

Your Savings or Your Health

*How Asset Limitations
Harm Low Income People*

*What Can Be Done to Eliminate
the Medicaid Asset Test*



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Executive Summary

The Medicaid asset test is a major barrier to health care for low-income people who want to save money and improve their lives. Not only is the asset test a savings disincentive, its very presence causes many eligible individuals to avoid applying for Medicaid because of the invasive application procedure.

While some states have eliminated the asset test for families and low-income single adults without dependent children as part of their Medicaid or Medicaid expansion programs, many states continue to maintain asset limitations in their traditional Medicaid and/or Medicaid expansion programs.

The importance of asset accumulation is not easily overstated. Research shows that owning assets reduces marital dissolution, promotes physical and mental health, encourages better education, promotes economic stability, and decreases intergenerational poverty. Most state programs deny Medicaid recipients the ability to take advantage of these benefits by limiting their ability to accumulate assets.

Low-income people who choose to accumulate assets and, as a result, lose Medicaid coverage face a "Catch 22." Health care crises are major contributors to personal bankruptcy. Low-income people who lose Medicaid coverage because they choose to save money may find themselves in debt or even bankrupt if they are faced with a medical crisis.

The Medicaid asset test is expensive to administer. State officials in states that have eliminated the asset test believe that total program costs have not increased as a result of eliminating asset limitations, despite increased enrollment.

This paper reviews the importance of asset building policies as well as the importance of assets and health care to low-income individuals. It provides an overview of the current laws that govern asset limitations for Medicaid and Medicaid expansion programs, examines the Medicaid asset limitations in states that still maintain these limitations and in the states that have eliminated these Medicaid asset tests, and looks at the history and impact of eliminating the asset test for families and adults without dependent children in various states.

Introduction

Medicaid asset tests are a major barrier to health care for low-income people who want to save money and improve their lives. Americans work to accumulate assets by saving money in checking and savings accounts, investing money in stock and bond markets, or by major investments such as homes and cars. These assets provide basic necessities (shelter and transportation), insure Americans in times when their incomes are limited, and help them save money for larger investments such as college education for their children. Government policies often encourage moderate and high-income people to accumulate wealth, but discourage low-income people from accumulating assets by mandating that applicants for state health care and public income assistance programs maintain an extremely low level of assets.

Public policy designed to limit assets originated with welfare (Aid to Families with Dependent Children) with the argument that cash support should only be a temporary crutch extended when the family had no other resources available. The policy was extended to the Medicaid and food stamp programs when they were established, cementing these programs to the welfare system. Medicaid was weighed down by the

stigma of welfare in other ways too: by packaging Medicaid coverage with welfare, requiring families to go to the same office and face the same case-worker with the same long forms, difficult documentation requirements, and demeaning questions.

Congress broke the legal link between cash assistance and Medicaid when it enacted welfare “reform” in 1996. The new work requirements and time limitations placed on cash assistance were not extended to Medicaid. Congress separated income assistance eligibility from Medicaid in order to facilitate people having health coverage while moving into the work force. Theoretically, this allowed people to keep Medicaid for several months after taking a job. The 1996 changes even allowed states to expand Medicaid to adults at whatever income level the state chose and gave states the flexibility to expand coverage without asset limitations or other barriers to enrollment.

In practical terms, the separation of welfare and Medicaid has led to more than one million people losing Medicaid. The increase in the number of uninsured nationally from 1997 to 1998 of one million people – from 43 to 44 million – was entirely due to a drop in Medicaid enrollment. A Families USA study released in June 2000 found a drop in

enrollment of almost one million people in the 15 states with the largest Medicaid enrollment.

In most states, Medicaid remains encumbered with the restrictions of welfare: severe asset limitations and a demeaning application process. In New York, for example, the application form that adults must complete to prove Medicaid eligibility is actually a “joint application for Medicaid, Public Assistance, and Food Stamps” (Care for the Homeless, 2001). As long as Medicaid remains tied to the barriers embodied in cash assistance, enrollment will continue to be significantly lower than eligibility.

Asset limitations maintain and reinforce Medicaid as a punitive, stigmatized system. People who apply for Medicaid are forced to fill out a lengthy application in which they answer detailed questions about their assets and then go through a face-to-face interview where they are grilled about everything they own.

Applicants must supply documentation regarding citizenship status, income, address, identity, resources, childcare expenses, financial maintenance, and other health insurance coverage. In addition, the rules are very complicated¹

¹For example, in New York a child may have a savings account of \$500 but only if it comes

and have become even more complicated since the passage of welfare reform.² These complications lead to arbitrary determinations, delays and illegal denials.

The resource limitations also force people on and off Medicaid as changes in assets over time result in short-term changes in eligibility. The result is to interfere with continuity of care and force people to go to the emergency room while off Medicaid. The administration of asset tests also adds a considerable administrative burden to the Medicaid program.

The harm done by asset limitations extends well beyond their impact on Medicaid. There is considerable evidence that building up assets is a key to lifting people out of poverty. Research shows that assets: reduce marital dissolution, promote physical and mental health, education, economic stability and decrease intergenerational poverty. Home ownership, for example, is significantly associated with women's health, even controlling for income and education. The research also shows that

from the child's own earnings or gifts from adults who are not legally responsible for the child.

² There are three different rules in New York for the allowable value of a car, depending on whether the adult is eligible under the AFDC rules, the TANF rules or as an adult without dependent children.

assets have a particularly positive impact on children and African-Americans (Boshara, 1998).

Former President Bush recognized the importance of asset building when he proposed raising welfare asset limits from \$1000 to \$10,000 in his 1992 budget (Sherraden, 2000). This proposal was never implemented, and today many lower-income Americans still must deal with laws mandating that they choose between maintaining low asset levels and losing their health care coverage.

