Thompson developed a widely-regarded program known as "BadgerCare" that expanded Medicaid to cover children and parents in low-income working families with incomes up to 185 percent of the poverty line, using a combination of Medicaid and SCHIP funds.)

- In 1999, the latest year for which these data are available, ten million parents caring for children age 18 or younger — one of every six in the country — were uninsured. (Table 1 provides estimates of the number of uninsured parents in each state.)

- Nearly 70 percent of these parents — 6.9 million of the ten million uninsured parents — live in low-income families. (Table 2 provides estimates of the number of uninsured low-income parents in each state.)

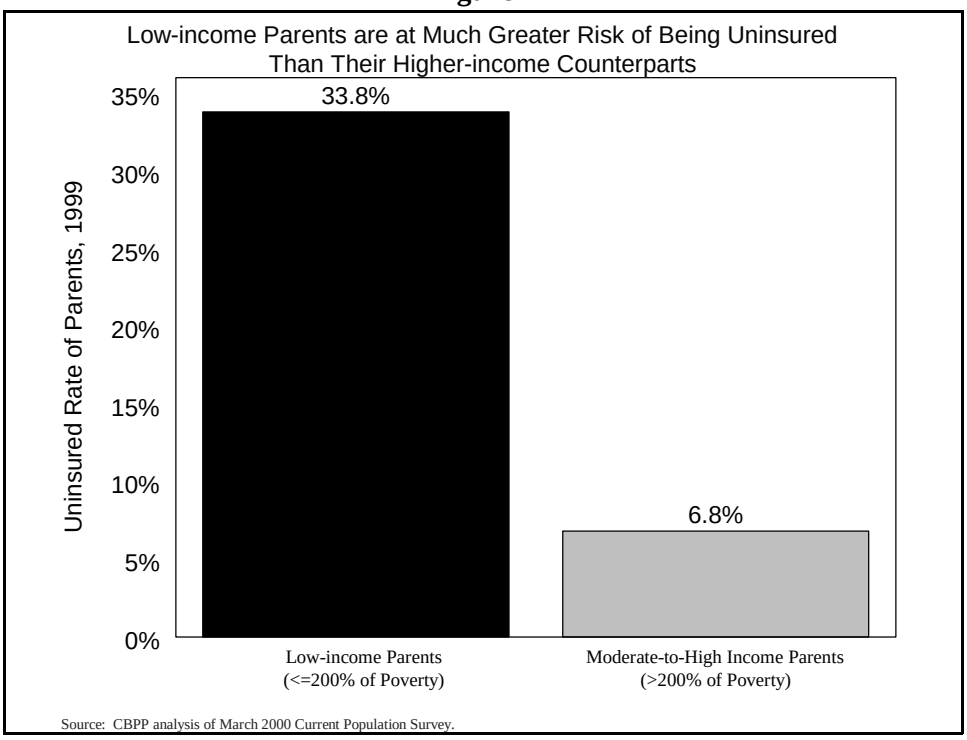
- Close to nine of every ten low-income uninsured parents — 87 percent of them — are members of working families.

Low-income parents are much more likely to be uninsured than parents at higher income levels.

- One in three parents in low-income families — 33.8 percent — lack coverage.

- By contrast, one in 14 parents in moderate-to-higher income families (defined here as those with family income above 200 percent of the poverty line) — or 6.8 percent — are uninsured. Low-income parents are nearly five times as likely to lack coverage as their higher-income counterparts.

Figure 2



The problem of low-income parents lacking health insurance coverage seems to have worsened due to welfare reform and other factors. The sharp welfare caseload declines and the movement of many families from the welfare rolls to low-wage jobs that fail to offer health insurance appear to have had the unintended effect of causing substantial numbers of parents in low-income families to become uninsured. Between 1994 and 1999, the proportion of low-income parents without health insurance increased steadily, rising from 29.9 percent in 1994 to 33.8 percent in 1999.[6] (Children in low-income families also lost coverage in the mid-1990s, but then their coverage rates improved in the late 1990s due to implementation of SCHIP, improved Medicaid outreach for children, and other factors.)

