Taking the Next Step

States Can Now Take Advantage of Federal Medicaid Matching Funds to Expand Health Care Coverage to Low-income Working Parents

CENTER ON BUDGET AND POLICY PRIORITIES

Taking the Next Step

States Can Now Take Advantage of Federal Medicaid Matching Funds to Expand Health Care Coverage to Low-income Working Parents

Jocelyn Guyer
Cindy Mann

CENTER ON BUDGET AND POLICY PRIORITIES

August 20, 1998

The **Center on Budget and Policy Priorities**, located in Washington, D.C., is a non-profit, research and policy institute that conducts research and analysis of government policies and the programs and public policy issues that affect low- and middle-income households. The Center is supported by foundations, individual contributors, and publications sales.

Authors

Jocelyn Guyer
Policy Analyst

Cindy Mann
Senior Fellow

August 20, 1998

Center on Budget and Policy Priorities
820 First Street, N.E., Suite 510
Washington, DC 20002
(202) 408-1080

E-mail:center@center.cbpp.org
HandsNet: HN0026
Web: www.cbpp.org

Contents

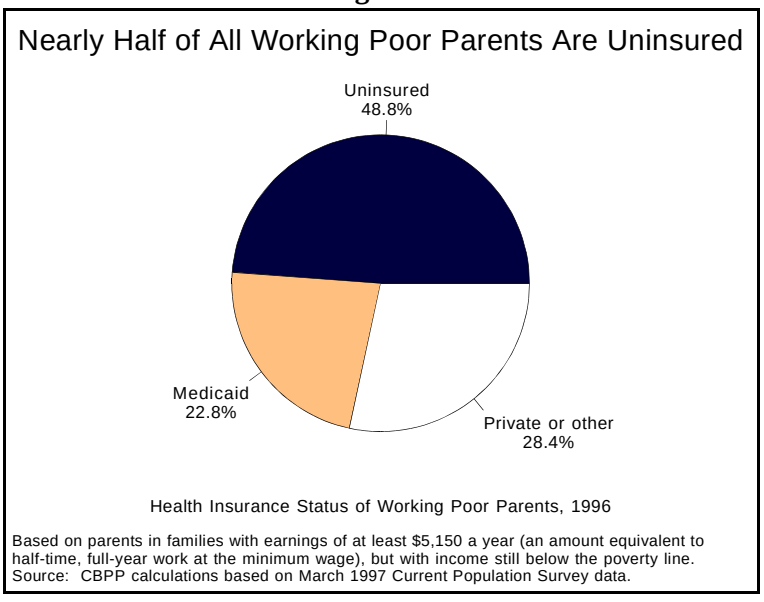
Figures and Tables

I. Executive Summary

In many states, the debate over how best to use the new child health block grant funds has spurred an interest in finding ways to cover the *parents* in low-income working families. While the potential to use child health block grant funds to cover parents appears to be quite limited, the federal welfare law enacted in August 1996 contains a little-recognized opportunity for states to expand coverage to poor and near-poor working parents through Medicaid. This opportunity is available at state option and does not require a federal waiver.

There is good reason for states to consider ways to extend coverage to poor and near-poor working parents — low-income working parents are at high risk of being uninsured. Nearly half (48.8 percent) of all parents in families with earnings of at least $5,150 a year (equivalent to half-time, full-year work at the minimum wage) but with income still below the federal

Figure 1



Health Insurance Status of Working Poor Parents, 1996

Based on parents in families with earnings of at least $5,150 a year (an amount equivalent to half-time, full-year work at the minimum wage), but with income still below the poverty line.
Source: CBPP calculations based on March 1997 Current Population Survey data.

poverty line are uninsured.[1] Low-income working parents are at high risk of being uninsured because often their jobs do not offer health insurance and in most states they are largely ineligible for Medicaid or other publicly funded coverage.

Currently, the major avenue to Medicaid coverage for parents (unless they are pregnant or disabled) is through the Medicaid eligibility category that replaced the automatic eligibility link between Aid to Families with Dependent Children and Medicaid. Under the new eligibility category — known as "section 1931" — states are required to provide Medicaid to families that meet the income and resource standards and conform to certain of the family composition rules that a state used to determine eligibility under its AFDC program on July 16, 1996. These standards generally limit eligibility to parents with incomes well below the poverty line — parents in families with earnings become ineligible for Medicaid when their incomes are still *55 percent below* the federal poverty level ($6,143 for a family of three) in the median state. Moreover, under these standards a parent typically must have countable resources of less than $1,000.

Some low-income working parents may be eligible for coverage through Transitional Medicaid Assistance. TMA was established under the Family Support Act of 1988 to help assure that families losing welfare due to earnings did not also lose Medicaid. It generally offers up to twelve months of coverage to families who become ineligible for regular Medicaid coverage under section 1931 because of their wages.

A major limitation of TMA is that in order to qualify for it a family must first receive Medicaid under the July 16, 1996, AFDC income and resource standards described above. It is not available to a parent whose income in recent months has not been low enough for her to meet these standards even though her earnings may be very low and she may have no health insurance coverage. Moreover, TMA is time-limited even for those parents able to qualify.

Although the routes to Medicaid coverage for parents have been very limited, states now have a new opportunity to provide coverage for poor and near-poor working parents. The opportunity arises primarily from the broad flexibility accorded states to define what *counts* as income and resources when they determine Medicaid eligibility under section 1931. Under the law, states can set their own methodologies for calculating countable income and resources in order to expand coverage for low-income working parents. States already have experience using their authority to define what counts as income to expand Medicaid coverage for other groups of beneficiaries under a

[1] Based on Center analysis of 1997 March Current Population Survey data. “Parents” include all family heads and spouses living in a household with children.

What About Medicaid Coverage for the *Children* in Low-Income Working Families?

This paper highlights the opportunity to expand coverage for the parents in low-income working families because many of the children in such families are already eligible for Medicaid and others are likely to be covered through Medicaid expansions or a separate child health program financed with the new child health block grant funds. As of May 1998, 36 states have elected to expand Medicaid to children over the age of 1 with family income above the federal minimum Medicaid income standards, and several others have established separate state insurance programs for children.*

Federal law requires states to provide Medicaid to children under age 6 with family income below 133 percent of the poverty line, as well as to older children born after September 30, 1983, with family income below 100 percent of poverty. The requirement to phase in coverage of older children ensures that by the year 2002 all children under the age of 19 will be eligible for Medicaid if they have income below the poverty line. At present, the requirement means that states must cover poor children between the ages of 6 and about 14. Until coverage for older children is fully phased in, states are required to cover older children only if they are eligible for Medicaid under section 1931 (which means, among other things, that their family income must fall below a state's July 1996 AFDC income standards).

Since the late 1980s, states have had the option of accelerating the phase-in of coverage for older children with family income below the poverty line and/or to increase the income eligibility thresholds for children above federal minimum standards. Moreover, since enactment of the child health block grant in August 1997, states have been able to receive federal funding on an "enhanced" matching basis to expand Medicaid for children, establish a separate state insurance program, or adopt a combination of these approaches. As a result of the new child health block grant, which is described in more detail in Section V, children of low-income working families are more likely than ever to have routes to Medicaid or other health care coverage that are not available to their parents.

* Center on Budget and Policy Priorities, *Medicaid Income Eligibility Guidelines for Children* (Washington, D.C.: May 1998).

similar provision in the Medicaid law that pertains to pregnant women and children.[2] The welfare law allows states to use this same flexibility in setting the rules for how income and assets are counted to expand Medicaid coverage to low-income working parents.

There are many reasons for states to consider expanding Medicaid coverage for parents. Such an expansion allows states to help low-income working families that have limited or no access to coverage through their employers. It also represents a potentially important tool for states seeking to encourage families to avoid applying for

[2] Specifically, states have relied on section 1902(r)(2) of the Social Security Act, which allows them to adopt less restrictive methodologies to determine the Medicaid eligibility of pregnant women and so-called poverty-level children.

welfare or to limit the amount of time they spend on welfare. It has long been widely believed — and there is now research to support the position — that parents are more likely to succeed in avoiding welfare or in limiting the duration of a stay on welfare if they and their children have access to health insurance coverage after they enter the job market. Finally, because the opportunity to expand coverage is via Medicaid, the federal government will finance anywhere from 50 percent to 80 percent of the cost of the coverage extended to poor and near-poor working parents, with the exact portion determined by each state's regular Medicaid matching rate.