The political resistance to eliminating New York's resource test remains strong. There's a story that has become folklore in the New York State Legislature. A woman from Niagara Falls who qualified for New York's Prenatal Care Assistance Program turned out to have \$50,000 - maybe it was \$100,000 - in the bank. The top health policy staff person in the Democratic-led Assembly told health advocates the story years after it may have happened as an explanation of why the Assembly insisted on keeping a resource test in its proposal to expand health coverage to low-income people: "We won't let ourselves be beaten up again on this by the Republicans."

The resource test was only removed from Family Health Plus, a Medicaid

funded expansion of affordable health coverage for low-income adults not eligible for traditional Medicaid, when Republican Governor George Pataki agreed as part of an overall political deal on hospital financing in 1998. A major campaign by the state's health care advocates and hospital organizations was required to remove the asset test from the program.

The Importance of Assets

There is a great deal of research detailing the importance of assets. According to Michael Sherraden, the Director of the Center for Social Development at Washington University in St. Louis (1999), those benefits include:

- Greater investments in education
- Better consumption decisions
- Improved health
- Greater sense of personal control
- Improved attendance records at school and work
- Better financial planning
- Lower rates of domestic violence
- Decrease in social isolation
- Lower pregnancy rates
- Improved financial status of offspring.

The current Medicaid system does not allow low-income people to achieve the positive benefits of asset accumulation because it limits the amount of assets they are able to acquire. According to Sherraden, asset accumulation is more important than income assistance in terms of helping the poor become self-sufficient. "While income transfers have helped to ease hardship, they have not enabled families to develop" (Sherraden, 2000). Yadama and Sherraden claim that income assistance policies overlook many variables that should point policymakers in the direction of designing programs to promote asset accumulation.

The effects of income on attitudes and behaviors are not as strong as the effects of savings. Social policy in Western welfare states is dominated by the provision of income, either as 'social insurance' or means tested transfer. If savings provide equal or stronger effects on attitudes and behaviors – and at the same time, economic development of households – then perhaps more social policy should promote asset accumulation... (Yadama and Sherraden, 1996)

Public policies that set low limits for assets encourage low-income people to minimize their assets while other

policies and tax incentives encourage those with money and assets to save. These conflicting policies have helped to create a wealth gap much larger than the oft-reported income gap. According to Boshara, "The top 20 percent of all American households earn over 43 percent of all income but hold over 68 percent of all net worth (all assets less all liabilities) and almost 87 percent of net financial assets."

A 1995 study by Hubbard, Skinner, and Zeldes indicates that asset testing for social insurance programs may contribute to this skewed asset distribution. Jonathan Gruber and Aaron Yelowitz examined this relationship in 1997 and found that "Medicaid eligibility has a sizable and significant negative effect on wealth holdings." Their study showed that the Medicaid program decreased wealth held by low-income people by 17.7 percent and actually increased their consumption by 5.2 percent (Gruber and Yelowitz, 1997). This increase in consumption may be attributed to the fact that people must spend more money than they would normally choose to spend so that they can maintain an artificially low level of assets.

The Medicaid asset causes recipients to consume more than they would without the asset test and limits their savings. It

helps perpetuate America's wealth gap and makes it difficult for those who desire to save money and improve their lives. In addition, Medicaid recipients are unable to take advantage of the many social, health, and financial benefits associated with asset accumulation.

Academic Research Related to Asset Accumulation

Many academic studies have been conducted to analyze the effects of assets and asset accumulation. In general, research concerning the benefits resulting from asset building can be grouped into four categories: benefits to families and women, benefits to children, mental and physical health benefits, and benefits to the community.

Benefits to Families and Women

The accumulation of assets provides many positive benefits to families and women. Galligan and Bahr (1978) report that asset accumulation has a substantial positive effect on marital stability. Hampton (1982) verifies this study by showing that assets significantly lower marital disruption, even when controlling for income and property ownership.

Assets are related to a reduction in marital violence, which may contribute to increases in marital stability. Peterson (1980) shows a general trend towards less violence in asset-owning households. Levinson (1989) substantiates this study by showing that wealth and property ownership reduces domestic violence. In addition, Michael Sherraden and Deborah Page-Adams have shown that asset ownership is related to improved economic security in families aided by public assistance (Page-Adams and Sherraden, 1997).

Eliminating the Medicaid asset test may also have many benefits for women and single mothers with children. Rossi and Weber (1996) found that single mothers with savings are more likely to maintain their families above the poverty line, emphasizing the importance of public policies that promote asset accumulation.

Savings help people better manage income shocks that may be related to job loss or illness. According to Esther Cho, assets "allow people to borrow against future income and therefore to smooth their lifetime consumption" (1999).

Benefits to Children

Parental asset accumulation is important to children, even if the children have

health care coverage. A 1989 study by Pritchard, Myers, and Cassidy reports that parental savings patterns are often associated with teen saving patterns. Cheng (1995) also observed a similar effect when she found that asset ownership reduces the likelihood that adult daughters who grew up in households headed by women will live in poverty.

Asset limitations on parents reduce the incentive to save. Because children tend to mimic their parents savings patterns, asset tests may increase the likelihood that children of poor parents will also grow up to be poor. This helps to maintain the intergenerational poverty cycle.

Children growing up in poverty face many obstacles in addition to an increased risk of adulthood poverty. Poverty level women are at higher risk for having low birth weight babies. According to the Ontario Public Health Association, "Low birth rate is the most decisive indicator of poor health at birth and closely linked with infant death, poor health during the first year of life, learning disabilities, and long-term behavioral and social problems" (1998).