Low-Income Working Parents Often Are Ineligible for Publicly-Funded Coverage Unless They Fall Far Below the Poverty Line

Low-income parents are at high risk of being uninsured even though they are working, in part because they often do not have access to affordable employer-based coverage through their own or a spouse's job. For example, among workers who earn less than $20,000 a year, almost half are not offered health insurance by their employers, and many who are offered insurance at work decline it because they cannot afford the insurance premiums.[7]

At the same time, unlike their children, low and moderate-income parents cannot qualify for Medicaid or SCHIP in most states unless they have income well below the poverty line. Some 40 states now extend coverage to the *children* in low-income working families up to 200 percent of the poverty line or higher. The majority of states provide coverage to *parents*, however, only if the parents are poor enough to qualify for welfare. As a result, most low-income working parents are ineligible for Medicaid even if they or a spouse work at jobs that pay low wages and do not offer health insurance.[8]

- In 34 states, parents in working families are ineligible for Medicaid if their earnings equal the poverty line ($14,630 a year for a family of three).

- In half of the states, parents are ineligible for Medicaid if their families' earnings exceed 69 percent of the poverty line ($10,082 a year for a family of three).

- In 11 states, parents are ineligible for Medicaid if their families' earnings exceed just 40 percent of the poverty line, or $5,852 a year for a family of three. In these states, parents are ineligible for health care coverage through Medicaid if they or a spouse work more than 16 hours a week at a job that pays $7 an hour.

- In some states, even fewer hours of low-paid work will make a parent with two children ineligible for Medicaid. In Alabama, a parent with two children who works more than 8 hours a week at a job that pays $7 an hour is ineligible for coverage.

In most states, low-income parents thus face the prospect that if they or other family members earn enough to lift their family to the poverty line, they must forego health insurance coverage. (See Table 3 for state-specific data on the amount that a working parent with two children can earn without losing eligibility for Medicaid or other publicly-financed coverage.) As a result of the low income eligibility limits for publicly-subsidized coverage that apply to parents in many states and the limited availability of employer-based coverage at low-wage jobs, working poor parents are more likely to be uninsured than their unemployed counterparts. In 1999, for example, nearly half of poor parents (49 percent) who secured a majority of their income from earnings were uninsured. In comparison, a little more than one in five poor parents (21 percent) who derived a majority of their income from sources other than earnings were uninsured.

Although most of the 6.9 million uninsured low-income parents who are insured are ineligible for coverage due to state Medicaid income limits that fall far below the poverty line, nine of every ten of these parents have a child who is enrolled in, or eligible for, Medicaid or SCHIP. As a result, states have a strong basis from which to extend coverage to low-income parents.

Expanding Coverage for Parents Builds Upon and Strengthens the Effectiveness of Child Health Initiatives

States have made significant strides in recent years in expanding coverage for children in low-income working families, in large part in response to creation of the State Children's Health Insurance Program (SCHIP) in 1997. SCHIP provides states with enhanced fiscal incentives (in the form of a higher federal matching rate than the regular Medicaid program provides) to extend coverage to more children in low-income working families through Medicaid, a separate state child health insurance program, or a combination of these approaches. All 50 states are using SCHIP funds, and many have adopted major eligibility expansions.[9] As a result, nearly all uninsured children living below 200 percent of the poverty line now are eligible for Medicaid or a separate SCHIP-funded program.[10] (The major exception is that many legal immigrant children

Why Can't States Just Use Their SCHIP Funds to Expand Coverage for Parents?

In the past, it was widely reported that a significant number of states could not use all of the SCHIP funds that were made available to them, causing some to suggest that states do not need new SCHIP funds to expand coverage for low-income parents. Although these stories accurately described the experiences of many states during the implementation phase of SCHIP, such accounts increasingly are outdated.

