

Welfare And Immigration Reforms: Unintended Side Effects For Medicaid

Medicaid caseloads have been shrinking as federal welfare reform and immigration restrictions begin to take effect.

by Marilyn R. Ellwood and Leighton Ku

ABSTRACT: Welfare reform and changes in immigrants' eligibility may lead to significant reductions in Medicaid caseloads, even though many states are expanding Medicaid eligibility rules to accommodate changes under the new welfare programs. In 1996, for the first time in almost a decade, Medicaid participation of adults and children fell about 2 percent, and further reductions seem likely in 1997. The gradual restrictions on new immigrants also will affect future caseloads. Although new initiatives such as the State Children's Health Insurance Program (CHIP) should expand health coverage for children, the welfare reform and immigration changes will disproportionately lead to loss of insurance among adults.

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STATE WELFARE PROGRAMS for families have experienced unprecedented caseload declines. From 1993 through 1997 enrollment in the Aid to Families with Dependent Children (AFDC) program and its replacement, Temporary Assistance to Needy Families (TANF), dropped 26 percent, from 14 million to 10.5 million. These caseloads fell 50 percent in Wisconsin, Tennessee, and Oregon. The reductions began even before the federal welfare and immigration reform law, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, was passed. This new law gave states almost complete control over their welfare programs but enjoined them to stiffen work requirements and impose time limits for the receipt of welfare. To a great extent, PRWORA continued welfare policies already under way; more than forty states already used federal waivers for major welfare reform

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changes. The combination of a strong economy and state policy changes led to falling caseloads even before the federal legislation was passed.

The welfare caseload reductions raise a vital question: How will welfare changes affect health insurance coverage for low-income families under Medicaid? Historically, AFDC has been the main avenue to Medicaid eligibility for most children and families. Will Medicaid enrollment follow the dropping welfare caseloads, even as the number of uninsured Americans continues to grow?

While Congress debated welfare reform, it was considering the Medicaid block grant proposal (Medigrant). Realizing that Medigrant was not going to pass, Congress decided at the last minute to revisit the linkage of welfare and Medicaid eligibility. PRWORA tried to minimize the adverse effects of welfare reform on Medicaid by decoupling welfare and Medicaid. Thus, the Congressional Budget Office (CBO) predicted no reduction in Medicaid participation or spending but lower welfare caseloads.¹

However, troubling questions arose from the start. Would persons losing welfare know that they might still be eligible for Medicaid? Would publicity about welfare reform deter families from applying for Medicaid? Would states try to make sure that low-income families got the Medicaid coverage they were eligible for?

Another part of PRWORA restricts Medicaid eligibility for new immigrants. Most legal immigrants who entered the United States after August 1996 (when PRWORA was enacted) are not eligible for full Medicaid coverage but can still receive emergency services. This is a marked change from the prior social contract in which immigrants who entered the country legally were treated similarly to U.S. citizens; only undocumented (illegal) aliens were restricted to emergency services.

Although the reductions in legal immigrants' benefits (including other programs such as Food Stamps) were responsible for about half of the total budget savings in PRWORA, the immigrant provisions were much less visible during the congressional debates. In fact, many Republican governors, who had been some of the main advocates of welfare reform, expressed dismay about the immigrant provisions and tried to reverse some of the policies.²

This paper seeks to illuminate the murky connection between welfare reform, changes in immigrant policies, and Medicaid. We illustrate these issues by drawing examples from the thirteen states of the Urban Institute's Assessing the New Federalism (ANF) project: Alabama, California, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington, and Wisconsin.³ Information came from on-site interviews

with state officials and advocates in 1996 and 1997, telephone updates in late 1997 and early 1998, analyses of federal administrative data, and a review of relevant research, state plans, and legislation.

The Same Old Rules For Medicaid Eligibility?