Parental wealth and assets also impact a child's self esteem. According to Whitbeck et al. (1991), economic hardship reduces parental support for

children and negatively impacts a child's self-esteem in adolescence. Lower self-esteem has many negative effects on children. Children with low self esteem score lower on achievement tests than those with a high level of self-esteem (Covington, 1989). Kelley (1978) found a correlation between delinquency at school and low self-esteem.

Teenage pregnancy may also be linked to lower self-esteem. Crockenberg and Soby (1989) found that four out of five research studies link low self-esteem with less frequent use of contraceptives.

Asset limitations make it difficult for families to work their way out of poverty and increase the number of children living in poverty who are negatively impacted by parental economic hardship. Economic hardship leads to lower self-esteem, which is related to lower achievement test scores, higher rates of delinquency at school, and higher risk of unintended pregnancy.

Mental and Physical Health Benefits

Asset accumulation results in many positive mental and physical health effects. These effects are especially dramatic for women and older Americans. According to Pugh et al., (1991) women with assets are 2.5 times less likely to die from lung cancer than

women without assets. This may be related to a higher incidence of smoking in women with lower levels of assets.

Liquid assets are also related to lower incidences of chronic conditions in older Americans (Robert and House, 1996). In addition to chronic illnesses, assets also effect how people rate their own health. This effect is especially significant for older populations. Robert and House found that older people with liquid assets rate their own health higher than those who do not have liquid assets.

Asset accumulation also results in positive mental health effects. A 1995 study by Yadama and Sherraden shows a correlation between savings and self worth, long range planning, and prudence.

According to the authors, assets:

- (1) Have a positive effect on expectations and confidence about the future,
- (2) influence people to make specific plans with regard to work and family,
- (3) induce more prudent and protective personal behaviors, and
- (4) lead to more social connectedness with relatives, neighbors, and organization.

These findings show that asset possession contributes to an individual's mental health and to positive personal behavioral choices.

Benefits to the Community

Asset building is an important prerequisite to homeownership, which has many positive community impacts. According to Boshara, "Discussions of neighborhood impacts generally contend that homeownership effects neighborhoods by enhancing property values, decreasing residential mobility, increasing property maintenance, and increasing social and civic involvement" (1998). Boshara's analysis is based on a 1996 study by Rohe and Stewart that shows homeownership tends to increase property values, improve property maintenance, and increase social and civic involvement.

Academic research shows the importance of assets and asset accumulation for families, women and children. Assets and asset accumulation improves family stability, mental and physical health, and helps build low-income communities. By limiting the amount of assets that a person may possess, the Medicaid asset test does not allow people and communities to realize the significant benefits associated with asset accumulation.

The Importance of Health Care Coverage

The Medicaid asset test makes low-income people choose between limiting their savings so they can qualify for Medicaid or taking advantage of the benefits associated with asset accumulation. A low-income adult who chooses to forgo medical coverage so she can save money is taking a dangerous risk. A study by Jacoby et al., (2000) surveyed reasons that drove people to personal bankruptcy and found that the majority of personal bankruptcies were related to medical problems. People who choose to accumulate assets and lose their Medicaid eligibility may find themselves in debt or even bankrupt if they are faced with a personal health crisis.

Health care coverage is extremely important. Access to health insurance is a major predictor of whether someone will seek health care when ill. According to the Kaiser Commission on Medicaid and the Uninsured (2000):

Nearly 40% of uninsured adults skipped a recommended medical test or treatment, and 20% say they have needed but not gotten care for a serious problem in the past year.

Uninsured adults are over 30% less likely to have had a checkup in the past year; uninsured men 40% less likely to have had a prostate exam and uninsured women 60% less likely to have had a mammogram compared to the insured.

The uninsured are more likely than those with insurance to be hospitalized for conditions that could have been avoided, such as pneumonia and uncontrolled diabetes.

The uninsured with various forms of cancer are more likely to be diagnosed with late stage cancer. Death rates for uninsured women with breast cancer are significantly higher compared to women with health insurance.

Low-income elderly people are more vulnerable to health problems and do not always have the means to pay for necessary health care (The Kaiser Commission on Medicaid and the Uninsured, 1999).

Children are positively affected by expanding health care coverage to their parents. The number of low-income children on Medicaid also increases when health care coverage is expanded to families. Parents are more likely to

apply for health care for their child if the entire family is eligible. A study by the Center for Budget and Policy Priorities demonstrated that states implementing comprehensive health care programs between 1990 and 1998 showed higher levels of young, low-income children covered by Medicaid in states that implemented health care programs targeted specifically at families with children (Ku and Broaddus, 2000).

Health insurance coverage is important for children. According to the Children's Defense Fund, "Uninsured children in low-income families get sick more often from preventable acute and infectious illnesses.... Low income children are also likely to suffer from lead poisoning, serious dental problems, and chronic medical conditions" (2000). States have recognized the importance of health insurance by developing broad coverage initiatives for children. Unfortunately, children are negatively impacted when their parents are not allowed health insurance coverage or forced to limit their assets to remain eligible for state Medicaid programs.

Federal Laws Regarding the Medicaid Asset Test

The Personal Responsibility and Work Opportunity Reconciliation Act

(PRWORA) of 1996 delinked welfare and Medicaid and provided several options for states that want to eliminate the Medicaid asset test. According to Section 1931 of the Social Security Act, more liberal methods may be used to determine the amount of a family's countable income and resources.