Many states confronted a series of implementation challenges when they first established their SCHIP programs in the late 1990s, but since then, they have steadily increased enrollment in SCHIP. State spending on SCHIP has increased correspondingly, jumping from $200 million in fiscal year 1998 (the first year of the program) to $600 million in fiscal year 1999 and $1.8 billion in fiscal year 2000. In fiscal year 2002, the Office of Management an Budget expects spending to reach $3.4 billion a year.*

In fact, the Office of Management and Budget issued estimates earlier this year that suggest that funding for the SCHIP program will fall short of what is needed simply to maintain children's enrollment in coverage, beginning in fiscal year 2005. According to the OMB estimates, the number of children enrolled in SCHIP coverage will continue rising through fiscal year 2004 and reach 3.3 million children that year, but then will drop to 3 million in fiscal year 2005 and 2.9 million in fiscal year 2006 — a decline of 400,000 children. The decline can be attributed both to states' increasing need for SCHIP funds, and to a significant reduction in SCHIP funding that is slated to begin in fiscal year 2002 and continue through fiscal year 2004.

Given the pending shortfall in SCHIP funds, it is unrealistic to expect that most states will be able to use their existing SCHIP resources to extend coverage to the parents of children eligible for publicly-funded coverage. In fact, some states will need additional resources simply to maintain the enrollment of children in coverage.

* In fiscal year 2001, SCHIP spending is expected to spike temporarily due to a one-time transfer of funds from Medicaid to SCHIP generated by a technical accounting situation, and, thus, the fiscal year 2001 spending level is not presented here.

whose families entered the United States after enactment of the 1996 federal welfare law are not eligible for federally-funded coverage).

In 1999, the latest year for which data are available, the number of uninsured children in the United States declined by more than one million, in part due to the early effects of the SCHIP program and state efforts to simplify Medicaid application procedures for children under Medicaid. The experience of children contrasts sharply with that of their parents, who, as noted above, have experienced a deterioration in coverage in recent years.

Many states have undertaken campaigns to educate working families about the availability of health care coverage for their children and to streamline application and re-enrollment procedures under both Medicaid and separate child health insurance programs, although more needs to be done.[11] But, despite the latest, positive trends in coverage for children, there remain more than 10 million uninsured children in the United States. The large majority of these children are eligible for Medicaid or a separate SCHIP program but are not enrolled.

A growing body of evidence suggests that extending coverage to parents may be a particularly effective strategy for increasing the enrollment of eligible children in Medicaid and SCHIP-financed coverage. A study released by the Center on Budget and Policy Priorities in August 2000, as well as research conducted by the Urban Institute, the Commonwealth Fund, and the Agency for Health Care Policy and Research (since re-named the Agency for HealthCare Research and Quality) all indicate that extending coverage to parents promotes the enrollment of eligible children.[12] In addition, a new study by researchers at Pennsylvania State University finds that children are more likely to receive preventive care such as well-child visits when both the child and the parent are insured and in public programs.[13]

The observations of officials in states that have adopted parent expansions also indicate that covering parents strengthens the effectiveness of child health initiatives. Gary Stangler, the former human services commissioner for Missouri, describes what happened in his state after it implemented a Medicaid expansion for parents: "With no outreach, no advertising, no partnerships to spread the word, enrollment soared." According to Stangler, "helping adults greatly contributed to the enrollment of children."[14] Similarly, Secretary of HHS Tommy Thompson testified at his confirmation hearing that not allowing parents to enroll in SCHIP prevents substantial numbers of children from being enrolled.[15]

Significant Regional Disparities in Coverage of Parents

A modest number of states have found ways under current law to extend coverage to uninsured parents in low-income working families. With a few exceptions, however, these states are heavily concentrated in the Northeast, Upper Midwest, and West, and generally have more resources than their counterparts in other parts of the country with which to finance expansions

without additional federal funds. One result has been increasing disparities among states in coverage for low-income working families.

As the experience with SCHIP illustrates, the disparities across states in eligibility levels for parents are likely to persist unless Congress uses the $28 billion to give states fiscal incentives to expand coverage for parents. States were permitted to expand Medicaid coverage for children beyond the federal minimum eligibility limits long before SCHIP was established, but a number of states felt themselves able to do so only after SCHIP provided enhanced fiscal incentives for such expansions. Prior to enactment of SCHIP, only eight states had expanded coverage for children to 200 percent of the poverty line. Now, 39 states (including the District of Columbia) have done so. Moreover, all of the remaining 12 states have adopted some expansion in coverage for children beyond federal minimum levels as a result of SCHIP even though they have not reached 200 percent of the poverty line.