Welfare reform, as embodied by both PRWORA and prior state waivers, allows states almost complete discretion to decide who is eligible for welfare and the level of assistance. The key federal requirements involve work and time limits: Adult recipients must participate in work activities within two years of entry and may not get federally funded TANF benefits for more than sixty months over a lifetime. States may add more restrictions, such as shorter time limits, family caps (no increase in benefits for additional children), or school attendance requirements. States also may use their new flexibility to increase work incentives, increase benefits, or expand child care.

Because Congress did not want anyone to lose Medicaid eligibility as a result of welfare reform, the law requires states to continue using their old AFDC rules for Medicaid eligibility that were in effect in July 1996, just before PRWORA was passed. Thus, the legislation severed the mandatory link between welfare and Medicaid eligibility for children and families. A family's TANF status is immaterial to eligibility for Medicaid, although, as we discuss below, many states have adjusted their AFDC rules for Medicaid to ensure that families who get TANF also are eligible for Medicaid.

Although states must use their old AFDC rules, they have some flexibility. Of particular importance, states may adopt less restrictive methods of counting income and assets for AFDC-type families. This mild-sounding change allows states to expand eligibility by "disregarding" certain levels or types of income or assets. However, states may not impose any time limits for Medicaid or terminate coverage for children or pregnant women because of TANF work sanctions.⁴ Also, Congress left unchanged the other routes to Medicaid eligibility, such as poverty-related eligibility for children and pregnant women, medically needy programs, or transitional benefits.

Many states are using the flexibility provided by PRWORA to expand their old AFDC/Medicaid rules. Here we review how the ANF states have responded to the welfare reform legislation.

■ **Earned income and asset rules.** To provide a work incentive, a majority of case-study states increased earnings "disregards" under TANF (by limiting the amount a welfare payment is reduced for each additional dollar of earned income). Close to half of them (California, Florida, Michigan, Minnesota, New York, and Washington) also have modified their old AFDC rules to increase the amount of

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earnings families can have and still be eligible for Medicaid.

California allows newly enrolled families to disregard monthly earnings of \$225 plus 50 percent of earnings for both TANF and AFDC/Medicaid. A family of three can now earn up to \$1,355 per month and qualify for full Medicaid and TANF benefits. The previous AFDC limit was \$938, and even that was only allowed for a few months. Even after a family’s earnings exceed the AFDC/Medicaid threshold, it qualifies for twelve months of transitional Medicaid. By contrast, New Jersey opted not to let Medicaid “disregards” rise with TANF but instead extended the time allowed for transitional Medicaid benefits from twelve to twenty-four months, using state monies.

Also, Alabama, California, Colorado, Florida, Michigan, Minnesota, Texas, and Washington have opted to use more generous asset rules for both TANF and Medicaid, usually raising the asset limit from \$1,000 to \$2,000.⁵ In other states (such as Wisconsin) TANF is using higher asset rules, but Medicaid has elected to keep in place the old AFDC rules.

■ **Income thresholds.** PRWORA allows states to slightly modify their AFDC income standards for Medicaid eligibility. The basic rule is that any increase cannot exceed the rate of Consumer Price Index (CPI) increases, and any decrease cannot go below the standards in effect in 1988. This latitude allows a state to make Medicaid less restrictive without broadening welfare at the same time. States could use this provision to allow more single-parent families entrance into Medicaid. Also important, the AFDC/Medicaid thresholds determine medically needy thresholds.⁶ Although increasing limits based on inflation have a small short-term effect, eligibility thresholds could be greatly affected over a decade.

Discussions indicate that the case-study states are not typically changing their AFDC income thresholds for Medicaid to adjust for inflation. Instead, they are opting for higher levels of earnings to be disregarded, which effectively increases the Medicaid income criteria for working families.

■ **Termination of Medicaid.** PRWORA permits states to terminate Medicaid temporarily or permanently for adults who fail to meet their TANF work requirements, but only Alabama, Michigan, and Mississippi among the case-study states are doing so.

Problems Of Implementation, Not Policy?