In essence, states have been granted "unlimited flexibility to disregard assets..." for certain categories of recipients (Birnbaum, 2000). Several states have used this law to eliminate the asset test altogether, while other states have used waivers that were granted before welfare reform to continue demonstration programs that were not asset tested. In addition to Sections 1931 and Section 1115 of the Social Security Act, states may also develop their own state-funded programs that include state-designed eligibility criteria.

Limitations in States that Retain the Asset Test for Parents in Low-Income Families

Thirty-seven states currently retain asset limitations for parents in low-income families who apply for Medicaid. Most of these states (twenty-nine or 78%) have set Medicaid eligibility levels below 100% of the federal poverty level

(FPL). These states show no correlation ($r = .0003^*$) between their maximum income requirements and the maximum level of assets that applicants are able to possess (see figure 1).

Eight states (22%) maintain Medicaid eligibility levels at or above 100% of FPL. Twelve (32%) have Medicaid eligibility levels below 50% of the FPL and four (11%) are above 150% of the FPL (Appendix A: States that Retain Medicaid Asset Limitations).

A clear majority (68%) of these states maintain asset limitations at or below \$2,000. Only three states (8%) allow families who have more than \$3,150 in assets to receive Medicaid (see figure 2). New York allows a family of three to maintain \$3000 in assets.

Eighteen states (49%) disregard cars valued up to \$10,000 or disregard the value of one car completely. Three (8%) disregard more than one car of any value. Twelve states (32%), including New York, disregard the value of a vehicle up to \$4,650.

Five (14%) of the thirty-seven states that have retained asset limitations provide Medicaid coverage to adults without dependent children through a Section 1115 waiver from the federal Health Care Financing Administration. Three of these four states have income

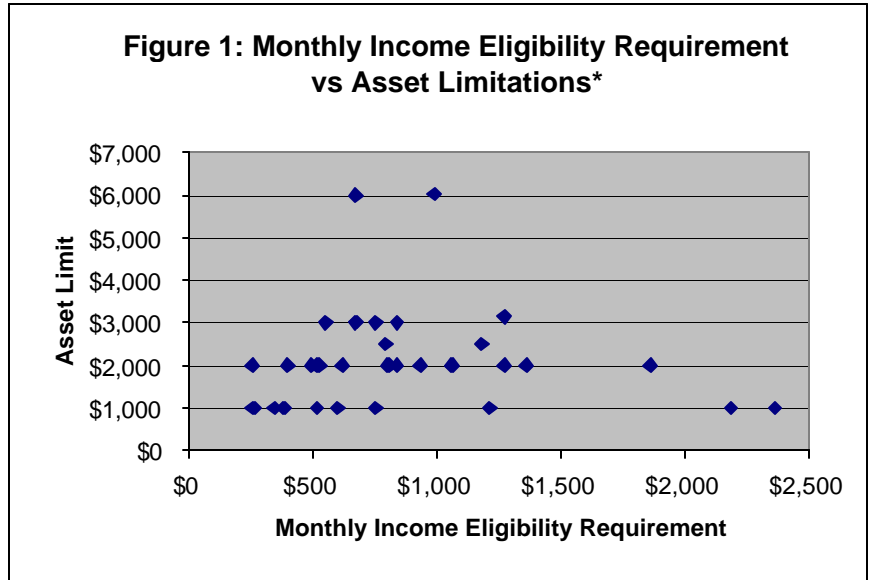
eligibility thresholds at or above 100% of the FPL. Hawaii and Oregon have the same eligibility thresholds for families with and without children. Vermont provides Medicaid to adults without dependent children at a slightly lower rate (8%) than adults with dependent children.

State Initiatives to Eliminate the Asset Test

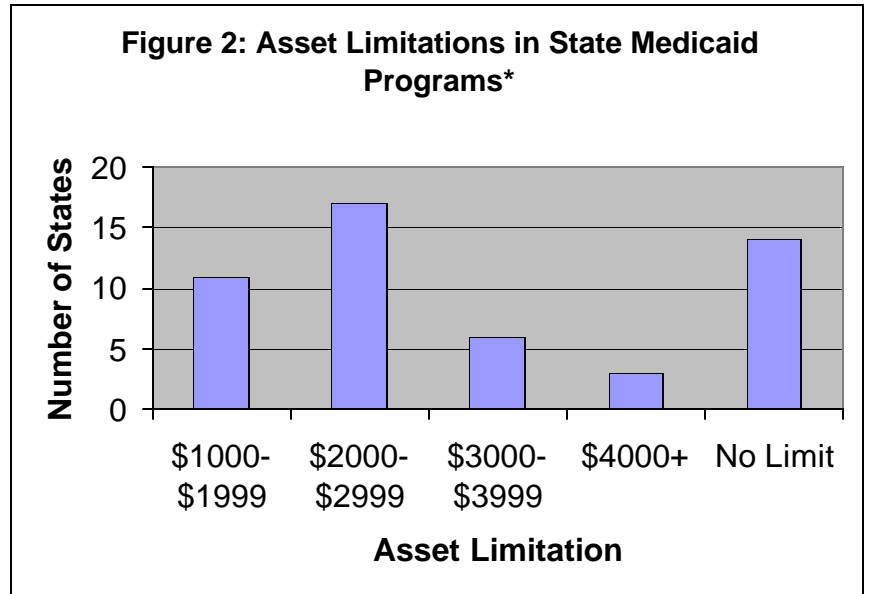
The federal government allows states a wide variety of alternatives when developing their Medicaid eligibility criteria. Most states have eliminated the Medicaid asset test for children and pregnant women.

While some states have eliminated the asset test in their traditional Medicaid program for parents in low-income families, other states have used the flexibility granted by the federal government to eliminate the asset test for low-income adults without dependent children as a part of a Medicaid expansion.