Proposals to Expand Coverage for Parents

A bi-partisan group of members of Congress has expressed support for providing additional fiscal incentives to expand coverage for parents. Last year, Senators Snowe and Kennedy introduced a bill (S. 2923) that would have expanded the size of states' SCHIP allotments and accorded states the flexibility to use the new funds to extend coverage to the uninsured parents of children eligible for Medicaid or separate SCHIP programs. (A companion bill, H.R. 4927, was introduced in the House by Representative Dingell.)

To assure that states meet the first purpose of SCHIP — covering uninsured low-income children — before expanding coverage to parents, the Snowe/Kennedy bill allows a state to use the new funds to cover parents only if the state has expanded coverage for children to 200 percent of the poverty line and does not have waiting lists for children in need of coverage. To gain the maximum benefit from family-based coverage, the bill also requires that states enroll parents and children in the same health insurance program

Senators Snowe and Kennedy are expected shortly to re-introduce their legislation. Since it targets resources at low-income working parents who already have a connection to Medicaid and SCHIP through their children, the bill could prove a strong basis from which to develop a package to help the uninsured with the $28 billion. When key elements of the Snowe/Kennedy bill were offered as an amendment to an appropriations bill on the Senate floor in August 2000, they won the support of a majority of Senators. (Even though the amendment won majority support, it was not adopted because for procedural reasons the amendment required 60 votes to be included in the appropriations bill on the floor at the time.)

Conclusion

The $28 billion included in the congressional budget resolution creates an opportunity for Congress to take a significant step toward reducing the number of uninsured Americans. By using the $28 billion to give states incentives to expand coverage to parents, Congress could help states provide affordable health insurance to the 6.9 million uninsured, low-income parents in the United States. Low-income working parents otherwise will continue to be at high risk of being uninsured because, despite their jobs, they often lack access to affordable employer-based coverage, and, unlike their children, are ineligible for publicly-funded coverage. Adding parents to coverage also would have another benefit — it would bolster the effectiveness of initiatives underway in the states to increase the enrollment of eligible children.

In the absence of quick action, Congress could lose the opportunity to use the $28 billion. There is a risk if Congress waits until late in the congressional session, it will have used up the entire surplus on Social Security and Medicare Hospital Insurance by the time it seeks to address the problem of the uninsured. The size of the available surplus already has been sharply reduced by the recent $1.35 trillion tax cut and it may be reduced further when the Congressional Budget Office releases revised estimates of the size of the remaining surplus later this summer.