Examples of How States Can Use the New Opportunity

- √ To cover working parents with income below the federal poverty line
- √ To extend the length of time for which transitional Medicaid coverage is available to parents entering the workforce
- √ To eliminate the asset test for low-income families seeking Medicaid

This paper discusses further some of the reasons states may want to consider expanding Medicaid for low-income working parents beyond federal minimum requirements, reviews the avenues to Medicaid coverage for low-income parents, and describes in detail the new opportunity to expand coverage. It concludes with a discussion of states' potential to use the new child health block grant funds to cover low-income working parents.

II. Reasons to Consider Expanding Medicaid Coverage to Low-Income Working Parents

There are a number of reasons for states to consider expanding Medicaid coverage to low-income working parents.

Federal Medicaid Matching Funds Are Now Available

In the past, states could provide health insurance coverage to working parents only if they were willing to use their own funds entirely or to pursue a waiver of federal law that would allow them to expand Medicaid to this population. The new option allows states to receive federal Medicaid matching funds to expand coverage for this group without a waiver. The federal government will finance anywhere from 50 percent to 77 percent of the cost of expanding coverage for low-income parents, with the exact portion determined by each state's regular Medicaid matching rate. (See Table 1 for each state's matching rate.)

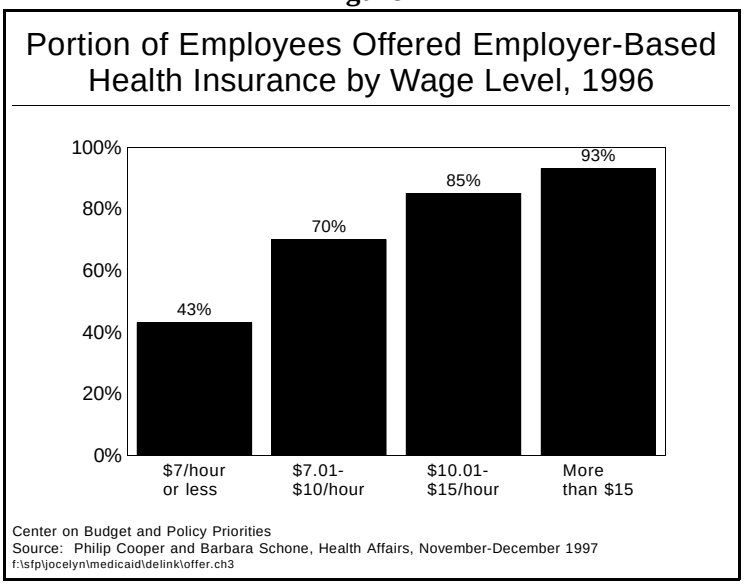
Low-Income Working Parents Are at High Risk of Being Uninsured

As noted above, nearly half of all working poor parents are uninsured. The high rate of uninsurance among these parents can be attributed to their limited access to both employer-sponsored coverage and publicly funded coverage.

While the vast majority of non-elderly adults look to their employers for health insurance coverage, the majority of workers in low-wage jobs cannot. Recent research indicates that in 1996 only 43 percent of workers making $7 or less per hour were

offered health insurance coverage by their employers.[3] In contrast, among workers making more than $15 an hour, 93 percent were offered coverage. Not all workers who are offered coverage take up the offer. Although in 1996 more than three-quarters of low-wage workers did take up coverage when it was offered, about a quarter — 24.2 percent — did not. Moreover, there has been a decline in take-up rates over the last decade; in 1987, only 10.6 percent of workers in low-wage jobs did not take up coverage when it was offered to them through an employer or through a family member's job. While there are a variety of factors that may explain this trend (which also applies to higher wage workers, but to a lesser extent), the decline in take-up rates is attributable in large part to increases in the cost to employees of premiums and cost-sharing obligations.[4] Data compiled by KPMG Peat Marwick indicate that families had to contribute an average of $1,615 a year for employer-based family coverage in 1996, an amount that makes coverage inaccessible for many low-income working families.[5]

Figure 2



At the same time, low-income working parents have little or no access to Medicaid coverage in most states. In the median state the section 1931 eligibility category — the major route to Medicaid coverage for parents who are not disabled or pregnant — allows for coverage of a parent in a single-parent household with two children only if she has gross earnings below $515 per month (about 55 percent below

---

[3] Philip F. Cooper and Barbara Steinberg Schone, "More Offers, Fewer Takers for Employment-Based Health Insurance: 1987 and 1996," *Health Affairs*, 16(6) (1997), pp. 142-149. The percentage of workers with wages at or below $7 per hour who have "access" to employer-based coverage is somewhat higher (55 percent in 1996) because some low-wage workers are offered coverage through the employer of a family member.

[4] An analysis by the Lewin Group, Inc. has found that eight million fewer Americans had employer-based coverage in 1996 because of a range of economic changes, of which the most significant was a rapid growth in required employee premium contributions. The analysis concludes that this one factor accounted for 76.4 percent of the decline in employer health coverage in recent years. See *Paying More and Losing Ground: How Employer Cost-Shifting Is Eroding Health Coverage of Working Families*, commissioned by the AFL-CIO (Lewin Group, Inc., 1998).

[5] Data from KPMG Peak Marwick cited in Lewin Group, Inc. 1998.

the federal poverty line). Under this standard, a parent is ineligible for Medicaid if she finds a job paying $7 per hour and works 17 hours or more per week. If she is working at the minimum wage, she will be ineligible for Medicaid under the basic minimum requirements in the median state if she is working 23 hours per week. (See Table 2 for the state-specific minimum eligibility standards required under federal law.) Similarly, the Medicaid resource test for parents under the minimum federal standard is quite strict — a family's countable assets must be less than $1,000.

The Number of Low-Income Uninsured Parents Is Likely to Grow

Over the next several years, changes in state welfare program rules are likely to increase the number of parents working in low-wage jobs. Under the 1996 federal welfare law, states are required to place a growing portion of their welfare caseloads in work activities and may terminate aid to families in which the parent fails to participate in work activities. In addition, the welfare law limits to 60 the number of months during which a family with an adult can receive federally-funded cash assistance, and it allows states to impose shorter time limits. Moreover, many states have adopted "work-first" strategies under which parents are required to begin looking for a job as soon as they begin receiving cash assistance or, in some states, as soon as they submit an application for cash assistance. Generally, parents are required to take the first job they are offered regardless of how much it pays or whether it offers health insurance benefits.

States already have experienced dramatic declines in their welfare caseloads in recent years owing to welfare program changes and the strong economy. For the United States as a whole, the welfare caseload has dropped 37 percent from the peak level it reached in March of 1994.[6] In some states, caseloads have declined more than 50 percent. While it is not clear what has happened to all of the families who no longer are on the welfare rolls, a substantial portion are likely to be working in the low-wage labor market, without access to publicly funded or employer-based coverage.

The data available to date confirm that the parents in families that leave welfare are at high risk of being uninsured. When two researchers, Moffitt and Slade, reviewed the studies available on the issue in 1997, they concluded that the studies show "unequivocally that fewer than half of women who leave welfare have health insurance three years later."[7] Using data from the National Longitudinal Survey of Youth on

---

[6] Center calculation based on AFDC/TANF caseload data provided by the Department of Health and Human Services. This calculation compares the national caseload in March of 1994 with the national caseload in March of 1998, the latest month for which data are available.