The Kaiser Commission on Medicaid and the Uninsured recently surveyed the results of eliminating the Medicaid asset test for families with children in nine states and the District of Columbia.



*Excludes Minnesota



*Asset limitations for a family of three

This survey is by no means a comprehensive study of the effects of eliminating the Medicaid asset test for all populations, but does give an example of the results of eliminating the test for families.

State Medicaid officials were surveyed in Pennsylvania, Massachusetts, Delaware, Ohio, Oklahoma, Missouri, Rhode Island, Mississippi, and New Mexico. The state officials surveyed stated that the asset test was difficult to administer and that it did not disqualify many people from health care coverage. According to the report, “despite being cumbersome for agency staff to administer and onerous for applicants to document, an asset test actually kept few families from meeting Medicaid eligibility requirements and may have prevented some from completing the application process.” While the asset test does not disqualify many people from health care coverage who would not otherwise qualify, it still serves to discourage those who would qualify for Medicaid from applying for the program.

State officials gave various reasons for eliminating the asset test. These reasons included: streamlining the eligibility process, improved productivity, automation of eligibility determination, and welcoming families into the program who were not willing to fill out long and complicated verification forms. The impetus for eliminating the asset test for families came from within the state Medicaid agencies.

None of the state officials reported being pressured by interest groups to pursue these changes until after the state suggested changing the qualification criteria. Interest groups in Illinois, however, claim that they initiated the effort to eliminate the asset limitations.

According to one Illinois health care advocate³, the asset test was eliminated because rural constituents, especially farmers, were strong advocates for its elimination. The farm economy is often unstable, and farmers did not believe that they should be punished because of their investments in land and farm equipment. If they cannot afford private health care coverage during a year in which income is low, they may not qualify for Medicaid because of the state’s Medicaid asset test.

Legislators also agreed that families should not be punished for saving money toward a child’s college education. In addition, health care access in rural areas often requires a dependable automobile. Because automobiles were a part of Illinois’s system of asset determination, automobile ownership may have kept a rural Illinois resident from being eligible for Medicaid.

The Kaiser report asserts that states were successful in meeting their objectives of reducing the administrative workload and simplifying the application process by

³ Personal conversation with Jim Duffet, Director of the Illinois Campaign for Better Health, April 2001.

eliminating the asset test. Several states experiencing staffing shortages found that eliminating the asset test allowed workers who verify assets more time for other duties. In addition, state officials believed that streamlining the application process allowed the states to enroll people who did not apply while the asset test was in effect because of the lengthy and invasive application procedure.

While many state officials believe that eliminating the asset test has saved their programs money, only one state has studied the savings that resulted from eliminating the test. "Oklahoma officials indicated that they had been spending \$3.5 million in general revenue dollars for administrative activities related to the verification of assets. They found they would spend just two-thirds of that amount or \$2.5 million in general revenue on benefits for persons who might have been denied" (Smith et al., 2001). New Mexico studied the differences in pre and post asset test elimination acceptance rates and concluded that only "38 applicants per month were denied eligibility due to the asset test before it was lifted" (Smith et al., 2001).

It is reasonable to believe that eliminating the asset test will increase the number of people who use a state's Medicaid program and save money in program administration. These finding may prove to be extremely important as states examine the effects of eliminating the Medicaid asset test.

Other Coverage Expansions

Many states have also eliminated the asset test from Medicaid expansion programs for uninsured parents and/or adults without dependent children. While most of the states have also eliminated the asset test for families eligible for their Medicaid expansion programs, not all of them have eliminated the asset test for traditional Medicaid families. States who have eliminated the Medicaid asset test for uninsured adults without dependent children through their expansion programs include Arizona, Delaware, Illinois, Massachusetts, Mississippi, Missouri, New Jersey, New Mexico, New York, Oregon, Pennsylvania, Rhode Island, South Carolina, and Washington, D.C.

Arizona

Until recently, Arizona's Medicaid program only covered parents whose incomes fell below 36% of the Federal Poverty Level (FPL) and whose assets did not exceed \$2000. There was no coverage for healthy, low-income adults without dependent children.

Arizona Medicaid now covers all adults under the age of 65 who fall below 100% of the federal poverty level. There is no asset test for low-income parents or low-income

adults without dependent children. The state expanded its coverage as a result of Proposition 204, which was approved by Arizona voters in November 2000.

The Health Care Financing Administration (HCFA) approved a Section 1115 waiver in January that allowed the state to expand its coverage to adults without dependent children. The expanded coverage was a result of Proposition 204, which was approved by Arizona voters in the November 2000 elections and required that the state spend its tobacco settlement funds to support expanded coverage (Scutari, 2001). Proposition 204 was one of two health care initiatives on the November ballot. Proposition 200 mandated that the state cover low-income parents of the children already enrolled in Arizona's Healthy Arizona program, but did not include low-income adults without dependent children. Proposition 200 was approved by voters, but it was not implemented because the more inclusive Proposition 204 received more votes. Proposition 204 was supported by many of Arizona's state health care advocacy organizations.

Delaware

Delaware offered limited coverage to low-income adults without dependent children before implementation of the Diamond State Health Plan. General Assistance Health First covered low-income adults

without dependent children whose incomes were below 20% FPL and imposed a \$1000 asset limitation. Families were also subjected to a \$1000 asset limitation, but were covered up to 185% FPL. The Diamond State Health Plan covers the Medicaid eligible population, including the expanded population of adults without dependent children who have incomes below 100% of the federal poverty level (FPL). Families are covered up to 185% of FPL. As part of the Diamond State Health Plan, Delaware eliminated asset limitations for all healthy adults. Covered individuals must enroll in managed care organizations (Summer, 1998).