Table 1

Parents Without Health Insurance, Late-1990's

State	Parents	Uninsured Parents	Uninsured Rate	90 Percent Confidence Interval*	
				Low	High
United States	**65,608,000**	**10,157,000**	**15%**	**15%**	**16%**
Alabama	993,000	164,000	17%	15%	19%
Alaska	177,000	26,000	15%	13%	16%
Arizona	1,177,000	287,000	24%	22%	26%
Arkansas	620,000	119,000	19%	17%	21%
California	8,286,000	1,739,000	21%	20%	22%
Colorado	953,000	116,000	12%	10%	14%
Connecticut	767,000	73,000	10%	8%	11%
Delaware	175,000	22,000	12%	10%	14%
District Of Columbia	80,000	15,000	18%	15%	21%
Florida	3,095,000	611,000	20%	19%	21%
Georgia	1,900,000	334,000	18%	16%	19%
Hawaii	291,000	17,000	6%	4%	7%
Idaho	335,000	72,000	21%	19%	23%
Illinois	2,996,000	355,000	12%	11%	13%
Indiana	1,490,000	163,000	11%	9%	13%
Iowa	693,000	57,000	8%	7%	10%
Kansas	633,000	66,000	10%	9%	12%
Kentucky	980,000	165,000	17%	15%	19%
Louisiana	1,066,000	208,000	19%	18%	21%
Maine	293,000	40,000	14%	12%	16%
Maryland	1,175,000	122,000	10%	9%	12%
Massachusetts	1,327,000	117,000	9%	8%	10%
Michigan	2,396,000	289,000	12%	11%	13%
Minnesota	1,205,000	86,000	7%	6%	8%
Mississippi	741,000	131,000	18%	16%	20%
Missouri	1,307,000	115,000	9%	7%	10%
Montana	227,000	43,000	19%	17%	21%
Nebraska	407,000	36,000	9%	7%	10%
Nevada	440,000	81,000	18%	16%	20%
New Hampshire	304,000	35,000	11%	10%	13%
New Jersey	1,892,000	256,000	14%	12%	15%
New Mexico	425,000	119,000	28%	26%	30%
New York	4,226,000	703,000	17%	16%	18%
North Carolina	1,806,000	257,000	14%	13%	16%
North Dakota	150,000	19,000	13%	11%	15%
Ohio	2,709,000	262,000	10%	9%	11%
Oklahoma	795,000	135,000	17%	15%	19%
Oregon	774,000	92,000	12%	10%	14%
Pennsylvania	2,754,000	252,000	9%	8%	10%
Rhode Island	213,000	15,000	7%	6%	9%
South Carolina	958,000	162,000	17%	15%	19%
South Dakota	170,000	19,000	11%	10%	13%
Tennessee	1,362,000	169,000	12%	11%	14%
Texas	5,284,000	1,351,000	26%	24%	27%
Utah	587,000	65,000	11%	10%	12%
Vermont	148,000	13,000	9%	7%	10%
Virginia	1,638,000	204,000	12%	11%	14%
Washington	1,404,000	140,000	10%	8%	12%
West Virginia	380,000	83,000	22%	20%	24%
Wisconsin	1,276,000	119,000	9%	8%	11%
Wyoming	125,000	21,000	17%	15%	19%

* There is a 90 percent chance that the actual uninsured rate among parents, if it were determined from a survey of all households, would fall in the range defined by the low-end and high-end estimates of the 90 percent confidence interval. The confidence interval is wider in states with smaller sample sizes.

Source: CBPP tabulations of Census Bureau's March Current Population Survey data from 1998-2000. Data reflect individuals' health insurance status for 1997-1999, respectively. Based on household heads and their spouses between the ages of 18 and 65 living with children. Due to rounding error, the uninsured rate presented in column 4 may not equal the quotient of columns 2 and 3.

Table 2

Parents Living in Families with Income Below 200 Percent of Poverty Without Health Insurance, Late-1990's