[7] Robert A. Moffitt and Eric P. Slade, *Health Care Coverage for Children Who Are on and off Welfare*, The (continued...)

mothers who were on welfare in 1989 but off welfare in the three subsequent years, Moffitt and Slade also conducted their own analysis of the health insurance status of parents who leave welfare. They found that in the first year after leaving welfare, 52 percent of the mothers had Medicaid coverage, presumably in large part because of time-limited Transitional Medical Assistance; 23 percent had employer-subsidized coverage; and nearly all of the remaining 25 percent were uninsured. Over time, however, the situation worsened. While a growing number of mothers gained access to employer-subsidized coverage, these gains were not enough to offset declines in Medicaid coverage. After three years, 38 percent of the women had employer-subsidized coverage (about half through a spouse's employer), but only 16 percent had Medicaid coverage, leaving nearly half of the mothers uninsured.

Since Moffitt and Slade's literature review, two studies have been released that provide more recent data on the health insurance status of parents who leave welfare. Both studies confirm that these parents are at a high risk of being uninsured. The first study was based on interviews conducted in early 1997 with 1,600 families that had participated in Indiana's welfare program between May 1995 and May 1996. The study found that nearly two-thirds of the parents in families no longer receiving aid at the time of the interview were working. Despite this relatively high rate of participation in the workforce, nearly half of the parents who had left welfare were uninsured.[8]

Similarly, a recent study in South Carolina found that half of the adults who leave welfare are uninsured even though a vast majority are working. The study, which was done by the South Carolina Department of Social Services, was based on interviews conducted in February, March and April of 1998 with almost 400 families that had left the state's welfare program between April and June of 1997 and had remained off welfare.[9] As in Indiana, about two-thirds (69.6 percent) of the adults who had left

---

[7] (...continued)
Future of Children, Welfare to Work, Volume 7, No. 1 (California, the David and Lucile Packard Foundation: 1997).

[8] Abt Associates, *The Indiana Welfare Reform Evaluation: Who Is on and Who Is off? Comparing Characteristics and Outcomes for Current and Former TANF Recipients* (September 1997). This study did not identify the source of coverage for insured parents; it is not known how many of these parents received Medicaid or had employer-based coverage.

[9] South Carolina Department of Social Services, *Survey of Former Family Independence Program Clients: Cases Closed During April Through June, 1997* (South Carolina: June 1998). This study included only families in which the adult was required to look for work (or was voluntarily seeking work) while receiving assistance under the state's welfare program. Two earlier, nearly identical studies conducted by the state found similar problems with adults losing coverage and finding it more difficult to meet medical needs after leaving welfare. See South Carolina Department of Social Services, *Survey of Former Family Independence Program Clients: Cases Closed During October Through December, 1996* (South Carolina: 1997) and South Carolina Department of Social Services, *Survey of Former Family Independence Program*
(continued...)

welfare were working at the time that they were interviewed. The South Carolina study also included data suggesting that the lack of coverage translates into difficulties securing health care services — more than twice as many households reported that they had unmet medical needs *after leaving welfare* (9.7 percent) as reported they had the same problem *while on welfare* (3.8 percent).

The rate of decline in welfare caseloads is accelerating — caseloads declined 14 percent between March of 1996 and March of 1997 and another 19 percent between March of 1997 and March of 1998. As more and more parents find jobs in the low-wage job market, the number of low-income parents without health insurance coverage also can be expected to grow. The new opportunity to expand Medicaid coverage for poor and near-poor working parents can help reverse this trend and allow states to lower the number of uninsured working parents.

Expanding Health Insurance Coverage for Low-Income Working Parents Will Help to Promote Work and Reduce the Need for Welfare

Providing health care coverage to low-income working parents will make leaving welfare and entering the low-wage job market a more viable option for many parents. At present, parents who take this step are likely to receive at most a year of transitional coverage. A state that expands coverage under section 1931 can assure these parents that leaving welfare for work will not cause them to become uninsured. In recent years, academic research has provided empirical evidence supporting the notion that delinking welfare and health insurance eligibility and expanding health insurance coverage for low-income working families can help reduce welfare caseloads. (See box on next page.)

Similarly, providing low-income working parents with the opportunity to receive regular health care could promote job retention. Coverage may help parents avoid bouts of illness that might cause them to miss work or, in more serious cases, to lose a job. Moreover, for those parents in need of ongoing medical care, coverage will avoid the need for them to choose between forgoing essential health care in order to keep a job and leaving a job to qualify for Medicaid. Parents with serious health care needs who are forced to leave a job and return to welfare to gain Medicaid coverage lose the benefit of uninterrupted work experience, use up part of their limited lifetime

[9] (...continued)
Clients: Cases Closed During January Through March, 1997 (South Carolina: 1998).

Research Shows That Expanding Medicaid Can Help Reduce Welfare Caseloads

Two recent studies support the widely accepted belief that expansions in health insurance coverage help some families to make the transition from welfare to stable employment and others to avoid the need to apply for welfare in the first place.

Using the variations in how quickly states enacted Medicaid expansions for low-income children and in the size of these expansions, Aaron Yelowitz (an economist at the University of California at Los Angeles) tested the theory that families are less likely to use welfare if they can get health insurance for their children without going on welfare.[*] In his study, based on Current Population Survey data from 1989 to 1992, Yelowitz found that the generosity of a state's Medicaid expansion for children — measured by the difference in the eligibility thresholds for the state's Medicaid and AFDC programs for children of different ages — had a significant effect on the probability that a female-headed family would be on welfare or be active in the labor force. In states that had expanded Medicaid coverage to more children, a smaller portion of female-headed households were receiving AFDC and a higher portion were in the labor force.[**]

Similarly, researchers with the Minnesota Department of Human Services have studied the effect of MinnesotaCare on the size of the state's welfare caseload.[***] MinnesotaCare is a large health insurance program financed with state and federal Medicaid funds that offers subsidized coverage to families with children with incomes up to 275 percent of the poverty line and to adults without children with incomes up to 135 percent of the poverty line. After controlling for other factors that might explain changes in the state's AFDC enrollment levels over time, including changes in the state's unemployment rate and the level of its welfare benefits, the researchers found that the MinnesotaCare expansion effectively reduced welfare caseloads by 9.6 percent by deterring families from ever applying for welfare and by making it easier for families to leave welfare once they were enrolled.

It is not necessarily appropriate to use these studies to estimate the specific effect on welfare caseloads of expanding Medicaid for low-income working parents. This is because the studies are based on data collected prior to enactment of the federal welfare law and, in the case of the Yelowitz study, because it examines the effect of a Medicaid expansion for children rather than parents. Nevertheless, these studies offer strong empirical evidence to suggest that expanding coverage for parents will help families to seek and retain employment.

---

[*] Aaron S. Yelowitz, *The Medicaid Notch, Labor Supply, and Welfare Participation: Evidence from Eligibility Expansions,* Discussion Paper No. 1084-96 (Wisconsin, Institute for Research on Poverty: 1996).

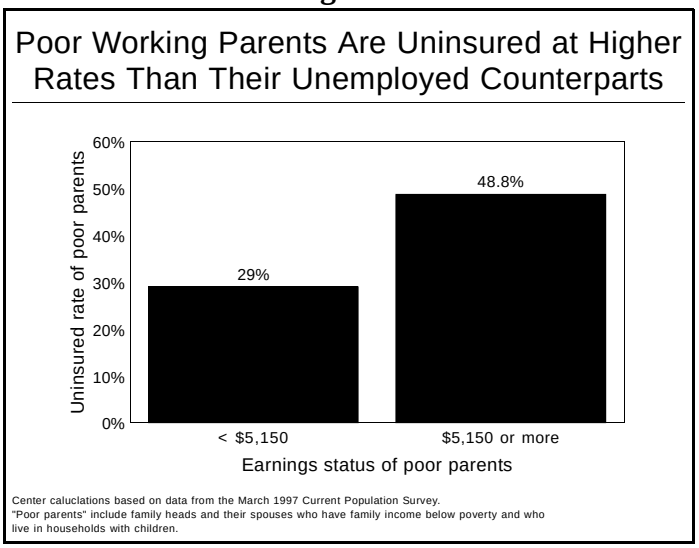
[**] Among other things, the study controls for the effect on welfare receipt and labor-force participation of families' demographic characteristics, the state in which a family resides, and the year in which the decision of whether to participate in the labor force was made. By including these "state and year" effects, the study takes into account such factors as changes in macroeconomic conditions over time and variation across states in their economic conditions and their AFDC benefit levels.

allotment of cash assistance, and may be subject to welfare sanctions.[10] Moreover, once welfare time limits take effect across the country, women who leave their jobs because they become ill or develop a medical condition that requires costly medical care could be left without any source of income.