Advocacy groups did not play a large role in the implementation of the Diamond State Health Plan. In 1994 the Delaware Health Care Commission released a report called *A Strategic Plan for Health Care for the State of Delaware*. The report recommended that the state place the Medicaid population in a managed care program and use the cost savings to expand coverage to uninsured adults. The state followed this recommendation and expanded its covered population.

New Jersey

New Jersey's Medicaid program traditionally covered low-income parents only if they met AFDC eligibility criteria. In January of 2000, the income eligibility level for cash assistance and Medicaid for family

of three was \$443, which was equivalent to 37.5% FPL. To be eligible for Medicaid, parents were limited to \$2000 in assets. The state's Medicaid program did not cover low-income adults without dependent children.

NJ FamilyCare was phased in beginning in the fall of 2000. It covers childless adults up to 100% of FPL, children up to 350% FPL, and working parents up to 200% FPL. There is no asset test. Parents who are not working qualify for Medicaid if their incomes and assets fall under the old AFDC eligibility guidelines. Asset limitations remain in effect for parents who receive traditional Medicaid.

The New Jersey Department of Human Services first advocated expanding coverage after reviewing ways to improve the state's health program. Hospital organizations were major supporters of expanding coverage because of the expenses associated with caring for uninsured individuals.

Prior to the coverage expansion, hospitals were inundated with adults receiving services mostly covered by charity care. These uninsured individuals would often delay care for minor illnesses and only access the hospital system after they were very sick and expensive to treat. Expanding coverage allowed hospitals to recover some of the costs associated with treating previously uninsured patients.

Vermont

Until recently, Vermont's Medicaid program covered low-income parents only if their incomes fell below 158% FPL and they held less than \$2000 in assets. There was no coverage for low-income adults without dependent children.

Vermont created the Health Access Plan (VHAP) in 1996. It is a Medicaid expansion program that provides coverage to adults without dependent children whose incomes fall below 150% of FPL and parents who do not have Medicaid and whose incomes are below 185% of FPL. Vermont retained its \$2000 asset test for families eligible for traditional Medicaid but eliminated it for the newly covered populations under VHAP. VHAP operates under a Section 1115 waiver and program funds come from a Health Security Trust Fund, which is funded by a 2.4 cent per pack tobacco tax (Summer, 1998).

Vermont's governor has been very active in expanding the state's public health coverage program. According to one Vermont health care advocate, the asset test was never a major issue in Vermont's health care reform package. "The lack of an asset test was something that the administration designed without much outside advocacy." The administration realized that asset verification is time consuming and complicated and that low-income people

rarely have significant assets when the state does check. Recent attempts to discuss adding an asset test to VHAP eligibility requirements were completely ignored by administration representatives during recent legislative committee meetings.

Washington State

Washington State's Medicaid program covers parents whose earned incomes fall below 90% FPL and who maintain less than \$1000 in assets. The state's traditional Medicaid program does not cover healthy low-income adults without dependent children.

Washington State's Basic Health Plan covers all state residents whose income falls below 200% FPL; enrollees pay a premium based on their income. There is no asset test for the Basic Health Plan. Parents whose income falls below 90% FPL may choose to join either the state's Medicaid plan, which includes an asset limitation, or the Basic Health Plan, which has a less comprehensive benefit package.

Advocacy groups and Washington's Medicaid Agency, the Medicaid Assistance Administration (MAA), played a strong role in working to ensure that there was no asset test in the Basic Health Plan. The MAA found that eliminating the asset test would not increase Basic Health Plan costs because of administrative savings.

New York

New York's Medicaid program provides health coverage for all New York residents who meet the categorical and financial requirements. Depending on the applicant's categorical status and financial situation, an asset or resource test may or may not apply (see Appendix B: Resource Limitations in New York State's Medicaid and Medicaid Expansion Programs).

There is no asset limitation for children's health programs in New York. Pregnant women are eligible for Medicaid up to 200% FPL and are not subject to asset limitations. Parents are eligible for Medicaid if they do not have more than \$3000 in cash assets. Single adults and childless couples are eligible for Medicaid if they possess less than \$2000 in assets, or \$3000 if they are older than 65. Individual Supplemental Security Income recipients may possess up to \$2000, while couples who receive Supplemental Security Income may save \$3000. The value of one automobile up to \$4,650 or the equity value of the automobile up to \$1,500, whichever is more favorable to the recipient, is omitted from the asset limitations. These arbitrary limitations are quite low and have not been increased over time to compensate for inflation.

The state's health care expansion programs, Child Health Plus and Family Health Plus, do not require an asset test. Child Health

Plus covers children up to 160% of the federal poverty level (FPL) at no cost. Parents whose income is between 160% and 250% of the FPL must pay small monthly premiums to insure their children through Child Health Plus. Family Health Plus is scheduled to cover parents whose income is at or below 150% of FPL on a phased in basis and adults without dependent children whose income is below 100% of FPL.

Family Health Plus was originally scheduled to take effect in January of 2001, but at the date of this paper's publication Family Health Plus still had not been implemented. New York's Family Health Plus program does not require low-income adults to limit their assets in order to be eligible for affordable health care coverage, while the state's Medicaid program still retains asset limitations for the poorest parents and adults without dependent children.

To be eligible for Family Health Plus, an adult cannot be eligible for Medicaid. Since Medicaid continues to have an asset test, adults applying for Family Health Plus must be screened to rule out Medicaid eligibility, and must answer all the detailed Medicaid questions on assets. Even though there is no asset test for Family Health Plus, the fact that the asset test is retained for traditional Medicaid means that Family Health Plus applicants will still be treated as though there were an asset limitation on the program, making the process much more complicated and demeaning.