Whether welfare reform reduces Medicaid caseloads may be more dependent on implementation than on policy. Discussions with state officials and advocates revealed several administrative areas that might contribute to enrollment declines.

■ **Separate eligibility criteria.** Most of the case-study states are trying to keep TANF and Medicaid eligibility requirements in tandem, but some TANF requirements, such as time limits, cannot apply to Medicaid. In states in which the TANF and Medicaid rules differ significantly, separate eligibility criteria can be a major challenge. TANF and AFDC/Medicaid rules can diverge in areas such as income standards, disregarded earnings, asset levels, eligibility of two-parent families, time limits, and work requirements.⁷

The ANF case-study states vary in their capacity to administer different rules for TANF and AFDC/Medicaid. In Alabama the determination of eligibility for TANF is highly automated, but eligibility for Medicaid is not. Wisconsin, on the other hand, uses a completely automated online system for both TANF and Medicaid eligibility determinations; neither program even uses a paper application. Full automation of eligibility determinations for both TANF and Medicaid is desirable, since it can be more efficient and reduce errors.

■ **Applications.** Even though PRWORA delinked TANF and Medicaid eligibility, the case-study states are generally continuing to use joint application forms. This is desirable, because experience with Supplemental Security Income (SSI) has shown that separate applications can reduce Medicaid participation.⁸ Most of the states are also using shortened application forms to improve poverty-related Medicaid coverage.

■ **Redeterminations.** Another aspect of Medicaid administration that may be affected by PRWORA rules is the redetermination of Medicaid eligibility for those exiting welfare. Redetermination of Medicaid eligibility is required at least every twelve months or whenever there is a change that might affect eligibility. Several states acknowledged problems with the redetermination process. Sometimes the effect is only short term. Minnesota has reported "churning," short-term interruptions in eligibility, among its Medicaid caseload because enrollees fail to respond to notices, which causes their eligibility to be temporarily interrupted. But states report that many times families disappear from the welfare system without getting Medicaid-only redetermination or twelve more months of transitional Medicaid coverage.

Part of the problem may be that families leaving welfare often assume that they are no longer eligible for Medicaid. Even before

PRWORA was passed, focus groups of welfare families in two states reported that 76 percent of them misunderstood how Medicaid coverage worked: 63 percent did not know about transitional Medicaid benefits for parents leaving welfare because of work, and 39 percent did not know that children could continue to qualify for Medicaid, even if the family no longer qualified for welfare.⁹

Advocates argue that states often fail to keep families leaving welfare enrolled in Medicaid until a redetermination occurs and that families are not receiving full information about Medicaid-only benefits. In addition, Health Care Financing Administration (HCFA) officials have pointed out that states can ease their Medicaid rules and documentation requirements so that termination from welfare coverage need not also trigger a Medicaid redetermination. Some states (for example, California) improved their redetermination procedures following class-action lawsuits. Automated eligibility systems also can help caseworkers to test for continued eligibility under multiple program rules without requiring families to submit additional paperwork.

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■ **Medicaid participation rates for noncash groups.** Welfare reform is putting the spotlight on one of Medicaid's long-term administrative problems: low participation for children and other family members whose Medicaid eligibility is not linked to their receipt of cash assistance. For example, in 1993 about 90 percent of AFDC-eligible children participated in Medicaid, versus 69 percent of those eligible only under poverty-related expansions.¹⁰ Low Medicaid participation rates also are reported for families eligible for twelve months of transitional Medicaid coverage, whose earnings exceed AFDC limits.¹¹

■ **Education and outreach.** Attention to education and outreach has increased, as states realize that recipients (and even staff) are understandably confused about Medicaid eligibility provisions. Wisconsin is launching a Medicaid outreach campaign, in large measure because state Medicaid caseload levels fell more than expected. The state will mail a notice to all families terminated from welfare over the past year who do not have anyone currently enrolled in Medicaid, informing them that they may still be eligible for Medicaid and how they can apply. In South Carolina the Southern Institute on Children and Families has developed Medicaid outreach brochures for use with welfare families, community organizations, and employers.