Expanding Coverage Will Offer Low-Income Working Parents the Same Access to Health Care as Parents Who Are Not Employed

In the past, the policy of offering Medicaid only to families who were receiving welfare (with narrow exceptions) meant that low-income parents who were working were uninsured at much higher rates than their counterparts who were unemployed. One study found that in the early 1990s working single mothers with income below 200 percent of poverty were uninsured at twice the rate of their unemployed counterparts.[11] More recent data also indicate that poor parents with earnings are far more likely to be uninsured than poor parents with little or no earnings — in 1996 among poor adults living in households with children, 48.8 percent of those making at least $5,150 a year were uninsured in 1996 compared with 29 percent of such adults with no earnings or earnings below $5,150 a year.[12]

Figure 3



The new opportunity created by the welfare law allows states to address this inequity by taking advantage of the delinking of welfare and Medicaid to expand coverage for low-income parents with incomes above the very low minimum eligibility standards associated with section 1931 Medicaid coverage. In the absence of expansions beyond the minimum levels, access to Medicaid for parents who are neither pregnant nor disabled is likely to continue to

[10] Technically, a parent need not go on welfare in order to qualify for Medicaid now that eligibility for parents for Medicaid is delinked from eligibility for welfare, but in practice federal minimum Medicaid income standards are so low that a parent seeking Medicaid is likely also to need and qualify for cash assistance (unless she is pregnant or disabled).

[11] Pamela Farley Short, *Medicaid's Role in Insuring Low-Income Women* (New York: The Commonwealth Fund, May 1996).

[12] Center calculations based on data from the March 1997 Current Population Survey.

be confined largely to those who are on welfare or who have extremely low incomes for other reasons.

Expansions for Parents Allows for Coverage of Entire Families

At present, states generally cover the children in low-income working families through Medicaid, using Medicaid income standards that are different, and generally much higher, than the standards that apply to their parents. Moreover, in some states Medicaid eligibility rules offer coverage to younger children at higher income levels than older children, creating situations in which a family may have a younger child who is eligible for Medicaid and an older child who remains uninsured or who is eligible for coverage under a separate child health insurance program. Thus, in virtually all states there are two Medicaid income standards that must be considered when determining family members' eligibility for Medicaid, and in many states three or four standards must be applied.[13] The new opportunity allows states to cover low-income working families as a unit. Thus, a state could use a single set of rules to determine an entire family's eligibility for Medicaid, including children of all ages as well as parents, or at least reduce the number of different standards that must be applied to determine eligibility for family members. Such a system should be easier for states to administer than a patchwork of eligibility rules that vary for individuals within a family; it should also be easier for families to understand and use.

Low-Income Working Parents are Relatively Inexpensive to Cover

The cost of providing coverage to adults under Medicaid is relatively low — adults are relatively inexpensive because they generally are healthy and not in need of extensive medical care. Nationally, the cost of covering an adult is only about half the average cost of covering Medicaid beneficiaries, and the cost of covering low-income working adults is likely to be even lower.[14]

The average cost per adult referenced above includes the cost of covering pregnant women who typically have high medical expenses. But federal law already

---

[13] States often have a separate and higher standard for infants and pregnant women.

[14] Nationally, according to data compiled by the Urban Institute, the cost of providing benefits to an adult Medicaid beneficiary is 45 percent below the average cost of providing benefits to all Medicaid beneficiaries. Kaiser Commission on the Future of Medicaid, *Medicaid Expenditures & Beneficiaries: National and State Profiles and Trends, 1990 - 1995* (Washington, DC: November 1997), Table 20.

requires states to cover pregnant women with family income below 133 percent of the poverty line, and a majority of states have expanded Medicaid coverage to at least 185 percent of the federal poverty line for pregnant women. This means that relatively few, if any, pregnant women are likely to be picked up by an expansion of Medicaid for low-income working parents. In addition, the majority of states already extend Medicaid coverage to parents in single-parent and some two-parent families with high medical expenses.[15] For these reasons, states may find that the adults covered through an expansion under section 1931 are significantly less expensive than those who are currently enrolled in Medicaid.

Is There a "Crowd-Out" Problem If States Expand Medicaid Coverage for Parents?

In the debate in many states over how to use the new child health block grant funds, concern has been raised that expanding publicly funded health insurance programs for children could "crowd out" private coverage; that is, it could cause employers to stop offering their employees health insurance coverage, or at least dependent coverage, and encourage employees to turn down offers of coverage made by their employers. Under the child health block grant, states that elect to use their funds to establish or expand a separate state program are required to describe in the child health plan submitted to the federal government the steps they will take to ensure that their new program does not substitute for private coverage.

While there is considerable controversy about the magnitude of the substitution problem, researchers agree that little crowd-out is likely to occur when states expand coverage for very low income groups. The simple reason is that people with very low incomes, including working parents, have severely limited access to private health insurance coverage and so there is little private coverage to "crowd out." Since, as noted above, federal minimum Medicaid standards require states to cover parents at only very low income levels, states have considerable room to expand coverage above these minimum standards without raising crowd-out concerns. For example, among parents who have income below 150 percent of the poverty line, less than one-third (31.2 percent) have private coverage. The potential for crowd-out is therefore significantly less among such workers than among workers with higher earnings and greater access to employer-based health insurance coverage.

Moreover, states have considerable flexibility in determining the scope of benefits for adults enrolled in Medicaid. While federal law requires states to offer all Medicaid beneficiaries certain specified services, such as inpatient hospital care and physician services, most services are optional and states have discretion in determining the "amount, scope and duration" of the services that are included in the Medicaid benefit package within the limits set by federal law. The primary exception to the states' broad flexibility to determine the generosity of the Medicaid benefit package applies only to *children* (defined by federal law in this context as individuals under age 21). Children enrolled in Medicaid must be provided with coverage that meets Early and Periodic Screening,

[15] According to data compiled by the National Governors Association in 1996, 34 states operate medically needy programs for parents and other relatives caring for children who have high medical expenses relative to their income. National Governors Association (Washington, DC: 1996).

Diagnosis and Treatment requirements.[16] EPSDT, however, does not apply to adults (age 21 and older) enrolled in Medicaid. Thus, to a large extent states can determine the parameters of the coverage they offer to adults, including adults covered through an expansion under section 1931.

[16] EPSDT rules require that if a health screening shows that a child has a medical problem, a state must cover medically necessary treatment for the child, even if the state's Medicaid program does not cover such treatment for adults.

III. Routes to Medicaid Coverage for Parents

In general, there are three ways for a parent to gain access to Medicaid coverage.[17] Parents must meet the state's standards and rules under the Medicaid eligibility category that replaced the automatic AFDC-Medicaid eligibility link, must be eligible for TMA, or must meet state eligibility standards for pregnant women. Each of these three routes to Medicaid eligibility is described briefly below.

Families Who Meet July 16, 1996, AFDC Income, Resource, and Family Composition Rules

Until the federal welfare law was enacted in August 1996, most parents could gain eligibility for Medicaid only if they received AFDC. Through the addition of section 1931 to the Social Security Act, the welfare law replaced the automatic eligibility link between welfare and Medicaid with a new Medicaid eligibility category. Under this new eligibility category, at a minimum states must provide Medicaid to children and parents:

- whose income and resources are below the state's AFDC income and resource standards that were in effect as of July 16, 1996 using the rules that were in effect on that date to calculate income and resources,[18] and

[17] A parent who is disabled or who has high medical expenses relative to her income may have additional routes to coverage, including through coverage related to receipt of Supplemental Security Income or under a medically needy eligibility category.

[18] The income standards typically require families to meet three tests. First, the family must pass a gross income test: its gross income — net of up to $50 in child support payments, Earned Income Tax

(continued...)