State	Low-income Parents	Uninsured, Low-income Parents	Uninsured Rate	90 Percent Confidence Interval*	
				Low	High
United States	**21,120,000**	**7,093,000**	**34%**	**33%**	**34%**
Alabama	350,000	128,000	37%	33%	41%
Alaska	42,000	12,000	30%	25%	34%
Arizona	517,000	236,000	46%	42%	49%
Arkansas	263,000	88,000	33%	29%	37%
California	3,205,000	1,261,000	39%	38%	41%
Colorado	211,000	75,000	35%	30%	40%
Connecticut	140,000	42,000	30%	23%	36%
Delaware	48,000	14,000	29%	24%	34%
District Of Columbia	35,000	10,000	28%	23%	33%
Florida	1,123,000	421,000	37%	35%	40%
Georgia	688,000	236,000	34%	31%	38%
Hawaii	99,000	11,000	11%	8%	14%
Idaho	124,000	54,000	43%	40%	47%
Illinois	817,000	242,000	30%	27%	32%
Indiana	366,000	108,000	29%	25%	34%
Iowa	201,000	37,000	19%	15%	22%
Kansas	177,000	50,000	28%	24%	33%
Kentucky	359,000	128,000	36%	32%	40%
Louisiana	438,000	146,000	33%	30%	37%
Maine	84,000	25,000	30%	25%	35%
Maryland	219,000	85,000	40%	34%	46%
Massachusetts	340,000	62,000	18%	15%	22%
Michigan	626,000	189,000	30%	27%	33%
Minnesota	248,000	55,000	22%	17%	27%
Mississippi	322,000	108,000	33%	30%	37%
Missouri	372,000	76,000	20%	16%	24%
Montana	87,000	29,000	34%	30%	37%
Nebraska	120,000	26,000	22%	18%	26%
Nevada	134,000	53,000	39%	34%	44%
New Hampshire	65,000	21,000	33%	27%	39%
New Jersey	445,000	149,000	34%	30%	37%
New Mexico	204,000	96,000	47%	43%	51%
New York	1,443,000	469,000	33%	31%	34%
North Carolina	580,000	181,000	31%	28%	34%
North Dakota	52,000	14,000	27%	23%	31%
Ohio	787,000	178,000	22%	20%	25%
Oklahoma	262,000	87,000	33%	29%	37%
Oregon	251,000	70,000	28%	24%	32%
Pennsylvania	775,000	177,000	23%	20%	25%
Rhode Island	51,000	10,000	20%	15%	25%
South Carolina	320,000	112,000	35%	31%	40%
South Dakota	49,000	13,000	25%	21%	30%
Tennessee	510,000	101,000	19%	16%	23%
Texas	2,152,000	1,009,000	47%	45%	49%
Utah	179,000	38,000	21%	18%	25%
Vermont	39,000	4,000	11%	7%	15%
Virginia	387,000	141,000	37%	32%	42%
Washington	331,000	71,000	22%	17%	26%
West Virginia	170,000	62,000	36%	33%	40%
Wisconsin	271,000	70,000	26%	21%	30%
Wyoming	41,000	14,000	33%	29%	38%

* There is a 90 percent chance that the actual uninsured rate among parents in working families below 200 percent of the poverty level, if it were determined from a survey of all households, would fall in the range defined by the low-end and high-end estimates of the 90 percent confidence interval. The confidence interval is wider in states with smaller sample sizes.

Source: CBPP tabulations of Census Bureau's March Current Population Survey data from 1998-2000. Data reflect individuals' health insurance status for 1997-1999, respectively. Based on household heads and their spouses between the ages of 18 and 65 living with children in families with income below 200 percent of poverty. Due to rounding error, the uninsured rate presented in column 4 may not equal the quotient of columns 2 and 3.

Table 3

How Much Can A Working Parent with Two Children Earn and Still Be Eligible for Publicly-funded Health Insurance? (as of Spring 2001)*

STATE	Monthly Earnings Threshold	Annual Earnings Threshold	As Percent of FY2001 Federal Poverty Line
Alabama	$254	$3,048	21%
Alaska	$1,208	$14,496	79%
Arizona	$1,309	$15,710	107%
Arkansas	$365	$4,380	30%
California	$1,309	$15,710	107%
Colorado	$511	$6,132	42%
Connecticut	$1,919	$23,025	157%
Delaware	$1,309	$15,710	107%
District of Columbia	$2,438	$29,260	200%
Florida	$806	$9,672	66%
Georgia	$514	$6,168	42%
Hawaii	$1,403	$16,830	100%
Idaho	$407	$4,884	33%
Illinois	$882	$10,584	72%
Indiana [1]	$378	$4,536	31%
Iowa	$1,065	$12,780	87%
Kansas	$493	$5,916	40%
Kentucky	$909	$10,908	75%
Louisiana	$323	$3,876	26%
Maine	$1,919	$23,025	157%
Maryland	$524	$6,288	43%
Massachusetts	$1,621	$19,458	133%
Michigan	$774	$9,285	63%
Minnesota	$3,353	$40,233	275%
Mississippi	$458	$5,496	38%
Missouri	$1,309	$15,710	107%
Montana	$836	$10,032	69%
Nebraska	$669	$8,025	55%
Nevada	$1,055	$12,660	87%
New Hampshire	$815	$9,780	67%
New Jersey	$2,438	$29,260	200%
New Mexico	$704	$8,442	58%
New York[1]	$974	$11,688	80%
North Carolina	$750	$9,004	62%
North Dakota	$988	$11,860	81%
Ohio	$1,219	$14,630	100%
Oklahoma	$591	$7,092	48%
Oregon	$1,219	$14,630	100%
Pennsylvania	$557	$6,684	46%
Rhode Island	$2,345	$28,146	192%
South Carolina	$668	$8,016	55%
South Dakota	$796	$9,552	65%
Tennessee [2]	$930	$11,160	76%
Texas	$395	$4,740	32%
Utah	$673	$8,076	55%
Vermont	$2,345	$28,146	192%
Virginia	$448	$5,376	37%
Washington	$2,438	$29,260	200%
West Virginia	$380	$4,560	31%
Wisconsin	$2,255	$27,066	185%
Wyoming	$790	$9,480	65%
US Median	**$836**	**$10,032**	**69%**