Education also is needed to emphasize the value of Medicaid's preventive services (especially for children) and the importance of signing up for coverage before a family member becomes ill.

■ **Changes in local welfare office "atmosphere."** One of the

most profound changes stemming from welfare reform may concern the operation of local welfare offices. Many of the case-study states, for example, are trying to change the expectations of local welfare staff so that they do not see their main job as issuing assistance checks. Indeed, the new image for some welfare offices is more like an employment center. Although this change may be appropriate for TANF, welfare offices are also the entry point into the Medicaid program for most low-income families. State officials and advocates are understandably concerned that information about the availability of Medicaid benefits may be overlooked, as local welfare offices focus on increasing employment and reducing dependency.

Early Evidence Of Medicaid Caseload Decline

The discussion above suggests that the overall impact of welfare reform on Medicaid could be ambiguous. On the one hand, the liberalization of eligibility in some states might increase Medicaid enrollment, even as welfare caseloads decline. Further, welfare reform might reduce the need for Medicaid coverage if people get jobs with health insurance benefits. On the other hand, welfare reform might reduce Medicaid rolls, even though eligibility rules for Medicaid were not tightened, because persons leaving welfare either are unaware of continuing Medicaid benefits or choose not to enroll, or state administrative procedures impede their timely enrollment.

■ **The numbers.** Unfortunately, national Medicaid data for the period following the adoption of PRWORA are not yet available. However, we can get a hint of things to come from examining the 1995–1996 period, when similar welfare reforms were already well under way in most states using federal waivers.

Between 1995 and 1996 AFDC/Medicaid enrollment declined nationally by 7.5 percent, while enrollment in the noncash groups rose 5.1 percent, leaving a net reduction of 1.8 percent in the total number of children and nondisabled adults enrolled in Medicaid (Exhibit 1). This net decline in Medicaid participation is noteworthy, since this is the first downturn in nearly a decade of steadily rising Medicaid participation rates.

Although the decline in AFDC/TANF caseloads in 1995–1996 was close to the decrease in AFDC/Medicaid caseloads, the overall reduction in Medicaid caseload was much smaller because of the partially offsetting increases in noncash participation.¹² One would expect the Medicaid caseload to fall less than the welfare caseload, since families leaving AFDC because of earnings can get transitional Medicaid coverage and children often qualify through the poverty-related criteria. Also, given the phased-in expansion of poverty-related child coverage, Medicaid noncash participation should have grown anyway.

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EXHIBIT 1
Changes In Medicaid And AFDC/TANF Participation Levels, 1995-1997

State	Percent change in annual Medicaid enrollment of adults and children, 1995-1996			Percent change in average monthly AFDC/TANF participation	
	Total	AFDC/Medicaid	Other (noncash)	1995-1996	1996-1997
Wisconsin	-12.3%	-26.6%	20.5%	-18.4%	-29.6%
Colorado	-4.0	-8.8	1.4	-9.5	-19.3
California	-3.3	-3.2	-3.5	-2.0	-8.5
Massachusetts	-3.2	-16.1	17.1	-13.4	-12.5
Mississippi	-2.2	-8.7	4.7	-10.5	-20.6
Michigan	-2.1	-9.5	11.5	-11.8	-14.9
Texas	-1.7	-7.9	2.9	-8.7	-16.1
New Jersey	-1.7	-9.0	10.4	-8.7	-13.1
New York	-1.2	-4.4	7.5	-5.3	-11.8
Alabama	-0.7	-8.5	4.8	-10.6	-18.5
Florida	-0.4	-5.7	6.8	-9.9	-19.5
Washington	6.6	-0.6	15.1	-4.2	-7.1
Minnesota	13.4	-9.8	44.6	-5.2	-8.3
United States	-1.8	-7.5	5.1	-7.4	-13.6
National participation level (thousands)	28,847	15,329	13,518	12,481	10,780

SOURCE: Preliminary data from the Health Care Financing Administration and Office of Family Assistance, U.S. Department of Health and Human Services.