- who meet certain AFDC family composition rules in effect on July 16, 1996. These rules generally limit coverage to families with a minor child who has at least one parent absent from the home or not able to provide support to the child for other reasons.[19]

As a result of the new section 1931 eligibility category, a family's receipt of welfare does not generally determine or affect its eligibility for Medicaid. For example, a single-parent family that reaches a welfare time limit remains eligible for Medicaid even though it no longer receives cash assistance as long as it continues to meet a state's July 16, 1996, AFDC income and resource standards and family composition rules. Similarly, a single-parent family that does not apply for welfare but that has very low income may qualify for Medicaid if the family meets the state's income and resource standards and family composition rules.

Because states' July 16, 1996, income and resource standards generally were quite low, families must have very low incomes and no more than $1,000 in countable assets in order to qualify for Medicaid under the *minimum* eligibility standards established by section 1931. This eligibility category leaves most poor and near-poor working parents without coverage even though it guarantees Medicaid eligibility for very poor families including those families that do not apply for or that do not receive welfare as a result of time limits or other welfare program changes.

As explained in Section IV, these section 1931 requirements for coverage are minimum requirements. The new opportunity to cover a broader range of poor and near-poor working parents results from the options available under section 1931 to expand Medicaid for working parents beyond these federal minimum standards.

---

[18] (...continued)
Credit payments, and a dependent child's income (which is subject to optional exclusions)— must fall below 185 percent of the state's "standard of need," a measure of the amount of income determined by the state as essential for a minimum standard of living. Second, the family must have net income below the state's standard of need. Finally, the family's net income must be below the state's "payment standard," the maximum amount of assistance the state would grant a family with no countable income. In most states, the payment standard is below the need standard. Under the AFDC resource rules, families must have countable assets of less than $1,000. States must disregard the value of a family's home, the equity value of one car up to $1,500, and a selected number of other items when calculating the amount of resources a family has.

[19] Under standard July 16, 1996, AFDC family composition rules, states could provide assistance only to certain kinds of families, generally single-parent families with children or two-parent families with children in which one of the parents was incapacitated (AFDC-I families) or met certain work requirements (AFDC-UP families). In order for a two-parent family without an incapacitated parent to qualify for AFDC-UP, the principal wage earner in the family must work *fewer* than 100 hours a month.

Transitional Medicaid Assistance

Time-limited coverage under Medicaid is available to some low-income working parents under TMA. Federal law requires states to extend Medicaid for a temporary period to families who otherwise would lose coverage that is based on section 1931 as a result of earnings, child support, or the lapse of an "earnings disregard" policy. Specifically, Medicaid coverage for families that otherwise would lose eligibility owing to child support income continues for four months, while families that otherwise would lose eligibility owing to earnings automatically are eligible for at least six months of coverage and an additional six months as long as their gross earnings (less child care expenses) are below 185 percent of the federal poverty line.[20]

The Family Support Act of 1988 established TMA to help families that were leaving welfare for work. While TMA is an important source of coverage for some working poor parents, it has significant limitations. The major shortcoming is that in order to qualify for TMA coverage, a family must first receive Medicaid (for at least three out of the most recent six months) under the section 1931 eligibility category described above. A low-income parent who has been steadily employed would have to quit her job or reduce her earnings in order to qualify for Medicaid under the July 16, 1996, AFDC income standard before she could become eligible for TMA. Moreover, TMA coverage is time-limited and is conditioned on the parent's ability to meet extensive reporting requirements that are burdensome to parents and states alike.

Although data are not generally available, it appears that only a small portion of families may be receiving the TMA coverage for which they are eligible. Some states have done little to advise families about TMA and, in particular, to inform families that they must be recorded as losing their regular Medicaid eligibility specifically because of an increase in earnings or child support in order to qualify for TMA. Many families in which a parent finds employment simply stop seeking assistance from their local welfare agency because they believe they no longer qualify for benefits. If families do not know about TMA, they have no reason to advise the agency that the reason they are no longer seeking assistance is that they have found employment.[21] Many families, therefore, are never evaluated for TMA eligibility.

---

[20] Twelve states have received waivers to extend TMA for longer than 12 months (Arizona, California, Connecticut, Delaware, Nebraska, New Jersey, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont), typically increasing the period of coverage to 18 months or 24 months. Jan Kaplan, *Transitional Medicaid Assistance* (Washington, DC: Welfare Information Network, December 1997).

[21] The South Carolina study discussed in Section II supports the hypothesis that relatively few parents leaving welfare realize that they may be eligible for TMA. That study found that almost half (44.8 percent) of former welfare recipients were not aware that adults who leave welfare for work may be eligible for TMA.

Coverage of Pregnant Women

The third avenue of Medicaid coverage for parents who are not disabled is limited to pregnant women. Federal law requires states to extend Medicaid coverage to pregnant women with income below 133 percent of the federal poverty line and gives states the option of expanding coverage to pregnant women further up the income scale. As of May 1998, 28 states had expanded coverage of pregnant women to at least 185 percent of the federal poverty line.[22]

In sum, unless a parent is pregnant, disabled, or otherwise in need of extensive medical care, she is not likely to receive coverage through Medicaid under federal *minimum* requirements unless her family income is extremely low and she has virtually no assets. For a time-limited period, a parent who initially qualifies for Medicaid under section 1931 rules and standards can receive TMA while she is working. Access to TMA, however, is limited because a parent first must qualify for Medicaid under the generally very low section 1931 minimum standards and because the systems for assuring TMA coverage is used by working families often are inadequate.

[22] National Governors Association (Washington, DC: 1997).

IV. The New Opportunity to Provide Coverage for Low-Income Working Parents

As already noted, the welfare law generally requires states to provide Medicaid coverage for parents who meet a state's July 16, 1996, AFDC income, resource, and family composition rules. At the same time, the welfare law accords states significant flexibility to expand coverage beyond these minimum levels. States have up to four different (and often overlapping) opportunities to adopt more expansive income, resource, and family composition rules in order to cover more low-income working parents.

The Option of Raising the Medicaid Income and Resource Standards

Federal law gives states the option of increasing their section 1931 income and resource standards by as much as the increase in the consumer price index since July 16, 1996.[23] In general, this is the least significant of the four sources of flexibility for expanding Medicaid coverage since the CPI cap allows for only a small change in the standards. This option, however, could be combined with the other options described below to ensure that Medicaid income and resource standards do not erode over time because of inflation.

[23] States also have the option of lowering their income standards, but not below May 1988 levels.

The Option of Using Less Restrictive Methodologies for Calculating Income and Resources

The main route for states to expand Medicaid coverage for low-income working parents is by exercising the flexibility they have under section 1931 to define *countable* income and resources when determining whether a family's income and resources fall below the state's July 16, 1996, AFDC standards.

Federal law requires states to disregard (i.e., not count) certain kinds and amounts of income and resources when calculating a family's *countable* income and resources. Eligibility is determined by comparing net (countable) income and resources with the state's standards. For example, states are required to disregard $90 per worker each month in earnings to help cover some of the expenses associated with working, such as transportation costs. Thus, a parent who earns $400 a month is treated as having *countable* income of $310 ($400 – $90 = $310).

The opportunity to expand coverage for working parents arises because the federal law offers states the option of adopting income and resource disregards that are more generous than federal law requires. Specifically, when evaluating whether a family meets the state's Medicaid income and resource standards established under section 1931, states have the option of using "methodologies" for counting income and resources that are "less restrictive" than those used in their AFDC programs.[24] This allows states to create or expand income and resource exclusions ("disregards"), exemptions, or deductions in order to make more people eligible for Medicaid. States can adopt any change to their income and resource counting rules that expands eligibility as long as the change does not cause anyone who otherwise would be eligible for Medicaid to lose coverage.[25] For example, a state can double the $90 per worker earnings disregard and thus treat a parent who earns $400 a month as having countable income of $220 ($400 – $180 = $220).

States already have extensive experience using less restrictive methodologies to expand Medicaid coverage with the support of federal matching funds for other populations. In the past, states have relied on a provision directly parallel to the new option — usually referred to as the "1902(r)(2) option" — to expand Medicaid coverage for so-called poverty-level children and pregnant women whose eligibility for Medicaid

[24] Section 1931(b)(2)(c) of the Social Security Act.