* Figures provided represent the earnings threshold applied to a parent in a 3-person family applying for coverage. Parents may be eligible for publicly-financed coverage through several means, including Medicaid, a Medicaid program operating under a waiver, a State Children's Health Insurance Program (SCHIP) operating under a waiver, or a state-only funded program. The eligibility thresholds presented are those used in states' programs with the highest earnings-eligibility thresholds for parents. The thresholds take into account earnings disregards applied in the evaluation of parents' eligibility for coverage.

[1] Indiana earlier this year approved an expansion to cover parents in Medicaid up to 100 percent of poverty and plans to implement the expansion later this year. New York received approval from the Center for Medicare and Medicaid Services in June 2001 of a waiver to extend Medicaid coverage to parents up to 150 percent of poverty. The state plans to implement this expansion later this summer.

[2] Under a waiver, Tennessee operates a program known as TennCare that is designed to provide subsidized coverage to parents (and others) with income up to 400 percent of poverty. However, due to fiscal concerns, enrollment in TennCare is currently limited in most cases to those parents with earnings below approximately 80 percent of poverty.

Source: A CBPP directed survey of state officials concerning eligibility policies and procedures in Medicaid and other publicly-financed health insurance programs available to low-income families with children.

1. Unless otherwise noted, the national data in the body of this paper on the number and characteristics of uninsured parents are based on the authors' tabulations of the March 2000 Current Population Survey which provides information on the health insurance status and income of individuals in 1999. The state-by-state data (and corresponding national estimates) included in Tables 1 and 2, however, are based on data from the March 1998 - 2000 Current Population Surveys. In developing the state-specific estimates shown in Tables 1 and 2, the Center used a standard strategy employed by researchers and others of pooling CPS data for a three-year period to increase the accuracy of state-specific estimates of uninsured rates. For purposes of both the national and state-specific estimates, the Center defined "parents" to include household heads and their spouses between the ages of 18 and 65 living with children.

2. In order to be financed with the $28 billion, a bill aimed at the uninsured must be reported by the Finance Committee in the Senate and the Ways and Means or Energy and Commerce Committee in the House.

3. Richard Kogan, Bob Greenstein, and Joel Friedman, *How Much of the Surplus Remains After the Tax Cut*, Center on Budget and Policy Priorities, June 27, 2001.

4. The reserve fund language notes that an appropriate use could include providing a tax deduction to moderate-income people without employer-based coverage.

5. Interview with Secretary of Health and Human Services Tommy G. Thompson, *Washington Post*, June 12, 2001, page A-8.

6. A parent is classified as being part of a "working family" if the earnings of family members (including the parent's own earnings) exceeded $500 during the preceding year. The vast majority of these parents are in families with earnings that significantly exceed the $500 threshold. For example, among uninsured parents in low-income working families, 88.8 percent are part of families with earnings that exceed $5,150 a year, the amount that a person working half time at the minimum wage for 50 weeks a year would earn.

7. Lisa Duchon, Cathy Schoen, Elisabeth Simantov, Karen Davis, and Christina An, "Listening to Workers: Challenges for Employer-Sponsored Coverage in the 21st Century," Commonwealth Fund, January 2000.