NOTES: AFDC is Aid to Families with Dependent Children. TANF is Temporary Assistance to Needy Families.

Yet in all but two of the case-study states there was a net decrease in Medicaid participation in 1996. The two exceptions were Washington and Minnesota, both of which had major growth in child participation linked to their respective state expansion initiatives, Basic Health Plan and MinnesotaCare.

The decrease in overall Medicaid participation levels was deeper for adults (-3.4 percent) than for children (-1.3 percent). Larger reductions occurred in AFDC/Medicaid participation for adults (-8.6 percent) than for children (-6.9 percent), and adults also had less growth (4.3 percent) in noncash participation than children had (5.5 percent).

It is important to remember that the 1995-1996 changes preceded the passage of PRWORA. National data about Medicaid enrollment for 1997 are not yet available, but interviews with states and press reports indicate that Medicaid caseloads are still falling.¹³ As shown in Exhibit 1, the welfare caseload fell nearly twice as much in 1996-1997 as before. Unless states have made extraordinary efforts to improve outreach and to ensure that families exiting welfare are being checked for Medicaid eligibility, it seems likely that Medicaid 1997 enrollment rates will drop further.

■ **Why the decline?** A fundamental question is: Why have the welfare caseloads declined so much? How much of this is attribut-

able to the policy changes under state welfare reforms and how much to a stronger economy? Although welfare researchers agree that both factors (and others, such as families' misunderstanding of eligibility criteria) have played a role, they disagree about their relative importance.¹⁴

We could view Medicaid caseload reductions in three different ways. First, if a stronger economy has helped welfare recipients to find jobs and private health coverage, then falling Medicaid coverage could be a sign of success. Second, if the economy has helped welfare recipients to get jobs but not health insurance, then the results are positive from the perspective of economic independence but negative from the perspective of health insurance. And finally, if welfare reform has caused some poor families to exit welfare and Medicaid without jobs or health insurance, then this would be a negative, unintended consequence. Unfortunately, there has not been sufficient research to know which view is most accurate.

However, we do know that the number of uninsured persons has risen every year since 1987. The most recent available data show that between 1995 and 1996 the percentage of uninsured persons rose from 17.4 percent to 17.7 percent; reductions in Medicaid coverage for children are thought to account for most of this increase.¹⁵

Declines In Medicaid Enrollment Of Immigrants

The other major change made by PRWORA was to restrict the eligibility of legally admitted immigrants. Unlike welfare reform, this change was expected to cause Medicaid enrollment to decline.

■ **Immigrants before enactment.** Almost all of the immigrants who were legally admitted to the United States before 22 August 1996 (when PRWORA was enacted) are still eligible for full Medicaid coverage, if they meet income and categorical standards. Although states may bar immigrants who entered before this date, none of the ANF case-study states has done so. The small exception to these grandfathering provisions is that immigrants who are permanently residing under color of law (PRUCOL) will lose full Medicaid coverage in 1998, no matter when they entered the country.¹⁶

■ **Immigrants after enactment.** In contrast, most legally admitted immigrants who enter the United States after August 1996 are ineligible for full Medicaid coverage during their first five years here. Even then, most still will not qualify for Medicaid, because another law requires that the income of the persons who sponsored their entry must be "deemed" available to them. Thus, few postenactment immigrants will appear to be sufficiently poor to qualify. An exception is that refugees and asylum seekers retain full Medicaid coverage for their first seven years in the United States.

■ **State flexibility.** States have some flexibility to modify the federal rules for the postenactment group. States may extend the ban on eligibility to more than five years, until citizenship is attained. Texas has indicated that it plans to exercise this option.