[25] Health Care Financing Administration, *State Medicaid Manual*, Part 3, Eligibility, section 3301.1(G).

is determined by comparing their countable income with the poverty line or with 133 percent of the poverty line.[26]

Some examples may help to illustrate the new opportunity.

- **Example 1: Covering working parents with income below poverty.** Consider a state that under its July 16, 1996 standards covers a mother with two children who has earnings if her monthly income is below $463 (or about 41 percent of the federal poverty line). If the state wants to expand Medicaid to working parents with income below the federal poverty line ($1,138 a month for a family of three in 1998), it could use a less restrictive methodology for calculating countable income and establish a disregard for earned income equal to $676 a month.[27] With an earned income disregard of $676 per month, a family of three with earnings at the poverty line ($1,138 a month) is treated for purposes of Medicaid eligibility as having *countable* income of $462 a month ($1,138 – $676 = $462). The family, therefore, would be

Gross earnings (federal poverty level for family of 3)	$1,138
Expanded disregard for earnings	–$676
Countable income	$462
Eligibility threshold	$463

[26] Similarly, states have broad authority to define what counts as income when determining eligibility for a separate state insurance program financed with the new federal child health block grant funds. While technically states are required to use their child health block grant funds to provide insurance coverage to children with income below 200 percent of poverty, at least one state has already received approval from HCFA to assist children with family income above this level by adopting income disregards. Connecticut is covering children with gross family income up to 300 percent of the federal poverty level. It can do so by adopting an income disregard and ensuring that a child with gross family income of up to 300 percent of poverty is treated as having countable or net income of below 200 percent of poverty.

[27] Under this approach, the amount of the disregard would vary by family size to allow the eligibility standard to correspond to the poverty line for families of all sizes. To prevent eligibility standards from eroding over time, the size of the disregard and/or the state's income standard would need to be adjusted to reflect changes in the federal poverty level. For example, New York has recently adopted a Medicaid disregard policy that adjusts on an annual basis to assure continued Medicaid coverage of working parents with incomes below the poverty line.

eligible for Medicaid under the state's July 1996 AFDC income standard.[28] [29]

- **Example 2: Extending coverage to the parents of some or all of the children covered under a Medicaid expansion financed with child health block grant funds**. Consider a state, such as South Carolina, that has decided to use its new child health block grant funds to expand Medicaid to children with family income below 150 percent of the poverty line (about $20,475 a year or $1,707 a month for a family of three). At present, South Carolina covers parents in a three-person family only if its income falls below $200 a month (about 18 percent of the poverty line).

  If a state like South Carolina wanted to cover parents as well as children with family income up to 150 percent of the poverty line, the state could disregard $1,508 in income a month for a family of three when determining Medicaid eligibility under section 1931. If it did so, a parent with income up to 150 percent of the federal poverty line (or income up to $1,707 a month for a family of three) would be treated as having *countable* income of $199 a month and so could receive Medicaid ($1,707 – $1,508 = $199). Then, the state could provide Medicaid for the children *and parents* in low-income working families with income below 150 percent of the poverty line.

Gross income (150% of the federal poverty level for family of 3)	$1,707
Expanded disregard for earnings	–1,508
Countable income	$199
Eligibility threshold	$200

- **Example 3: Extending "transitional" Medicaid to parents who enter the workforce**. Under federal Medicaid law, states must provide 12 months

[28] Under section 1931 minimum standards, a state typically will impose a net and a gross income test. A state seeking to cover all working poor parents may need to eliminate the gross income test, which requires a family to have gross income below 185 percent of a state's 1996 AFDC standard of need. This can be done by simply disregarding *all* income for purposes of the gross income test (a less restrictive methodology change). HCFA has already approved Wyoming's decision to use this strategy to effectively eliminate the gross income test. Eliminating the gross income test also allows states to simplify their Medicaid eligibility determination process.

[29] In this example, as in examples 2 and 3, a state must provide TMA to families that lose their Medicaid eligibility under the 1931 standards as the result of an increase in earnings or the lapse of an earnings disregard policy. Thus, in example 1, a family that loses regular Medicaid eligibility under section 1931 when its countable income exceeds 100 percent of the poverty line is eligible for up to 12 months of TMA.

of TMA to families that otherwise would lose Medicaid coverage under section 1931 because of earnings. In light of the very low income standards under section 1931, TMA is in practice typically available to parents who were receiving welfare and Medicaid but then get a job that makes them ineligible for welfare as well as for regular Medicaid coverage.

Consider a state that wants to provide time-limited coverage to newly employed families for more than 12 months but that does not have a waiver from the Department of Health and Human Services allowing it to do so. Under the less restrictive methodologies option, the state could disregard the earned income of a family whose income from wages otherwise would cause it to lose eligibility for regular Medicaid under section 1931. The disregard might be available for a specified period, such as 24 months. Such a policy would ensure that families continued to receive Medicaid under section 1931 for at least the first 2 years the parent was in the workforce.[30] Coverage would be time-limited and would not generally be available to low-income working poor families as would be the case under the first two examples.

- **Example 4: Eliminating the asset test for families.** A state also may decide that it no longer wants to impose an asset test on families seeking Medicaid coverage. Under section 1931, a state could effectively eliminate an asset requirement by disregarding *all* of a family's assets when evaluating whether it meets the minimum section 1931 asset standard of $1,000. While states have long had the option of eliminating the asset test when evaluating whether children are eligible for Medicaid under the "poverty-level" standards, the new less restrictive methodologies option allows states to eliminate an asset test for *all* members of a family, including parents covered under section 1931.

While the option to expand coverage under section 1931 involves the creation of a new or expanded income or resource disregard, states do not need to actually add a complicated calculation to their individualized Medicaid eligibility determination procedures in order to expand coverage using the less restrictive methodologies option.

---

[30] In addition to the 24 months of extended coverage under section 1931, the state would be required to provide twelve months of regular TMA to a family that became ineligible for Medicaid under section 1931 as a result of loss of the expanded disregard. Thus, in this example, the family might be eligible for up to three years of extended Medicaid — two years under the less restrictive methodologies option and one year under regular TMA. States using less restrictive methodologies to extend Medicaid coverage to those entering the workforce will want to take "regular" TMA into account when deciding the length of time for which the special disregard would be available.

By adopting a less restrictive methodology for computing income or resources a state is effectively establishing new income and/or resource standards, and state eligibility workers can simply apply these new standards when they determine eligibility. For example, a state that adopted an expanded income disregard under section 1931 that effectively provides coverage to all families with incomes below 133 percent of the federal poverty line would not have to apply the new disregard to individual cases but instead could simply compare countable family income, using existing disregards, to 133 percent of the federal poverty level.

The Option to Amend Family Composition Rules to Cover More Two-Parent Families

In the context of the new Medicaid eligibility category, the requirement that states cover families meeting July 16, 1996, AFDC family composition rules means that they must cover single-parent families, two-parent families in which one of the parents is incapacitated, and two-parent families in which the principal wage earner satisfies the "100-hour rule."[31] According to the 100-hour rule, for either parent to be eligible for benefits, the family's principal wage earner must work fewer than 100 hours a month.

On August 7, 1998, the Department of Health and Human Services issued a regulation that accords states the flexibility to adopt a less restrictive version of the 100-hour rule when determining the Medicaid eligibility of two-parent families. As a result of the new regulation, states can now decide not to impose any limit on the number of hours that the principal wage earner in a two-parent family can work and still retain Medicaid eligibility. For example, a state that wanted to expand Medicaid to low-income working adults up to 133 percent of poverty could elect to cover adults in two-parent families as long as they met this income test; it would not need to impose the additional requirement that they also work for fewer than a specified number of hours each month.