8. The information on how much a parent with two children can earn and still qualify for Medicaid or other publicly-funded coverage is taken from a survey of state officials conducted by CBPP. It is current as of the spring of 2001. For purposes of compiling this information, CBPP considered all of the Medicaid eligibility categories that a state might use to cover a parent who is not pregnant or disabled. In each state, we considered the rules that apply under a state's "delinking" or "family coverage" category. Under this eligibility category, states must, at a minimum, provide Medicaid to families with dependent children that meet a state's AFDC income, resource, and family composition rules as of July 16, 1996. States have the option to expand coverage beyond these minimum eligibility levels. Where applicable, we also considered the rules that a state applies to families with children under a "medically needy" eligibility category. The medically needy eligibility category is an optional category that states can use to extend Medicaid to families with income slightly above old welfare eligibility levels, as well as to cover families with high medical bills who "spend down" to the Medicaid eligibility limit. Finally, some states have secured Medicaid and SCHIP waivers from the federal government to expand coverage to groups not traditionally covered by Medicaid, including some parents. In these states, we took into account the rules that apply to parents under these waivers.

   The earnings thresholds presented in this report are based on a working parent with two children who applies for Medicaid. These earnings thresholds take into account the earnings disregard policies (i.e., policies of not counting some of a family's earnings when evaluating eligibility for Medicaid) that states apply to new applicants, but not other disregards or deductions. Individual parents applying for Medicaid may be eligible for coverage at a higher income threshold than presented in this report depending on their particular circumstances. For example, a parent with income from sources other than earnings might face a lower income eligibility limit because she will not benefit from her state's earnings disregard policy. Similarly, a working parent with child care expenses might qualify for coverage at a higher income level than presented in this report after a state's policy of disregarding certain child care expenses is taken into account.

Once enrolled in Medicaid, parents may be able to *retain* their coverage at higher earnings thresholds than presented in this report. This is because states often apply more generous earnings disregards to families receiving (rather than applying for) coverage, and because families can qualify for up to 12 months of Transitional Medical Assistance (or more in selected states) if they lose their eligibility for regular Medicaid due to an increase in their earnings.

9. Donna Cohen Ross and Laura Cox, *Making It Simple*, Center on Budget and Policy Priorities, prepared for the Kaiser Commission on Medicaid and the Uninsured, October 2000.

10. Matthew Broaddus and Leighton Ku, *Nearly 95 Percent of Low-Income Uninsured Children Are Now Eligible for Medicaid or SCHIP*, Center on Budget and Policy Priorities, December 6, 2000.

11. A handful of states have applied simplifications to their separate SCHIP programs but not to their Medicaid programs for children, making it easier for somewhat better off low-income families than for poorer families to secure coverage for their children. The vast majority of states, however, have used the impetus generated by the creation of SCHIP to improve procedures in both their separate SCHIP programs and Medicaid. As of July 2000, 42 states had eliminated the asset test for children in Medicaid, 40 had eliminated the face-to-face interview requirement for children in Medicaid; and 39 had gone to 12-month review periods for children in Medicaid.

12. See Leighton Ku and Matthew Broaddus, *The Importance of Family-Based Insurance Expansions: New Research Findings about State Health Reforms*, Center on Budget and Policy Priorities (September 2000).Lisa Dubay and Genevieve Kenney, *The Effects of Family Coverage on Children's Health Insurance Status*, Presentation to the Academy for Health Services Research and Health Policy Conference, Urban Institute (forthcoming); and Jeanne M. Lambrew, *Health Insurance: A Family Affair*, The Commonwealth Fund (May 2001).

13. Elizabeth Gifford and Robert Weech-Maldonado, *Encouraging Preventive Health Services for Young Children: The Effect of Expanding Coverage to Parents*, Presentation to the Academy for Health Services Research and Health Policy Conference, Pennsylvania State University (forthcoming).

14. Comment by Gary Stangler on "Supporting Work Through Medicaid and Food Stamps," by Bob Greenstein and Jocelyn Guyer in Blank, Rebecca M. and Ron Haskins, editors, *The New World of Welfare*, Washington, DC, Brookings Institution, forthcoming.

15. Confirmation hearing before the Senate Finance Committee, January 18, 2001, Washington, D.C.. A transcript of the hearing is available at http://www.kaisernetwork.org/health_cast.