States also may use state funds (separate from Medicaid and without federal match) to insure immigrants. Several case-study states are using state funds for partial coverage of some of the immigrants who are losing benefits under the federal law. Washington is using state funds to provide full benefits to low-income, postenactment immigrants who have resided in the state for more than one year. Massachusetts provides a basic health care package (no long-term care) to PRUCOL and postenactment immigrants but maintains full benefits (including long-term care) for those who were already receiving long-term care services. Minnesota offers a “wraparound” to emergency benefits for postenactment immigrants who seek citizenship; it also will provide prenatal and postpartum care to pregnant immigrants, while using Medicaid to cover labor and delivery services. Colorado also plans to cover prenatal care for postenactment immigrants.

California and New York, the two states with the most immigrants, are protecting immigrants, but under special extenuating circumstances. California is providing full coverage to all legal immigrants (who are otherwise eligible); Governor Pete Wilson (R) proposed restricting eligibility based on the rules for federal matching, but the legislature did not enact these changes. State funds will pay for nonemergency services. New York has followed the federal guidelines, with two exceptions. New York provides full benefits to pregnant immigrant women because of a court order in a long-standing lawsuit. The federal government is matching these payments under Medicaid but hopes to overturn the court ruling. New York also grandfathered in full coverage, including long-term care, for PRUCOL immigrants who were in institutions in August 1996.

Texas, Florida, and New Jersey have relatively large numbers of immigrants but have made no special efforts to insure those who are losing eligibility. Immigrants who are losing full coverage in these states and others still may be able to get charity care from health care providers or county-based programs, however.

■ **Administrative barriers.** Many state officials acknowledged in our interviews that immigrants may be confused about the new policies: Eligible immigrants are afraid to apply because they believe that they are ineligible or worry that getting Medicaid may adversely affect their immigration status or chances of attaining citizenship.

There also may be barriers to emergency services for postenactment immigrants, since most states will not declare immigrants eligible

until after an emergency has occurred. States are using one of two approaches in determining eligibility for emergency coverage. One model is typified by California: Those eligible for emergency services only (for example, undocumented aliens) may apply for Medicaid as other applicants do but receive a Medicaid card that limits them to emergency care. Most states, including New York, Texas, and Florida, use the other model: Those eligible for emergency services only cannot get a Medicaid card; they can be determined eligible only after an emergency occurs. Immigrants may avoid seeking even emergency care because they do not know that there is a way to pay for it. This also poses a risk to providers who must decide whether to provide emergency care, not knowing if they will be reimbursed by Medicaid.

■ **Number of immigrants in Medicaid.** States often are uncertain about the effects of the new rules because they do not know how many immigrants are in Medicaid; automated data systems usually do not include citizenship status. A recent analysis of Medicaid Quality Control data provides estimates of the potential impact of PRWORA.¹⁷ Nationwide, about 7.5 percent of Medicaid enrollees were noncitizen immigrants in 1994 (Exhibit 2). However, wide disparities exist across the states. In California about 25 percent of all Medicaid enrollees were immigrants, but in Mississippi and Alabama immigrants were less than 1 percent of the caseload. About one-sixth of adults and one-eighth of the aged in Medicaid

EXHIBIT 2
Number And Percentage Of Noncitizen Immigrants In Medicaid, By Average Monthly Enrollment, 1994

State	Number noncitizens in Medicaid (thousands)	Estimated percent of category who are noncitizens				
		All enrollees	Children	Adults	Aged	Blind and disabled
California	1,328	24.9%	14%	48%	37%	16%
New York	340	12.6	7	22	23	9
Texas	117	5.5	2	16	9	7
Florida	112	6.8	2	13	17	7
Massachusetts	62	8.4	5	14	18	6
Washington	57	9.6	8	15	11	6
New Jersey	41	5.9	2	12	13	4
Michigan	20	1.7	1	3	4	2
Minnesota	20	4.9	4	7	6	6
Wisconsin	20	4.0	4	7	2	2
Colorado	7	2.6	1	4	7	4
Mississippi	1	0.2	0	1	0	0
Alabama	1	0.2	0	0	0	0
United States	2,413	7.5	4.1	16.0	13.0	4.9

SOURCE: Estimates based on Medicaid Quality Control and Social Security Administration data (see note 17).

nationwide in 1994 were immigrants. Only 4 percent of child enrollees were immigrants, since children of immigrants often are born in the United States and therefore are citizens.