States will need to change the 100-hour rule, as well as increase their income thresholds, if they want to expand Medicaid to low-income working parents without

---

[31] Under former AFDC rules, a two-parent family without an incapacitated parent could receive AFDC only if the principal wage earner also satisfied a work history requirement (i.e., the principal wage earner in the family must have received or been eligible for unemployment benefits or must have had at least $50 of earnings in at least 6 of 13 quarters ending within a year before applying for benefits). Moreover, such families could not receive aid until 30 days after the date on which the principal earner became unemployed. HCFA has determined that the work history requirement and the 30-day waiting period do not apply under section 1931. In other words, whether or not a two-parent family satisfies the old work history and 30-day waiting period requirement has no bearing on its eligibility for Medicaid under section 1931. See section 3301.1 of Health Care Financing Administration, *State Medicaid Manual*, Part 3.

providing more favorable treatment to single-parent families than they provide to two-parent families. If states do not change the 100-hour rule, then adults in two-parent families will be cut off by the 100-hour rule even when they remain income-eligible for Medicaid.

For example, consider a state that increases its effective Medicaid income thresholds for parents to 100 percent of poverty ($1,138 a month for a family of three) without also changing the 100-hour rule. In such a state, adults in a two-parent family in which the principal wage earner makes $6 an hour lose Medicaid eligibility because of the 100-hour rule when the earnings of the principal wage earner reach $600 a month (53 percent of the poverty line for a family of three), even though the state has increased its effective income threshold to 100 percent of poverty. As a result, an adult in a *single-parent* family who makes $6 an hour could work up to 51 hours a week without losing Medicaid eligibility, but the principal wage earner in a *two-parent* family who makes the same hourly wage could work no more than 23 hours a week without losing Medicaid eligibility.

Authority to Continue AFDC Waivers for Purposes of Medicaid Eligibility

Some states have a fourth method of expanding Medicaid coverage to low-income parents. Under section 1931, states may use income, resource, and family composition rules that differ from the ones in their AFDC plans as of July 16, 1996, if the state had an AFDC waiver that allowed it to adopt alternative rules. The waiver had to have been submitted to HHS before August 22, 1996, and approved on or before July 1, 1997. A state can continue an AFDC waiver for purposes of determining Medicaid eligibility even if it has decided to discontinue the waiver for purposes of Temporary Assistance to Needy Families.

State AFDC waivers typically affected a range of policies. Many states had waivers that tightened work participation requirements, and some had waivers that established time limits. For purposes of Medicaid eligibility, however, states may continue to apply only the waiver rules that affect the section 1931 eligibility criteria — income, resource, and family composition rules. For example, a state that has an AFDC waiver expanding its earnings disregard can apply its waiver-based earnings rule when determining a family's countable income under section 1931. However, a state that had an AFDC waiver that allowed it to sanction families by cutting off all assistance for not following certain AFDC rules cannot carry its sanction policy over to Medicaid under section 1931.[32]

[32] Letter from the Health Care Financing Administration to state Medicaid directors, February 5, 1997.

States Already Have Taken Advantage of the "Less Restrictive" Methodologies Option

A number of states have adopted more generous earnings disregard policies in their TANF programs to allow families entering the workforce to keep a greater share of their earnings and to reduce the stringency of their cash assistance asset tests. To ensure that their TANF and Medicaid eligibility rules remain aligned — avoiding the prospect that a family would be eligible for TANF but not eligible for Medicaid — many of these states have used the flexibility available to them under the section 1931 "less restrictive methodologies" option to carry over these more generous earnings disregard policies and resource rules to Medicaid. Through these changes, these states have simplified program administration by keeping their TANF and Medicaid eligibility rules aligned and, at the same time, have expanded Medicaid coverage for low-income working families.

- Pennsylvania now disregards 50 percent of a TANF recipient's earned income when evaluating whether a parent who becomes employed remains eligible for TANF. It applies the same 50 percent disregard to Medicaid recipients under section 1931. This disregard effectively allows a single parent with two children to remain on Medicaid as long as her earnings continue to be below 74 percent of the 1998 poverty line for a family of three.

- Consistent with policies in its TANF cash-assistance program, New York has established a policy of disregarding as much of a Medicaid recipient's earnings as necessary to allow families to retain Medicaid coverage until their earnings reach the poverty line. At present, the state is disregarding 45 percent of the earnings of a family receiving Medicaid under section 1931. The disregard will be adjusted on an annual basis to assure that Medicaid eligibility continues to correspond directly to the poverty line, which is also adjusted annually.*

- Other states, including North Carolina, South Carolina, and Wyoming, have used section 1931 less restrictive methodologies to ease the asset test for families seeking Medicaid coverage. For example, North Carolina disregards the first $2,000 of otherwise countable resources when evaluating whether a family's assets fall below the section 1931 resource standard of $1,000. In effect, this policy raises the resource standard to $3,000. Using the less restrictive methodology option, North Carolina also exempts $5,000 in fair market value of a car instead of continuing the July 16, 1996, AFDC policy of disregarding $1,500 in equity value.

* New York has retained the "gross income test," which requires a family's gross income to fall below 185 percent of the standard of need for a given geographic area. In some parts of New York, where 185 percent of the standard of need is less than the poverty line, coverage for families under section 1931 will not extend fully to the poverty line.

The authority to rely on AFDC waiver provisions to vary from standard section 1931 Medicaid rules creates opportunities that largely overlap with the opportunities available to states to expand coverage under the less restrictive methodologies options described above. In general, states with an applicable waiver can either rely on their waiver or apply less restrictive methodologies and/or liberalize or eliminate the 100-hour rule. For example, for purposes of determining Medicaid eligibility under section 1931, a state that had an AFDC waiver to disregard the full value of an automobile under the state's pre-TANF asset test can continue to disregard the full value of a car either by relying on the AFDC waiver or by applying a less restrictive resource methodology. Similarly, states that had statewide AFDC waivers of the 100-hour rule could drop the rule by carrying those waivers over into Medicaid or by using the flexibility accorded to them under the August 7, 1998 regulation to adopt a less-restrictive version of the 100-hour rule.[33]

[33] While the August 7, 1998 regulation allows states to adopt a less-restrictive version of the 100-hour rule, it does not accord states the flexibility to change other family composition rules that apply under section 1931. A few states had AFDC waivers that allowed them to extend eligibility for AFDC to families consisting of children residing with a non-relative caretaker or to make other relatively minor changes in AFDC family composition rules. These waivers can be carried over to Medicaid for purposes of determining eligibility under section 1931 to broaden the category of families that can qualify for Medicaid coverage. In general, continuing these waivers is the only opportunity that states have to change aspects of the family composition rules used to determine Medicaid eligibility under section 1931 with the exception of the 100-hour rule.

V. Opportunities to Expand Coverage for Parents Under the New Child Health Block Grant

Some states have expressed an interest in using a portion of the funds available to them under a new child health block grant created by the Balanced Budget Act of 1997 to cover parents as well as children. Under the new child health block grant, states can elect to expand Medicaid coverage for children or to establish or expand a separate child health insurance program. States also can use a combination of these approaches. Regardless of which approach a state adopts, a state must spend some of its own funds as a condition of receiving the federal child health block grant funds available under Title XXI. However, the new child health block grant offers states an "enhanced matching rate" that allows them to spend proportionately less in matching funds than they would for "regular" Medicaid expenditures. Specifically, the enhanced matching rate available under the child health block grant reduces a state's share of the cost of financing health care coverage to 30 percent below its share of health care costs under the regular Medicaid matching system.

The child health block grant, which was established under Title XXI of the Social Security Act, is intended to expand coverage for children, not adults, but the new law offers two potential opportunities to take advantage of the more favorable matching rate to cover parents:

- **Family coverage waiver.** Title XXI allows states to apply for waivers from the Secretary of HHS to use child health funds to purchase family coverage. HHS has not yet issued guidelines on how it will implement its waiver authority, but the federal law allows HHS to grant such waivers only if a state can establish that it is cost effective to purchase family coverage instead of providing coverage for only the children in a family.

For example, a state might be able to establish that it is cost effective to help some families take up an employer's offer of partially subsidized insurance instead of enrolling the family's children in the state's Medicaid or separate state insurance program. Under the law, any coverage purchased through an employer with child health funds still must comply with Title XXI standards, including federal minimum benefit and cost-sharing standards.