A major campaign of the state's health care advocates, hospital unions and hospital organizations was required to remove the asset limitations from the Family Health Plus program.

Public Opinion

There is little evidence of polling that discerns American attitudes towards the Medicaid asset test. General attitudes towards health care and income assistance programs for the poor, however, have shown broad support for Medicaid and welfare objectives. Polls also show broad support for the expansion of government sponsored health care programs.

The National Devolution Survey Conducted for the W.K. Kellogg Foundation (1999) polled New Yorker's attitudes towards welfare and health care reform objectives. When asked to rate the importance of providing health insurance to the poor, respondents gave the objective a mean score of 8.6 out of ten. Respondents also believed that the objective of strengthening family values was very important. This objective was given a mean score of 9.0 by survey participants (Kellogg, 1999).

A national poll conducted on July 28, 2000 by *The Washington Post*, the Henry J. Kaiser Family Foundation, and Harvard University (Public Opinion Online) showed that 77% of those polled supported the expansion of

programs such as Medicaid and Children's Health Insurance Programs that provide support to low-income people. Polling numbers such as these suggest that there is broad support for expanding health care coverage to the uninsured.

Conclusion

State governments should eliminate the asset test for Medicaid recipients in both traditional Medicaid and Medicaid expansion programs. The asset test is a disincentive to low-income people who would like to save for a better automobile, a home, their child's education or their own, or to begin a new business. It is difficult for low-income people to work their way out of poverty without the opportunity to build their assets.

Low-income people find themselves facing a "Catch 22." Because health care crises are a major contributor to personal bankruptcies, those who choose to save money and are eliminated from the Medicaid program because of their assets may quickly find themselves in debt or even bankrupt as the result of an accident or illness.

Those who do limit their assets and continue to receive Medicaid coverage are denied the significant social, health, and financial benefits of asset accumulation. Their families will be less stable and their

children are more likely to live in poverty throughout childhood and suffer adverse effects that last into adulthood.

The Social Security Act provides several ways for states to eliminate the asset test for various Medicaid populations.

Eliminating the asset test would allow states to streamline the application process, while encouraging low-income people to save and take advantage of the many benefits that are associated with assets accumulation. Asset policies also raise serious equity questions. Not only is there a glaring disparity between policies that encourage assets accumulation for middle-income and wealthy individuals, yet deny the same benefits to the poor. There are also inequities in the way some states treat different low-income populations.

New York and Washington State, for example, maintain an assets test for their traditional Medicaid populations while lifting the asset test from expansion programs for those somewhat better off financially. In effect, this discriminates against the poorest citizens by making it even more difficult for them to work themselves out of poverty than it is for those moderately better off.

In many states, the Medicaid application process is still tied to cash assistance and food stamps -- in the perception of recipients -- who go to the same welfare

office, visit the same caseworker, and answer the same demeaning questions, despite the legal separation of these programs in 1996.

States that have eliminated the asset test from both their traditional Medicaid programs and their health care expansion programs have been able to simplify the application process and streamline their public health care programs. These steps achieve administrative savings, break the perceptual link between health care and welfare, and treat low and low-moderate income adults equitably.

Eliminating the asset test from all public health programs has allowed states to cover additional uninsured adults and given poor, and middle income adults and their families the chance to reap the many economic, health, social benefits associated with owning assets.

Appendix A: States that Retain Medicaid Asset Limitations

State	Income Eligibility - family of three (1) Monthly Earnings	As % of Poverty	Asset Limit (1)	Treatment of First Car (1)	Childless adults covered by 1115 Waiver (4)	Asset Test required for children? (3)	Are Asset (2)	Medicaid Rules TANF Asset Limit	And TANF the Same? TANF treatment of car
Alabama	\$254	22%	\$2,000	Disregard the value of one vehicle per licensed household member		NO	YES		
Alaska	\$1,208	82%	\$1,000	Disregard the value of one vehicle		NO	YES		
Arkansas	\$254	22%	\$1,000	Disregard the value of one vehicle		YES	NO	\$3,000	
California	\$1,269	108%	\$3,150	Disregard the fair market value of each of one or more vehicles up to a total of \$4,650		NO	NO	\$2,000	
Colorado	\$511	43%	\$2,000	Disregard the value of one vehicle		YES	YES		
Connecticut	\$835	71%	\$2,000 (a)	Disregard equity value of one vehicle up to \$9,500 or one vehicle used to transport a handicapped person (2)		NO	NO	\$3,000	
Florida	\$806	68%	\$2,000	For families subject to work requirements, disregard vehicles with combined income of up to \$8,500; for families not subject to work requirements, disregard one vehicle with a value up to \$8,500		NO	YES		
Georgia	\$514	44%	\$1,000	Disregard the equity value of one vehicle up to \$4,650		NO	YES		