If we assume that the 1994 distributions of the Medicaid caseload apply in future years, we can get a sense of how many immigrants enrolled in Medicaid will eventually be affected and lose full federal coverage. Of the 7.5 percent of Medicaid enrollees who are noncitizens, about 5 percent would be directly affected by PRWORA. Most of these immigrants are regular legal permanent residents, who would be barred from full federal coverage if they arrived after August 1996. A small share (about 0.3 percent) are PRUCOL immigrants, who would be disqualified no matter when they entered the country. The effects would be much greater in states such as California and New York, with larger immigrant populations.

■ **Emergency coverage.** Newly barred immigrants will still be eligible for emergency coverage. We can get preliminary insights about the provision of emergency benefits by examining the historical experience of undocumented aliens. Undocumented aliens in California were more than ten times more likely than those in other states were to be enrolled in Medicaid (comparing the number served and official estimates of the number of undocumented aliens residing in each state).¹⁸ The higher participation in California may have been attributable to the ability to apply prospectively as well as to greater awareness of benefits in the immigrant and provider communities.

Once they were enrolled, however, the cost of serving undocumented aliens was lower in California than in the rest of the states. The standardized Medicaid expenditure per undocumented alien enrollee in California was 60 percent of the overall average but in the other states was 223 percent of average. California gave greater Medicaid access to aliens, with lower average medical expenditures, while the other states served fewer people at a higher average cost.

Summary And Conclusions

The 1996 welfare reform law involved a massive reexamination of who “deserves” public assistance. The main decisions were that states should decide who was needy, welfare should be linked to work, welfare receipt should be time limited, and immigrants who arrive after the law’s enactment should not get full Medicaid benefits.

The decision to separate welfare and Medicaid eligibility was well intentioned; the goal was to protect poor families’ Medicaid coverage from possible cutbacks in welfare. Further, this might allow Medicaid to begin to operate apart from welfare and some day evolve into a freestanding health insurance system for low-income persons. However, falling welfare caseloads are leading to unex-

pected declines in Medicaid enrollment, even though many states changed their old AFDC rules to slightly expand Medicaid eligibility. Some of the most perplexing issues, such as how to maintain Medicaid for those who have reached TANF time limits, have not been addressed because few recipients have reached these limits yet. Over the longer term, the immigrant changes could lead to even lower Medicaid caseloads, especially in high-immigration states.

To avoid unintended Medicaid caseload reductions, states have many options. Procedural changes might include automating Medicaid eligibility systems, simplifying Medicaid-only applications, issuing Medicaid cards to immigrants for emergency care, or expanding outreach. Possible policy options include using state funds to protect nonemergency coverage of immigrants or adopting less restrictive methods of counting income and assets to broaden eligibility for families.

■ **Children's health insurance.** However, the issue that is drawing greater attention from policymakers at the moment is the design and implementation of the State Children's Health Insurance Program (CHIP) to expand health coverage for uninsured children with family incomes up to 200 percent of the federal poverty level. CHIP may help to cover some children who are losing Medicaid coverage because of PRWORA, although most of the welfare-related children were probably already eligible through poverty-related or transitional coverage. Postenactment immigrant children are not eligible for CHIP, although the Clinton administration has proposed to make them eligible. In addition, CHIP requires states to develop outreach campaigns to identify uninsured children, which may increase families' overall awareness of Medicaid eligibility.