- **Section 1115 waiver.** Under section 1115 of the Social Security Act, the Secretary of HHS has broad authority to waive provisions of the Social Security Act — including the provisions of Title XXI — in order to allow states to conduct demonstration projects that advance the objectives of the Act. Using section 1115, a state could attempt to secure a waiver of the provisions of Title XXI that generally restrict the use of the new child health funds to providing coverage to children under the age of 19. HHS, however, has stated that in light of the broad flexibility accorded to states under the law it is unlikely to consider waiving provisions of the new child health law under section 1115, at least until states have gained more experience with the new program.[34]

At least at the present time, therefore, neither the family coverage waiver option nor the section 1115 waiver route appears to offer states a general opportunity to use child health funds to cover parents. States that are interested in expanding coverage for low-income working parents will need to rely on the opportunity to provide such coverage under the regular Medicaid program using the flexibility accorded to them by section 1931. If at some time HHS determines that states are allowed to use their child health funds to cover parents more broadly, a state that offers coverage to parents under section 1931 could change the source of its funding from regular Medicaid to Title XXI in order to benefit from the more favorable matching rate.[35]

Moreover, even if further HHS guidance broadens the opportunity for states to use their child health funds to provide coverage to parents under the family coverage waiver option, states still may need to consider also using section 1931 to expand

---

[34] Health Care Financing Administration, *Questions and Answers about the State Child Health Insurance Program* (Washington, D.C., September 11, 1997), Question 14(b).

[35] Nothing in the Medicaid or child health laws prevents states from rescinding an expansion of coverage for parents under the less restrictive methodologies option and then covering the parents with child health block grant funds. A state could expand coverage to low-income working parents using the less restrictive methodologies option and then, should the opportunity to use child health funds to cover parents arise, rescind the section 1931 Medicaid expansion and replace it with coverage financed out of the child health block grant.

Medicaid coverage to at least some low-income parents. If they do not, they risk establishing a system under which there is a gap in coverage for a group of low-income parents. The potential for a gap in coverage arises under the family coverage waiver option because Title XXI bars states from using their new child health funds to cover children who qualify for Medicaid under the Medicaid eligibility standards that a state had in place in the spring of 1997. Presumably, Title XXI also would preclude states from using child health block grant funds to purchase family coverage for purposes of covering the *parents* of these children. Thus, if states want to use federal funds to cover low-income working parents whose income is above minimum section 1931 standards but below the eligibility standards established for children covered with Title XXI funds, they must rely on the section 1931 Medicaid option. If they do not do so, the parents of children who are eligible for Title XXI-funded coverage will have access to public health insurance, but many of the parents of children who are eligible for "regular" Medicaid will not, even though these parents have lower incomes.

For example, consider a state that covered under Medicaid all children with family income up to 100 percent of the poverty line as of June 1997, but that now uses the new child health block grant funds to expand coverage to children with income between 100 percent and 150 percent of the poverty line. If this state were to receive a waiver allowing it to use its child health funds to cover parents, the likelihood is that this waiver would extend only to parents whose children are eligible for coverage under the child health block grant. This means that parents with incomes between 100 percent and 150 percent of the federal poverty line would be eligible for coverage. Without a parallel expansion of coverage under section 1931 for parents whose children were eligible for Medicaid coverage prior to the enactment of the child health block grant, lower-income working parents — those with incomes above the state's July 16, 1996, AFDC standards and below 100 percent of the poverty level — would be left out of the parent expansion.

VI. Conclusion

Many states have expanded coverage for children under Medicaid, and the new child health block grant will push the expansion of coverage for children much further along. Low-income working parents, however, are at high risk of being uninsured because their jobs typically do not offer affordable employer-sponsored coverage and in most states they have very limited access to Medicaid. As implementation of the welfare law leads to greater numbers of parents working in low-wage jobs that do not provide health insurance, the number of uninsured low-income parents is likely to grow unless states take action.

States now have an important opportunity to address this problem by offering Medicaid coverage to low-income working parents. States that take advantage of this new opportunity can receive regular federal Medicaid matching funds to give families struggling to get by in the low-wage job market the same access to health care as families receiving cash assistance. By making health insurance coverage available to working poor families without regard to current or recent receipt of cash assistance, Medicaid coverage also can help parents avoid the need to apply for welfare or shorten their stay on welfare.

Table 1: Federal Medicaid Matching Rate
Fiscal Year 1998

State	Medicaid Matching Rate
Alabama	69.3
Alaska	59.8
Arizona	65.3
Arkansas	72.8
California	51.2
Colorado	51.9
Connecticut	50.0
Delaware	50.0
District of Columbia	70.0
Florida	55.7
Georgia	60.8
Hawaii	50.0
Idaho	69.6
Illinois	50.0
Indiana	61.4
Iowa	63.8
Kansas	59.7
Kentucky	70.4
Louisiana	70.0
Maine	66.0
Maryland	50.0
Massachusetts	50.0
Michigan	53.6
Minnesota	52.1
Mississippi	77.0
Missouri	60.7
Montana	70.6
Nebraska	61.2
Nevada	50.0
New Hampshire	50.0
New Jersey	50.0
New Mexico	72.6
New York	50.0
North Carolina	63.0
North Dakota	70.0
Ohio	58.1
Oklahoma	70.5
Oregon	61.5
Pennsylvania	53.4
Rhode Island	53.2
South Carolina	70.2
South Dakota	67.8
Tennessee	63.4
Texas	62.3
Utah	72.6
Vermont	62.2
Virginia	51.5
Washington	52.2
West Virginia	73.7
Wisconsin	58.8
Wyoming	63.0
Territories	50.0

Source: HCFA, September 10, 1997.

Table 2: Income Level at Which Parents Lose Eligibility for Medicaid Under the Federal Minimum Requirements of Section 1931

(Effective Cut-off Levels May Be Higher If States Have Exercised Opportunities to Expand Above Minimum Requirements)

State	Monthly income level at which eligibility is lost /1	Eligibility threshold as a percent of poverty /2	Maximum hours per week that can be worked at minimum wage before exceeding Medicaid eligibility standard /3
Alabama	$253	22%	11
Alaska	$1,117	78%	50
Arizona	$436	38%	20
Arkansas	$293	26%	13
California	$819	72%	37
Colorado	$510	45%	23
Connecticut	$961	84%	43
Delaware	$427	38%	19
District of Columbia	$509	45%	23
Florida	$392	34%	18
Georgia	$513	45%	23
Hawaii	$801	61%	36
Idaho	$406	36%	18
Illinois	$466	41%	21
Indiana	$377	33%	17
Iowa	$515	45%	23
Kansas	$518	46%	23
Kentucky	$615	54%	28
Louisiana	$279	25%	13
Maine	$642	56%	29
Maryland	$462	41%	21
Massachusetts	$654	57%	29
Michigan	$578	51%	26
Minnesota	$621	55%	28
Mississippi	$457	40%	20
Missouri	$381	33%	17
Montana	$630	55%	28
Nebraska	$453	40%	20
Nevada	$437	38%	20
New Hampshire	$639	56%	29
New Jersey	$532	47%	24
New Mexico	$478	42%	21
New York	$666	59%	30
North Carolina	$633	56%	28
North Dakota	$520	46%	23
Ohio	$430	38%	19
Oklahoma	$396	35%	18
Oregon	$549	48%	25
Pennsylvania	$510	45%	23
Rhode Island	$643	57%	29
South Carolina	$289	25%	13
South Dakota	$596	52%	27
Tennessee	$672	59%	30
Texas	$277	24%	12
Utah	$657	58%	29
Vermont	$739	65%	33
Virginia	$443	39%	20
Washington	$635	56%	28
West Virginia	$342	30%	15
Wisconsin	$606	53%	27
Wyoming	$679	60%	30
Median state	$515	45%	23

1/ CBPP calculation based on AFDC payment standards for a family of three as of January 1996, and an earned income disregard of $90. 1996 Green Book. If States have exercised their opportunities to adopt more generous disregards, cut-off levels will be higher than those presented in this table.

/2 1998 federal poverty line for a family of three, $13,650 per year. Department of Health and Human Services.

/3 Based on federal minimum wage of $5.15 per hour.

Center on Budget and Policy Priorities