Some interesting alternatives to CHIP have been proposed. Wisconsin, which made one of the most dramatic changes to its welfare program, has proposed using CHIP funds in conjunction with a broader Section 1115 Medicaid waiver to create a new program, called BadgerCare. This program would be available to families, including parents, with incomes up to 185 percent of poverty, with sliding-scale premiums at the upper end of the income distribution. Other states, such as Tennessee, Hawaii, Oregon, Minnesota, and Washington, already had family-related eligibility expansions, often using federal matching funds under Section 1115 waivers.

Short of major state reforms or changes in federal legislation, it seems likely that more adults (primarily mothers) will lose Medicaid coverage in the future. Welfare reform, in conjunction with a strong economy, may lead more welfare recipients to jobs, and some of them will obtain health benefits. However, many low-wage workers are not offered coverage or cannot afford it. Thus, it seems likely

that more adults will become uninsured. A recent study found that after leaving AFDC, 23 percent of women had private insurance, 52 percent had Medicaid, and 23 percent were uninsured one year later, but after three years 38 percent had private insurance, 17 percent had Medicaid, and 45 percent were uninsured.¹⁹ The prospects are also disheartening for immigrants. Even before PRWORA, 43 percent of nonelderly noncitizen immigrants were uninsured, a rate roughly triple the national average.²⁰

We expect that more adults than children will lose Medicaid coverage and that the future effects of immigrant eligibility changes will fall disproportionately on adults. In part, this reflects a deliberate policy choice: We, as a nation, want to expand health insurance for low-income children, while reducing the health coverage of parents. This is not a choice without consequences: A recent survey showed that uninsured adults encounter major barriers to medical care and that the health care safety net is not always available across states.²¹

The changes in Medicaid caseloads may have broader effects as well. For example, they may affect states' efforts to implement large-scale Medicaid managed care for adults and children. Provisions regarding emergency services for immigrants (or the need to separately account for emergency and nonemergency care) also may render managed care impossible for immigrants. Lower membership levels make it more difficult for managed care organizations to achieve necessary economies of scale. Further, those who remain on welfare and on Medicaid may have more chronic health problems (which prevent them from leaving welfare), which may change the case-mix for managed care plans.²² These factors may lead to higher capitation payments for managed care members. Thus, welfare reform is affecting not only those who will lose eligibility for Medicaid coverage, but also may indirectly affect those who remain in the program.

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 7. AFDC rules greatly limit the eligibility of two-parent families. Unless the second parent is disabled or works fewer than 100 hours a month, families with both parents in the home are generally ineligible for coverage.
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 11. J. Kaplan, *Transitional Medicaid Assistance* (Washington: Welfare Information Network, December 1997).
 12. AFDC/TANF participation levels vary from those for AFDC/Medicaid for various technical reasons but are broadly consistent. One factor is that AFDC/TANF uses average monthly participation, whereas Medicaid data are for those persons ever enrolled in a year.
 13. "Dwindling Medicaid Rolls Mean Rough Ride for HMOs," *Medicine and Health* 52, no. 8 (1998): 2.
 14. For example, see Council of Economic Advisers, *Technical Report: Explaining the Decline in Welfare Receipt, 1993-1996* (Washington: White House, May 1997); and A. Martini and M. Wiseman, *Explaining the Recent Decline in Welfare Caseloads: Is the Council of Economic Advisers Right?* (Washington: Urban Institute, July 1997).
 15. P. Fronstin, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1997 Current Population Survey," *EBRI Issue Brief* 192 (Washington: Employee Benefit Research Institute, December 1997).
 16. PRUCOL is an umbrella term for a number of special categories of people whose immigration status is in a "gray zone," such as those for whom deportation is being withheld or suspended.
 17. L. Ku and B. Kessler, *The Number and Costs of Immigrants on Medicaid: National and State Estimates* (Washington: Urban Institute, December 1997).
 18. *Ibid.*
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 22. G. Acs and P. Loprest, "The Effect of Disabilities on Exits from AFDC" (forthcoming).