Hawaii**	\$1,356	100%	\$2,000	Disregard the value of one vehicle for daily use or the fair market value of one vehicle up to \$4,500	YES	NO	NO ***	\$5,000	
Idaho	\$596	51%	\$1,000	Disregard the equity value of one vehicle up to \$1,500		YES	NO	\$2,000	Disregard fair market value of one vehicle up to \$4,650
Indiana	\$378	32%	\$1,000	Disregard the equity value of one vehicle up to \$5,000		NO	NO	\$1,500	
Iowa	\$1,060	90%	\$2,000	Disregard the equity value of one vehicle up to \$3,959		NO	NO	\$2,000 for app. \$5,000 for recip.	Disregard equity value of one vehicle up to \$3,916
Kansas	\$493	42%	\$2,000	Disregard the value of one vehicle		NO	YES		
Kentucky	\$616	52%	\$2,000	Disregard the value of one vehicle		NO	YES		
Louisiana	\$264	22%	\$1,000	Disregard the equity value of one vehicle up to \$10,000		NO	NO	\$2,000	
Maine	\$1,270	108%	\$2,000	Disregard the value of one vehicle		NO	YES		
Maryland	\$523	44%	\$2,000	Disregard the value of one vehicle		NO	YES		
Michigan	\$549	47%	\$3,000	Disregard the value of one vehicle		NO	NO		Disregard the value of all vehicles
Minnesota**	\$3,242	275%	\$30,000(c)	Disregard the value on one vehicle used for employment	YES	NO	NO	\$2,000 for app. \$5,000 for recip.	Disregard fair market value of any number of vehicles up to \$7500
Montana	\$836	71%	\$3,000	Disregard the value of one vehicle with the highest equity value		YES	YES		
Nebraska*	\$669	57%	\$6,000	Disregard the value of one vehicle used for medical or employment purposes		NO	YES		
Nevada	\$1,054	89%	\$2,000	Disregard the value of one vehicle		YES	YES		

New Hampshire	\$750	64%	\$1,000	Disregard the value of one vehicle for each parent/caretaker		NO	YES		
New York	\$667	57%	\$3,000	Disregard either the fair market value of one vehicle up to \$4,650 or the equity value of \$1,500, whichever is more favorable	YES	NO	NO	\$2,000	Disregard fair market value of one vehicle up to \$4,650
North Carolina	\$750	64%	\$3,000	Disregard the value of one vehicle per adult age 18 or older		NO			Disregard fair market value of one vehicle up to \$5,000
North Dakota	\$987	84%	\$6,025	Disregard the value of one vehicle		YES	NO	\$8,000	
Oregon**	\$1,179	100%	\$2,500	Disregard the equity value of one vehicle up to \$10,000	YES	YES	NO	\$10,000 for JOBS/JOBS Plus participants, \$2,500 for others	
South Dakota	\$796	68%	\$2,000	Disregard the value of one vehicle		NO	NO		Disregard fair market value of one vehicle up to \$4,650
Tennessee	\$930	79%	\$2,000	Disregard the equity value of one vehicle up to \$4,600		NO	YES		
Texas*	\$395	34%	\$2,000	Disregard the fair market value of one vehicle up to \$4,650		YES	YES		
Utah	\$673	57%	\$3,025	Disregard the equity value of one \$1,500 of one vehicle used for transportation		YES	NO	\$2,000	Same, but must be for income producing purposes
Vermont**	\$1,858	158%	\$2,000	Disregard the equity value of one vehicle	YES	NO	NO	\$1,000	Disregard equity value of one vehicle up to \$1,500

Virginia	\$381	32%	\$1,000	Disregard the equity value of one vehicle up to \$1,500		NO	NO		Disregard fair market value of one vehicle up to \$7,500 If fair market value exceeds \$7,500, equity value of \$1,500 is treated as countable asset
Washington	\$2,358	200%	\$1,000 for appl. No asset limit for recipients (b)	Disregard the equity value of one vehicle up to \$5,000 for applicants N/A for recipients		NO	YES	(\$3,000 in savings allowed)	
West Virginia	\$343	29%	\$1,000	Disregard the equity value of one vehicle up to \$1,500		NO	NO	\$2,000	Disregard value of one vehicle
Wisconsin**	\$2,181	185%	\$1,000	Disregard the equity value of one vehicle up to \$1,500		NO	NO	\$2,500	Disregard equity value of one vehicle up to \$10,000
Wyoming	\$790	67%	\$2,500	Disregard the value of one vehicle		NO	NO		Disregard fair market value of one vehicle up to \$12,000

States marked with a * have not established a Section 1931 eligibility category; in these states, the table presents the earnings thresholds that apply under the state's medically needy category.

States marked with a ** have expanded coverage to low-income working parents under a Section 1115 waiver. The table presents the eligibility rules that apply to parents under the waiver.

States marked with a *** provide Medicaid to all TANF participants.

(a) CT was supposed to eliminate asset limitations as of January, 2001. As of March 2001, it remains unclear whether this has been done or not.

(b) As of February 1, 2001, according to Center for Budget and Policy Priorities, March, 2001

(c) As of March 1, 2001, according to Center for Budget and Policy Priorities, March, 2001

(1) "Medicaid Income Eligibility Levels and Asset Rules for Parents in Low-income Families", Eliminating the Medicaid Asset Test for Families: A Review of State Experiences, Kaiser Commission on Medicaid and the Uninsured. (Source: Kaiser Foundation on Medicaid and the Uninsured. Upcoming report.)

Income thresholds are based on a three-person family with one wage earner (100% of poverty in 2000 is \$14,150 for a family).

The thresholds presented assume that the family's only source of income is from earnings and does not take into account disregards or deductions other than those for earnings.

(2) State Policy Documentation Project, State's Asset Rules Under the Medicaid Family Coverage Category and TANF. Available at www.spdp.org/medicaid/table_6.htm. Accessed 2/28/01.

(3) "Medicaid /CHIP Income Eligibility Levels and Asset Tests for Children, The Kaiser Commission on Medicaid and the Uninsured. (Source, Center for Budget and Policy Priorities, 2000) Compiled in *Eliminating the Medicaid Asset Test for Families: A Review of State Experiences*, The Kaiser Commission on Medicaid and the Uninsured, February, 2001 (from pre-publication copy, must get permission to to officially cite this reference).

(4) Information from Health Care Financing Agency website - www.hcfa.gov. February, 2001. Other states that provide Medicaid to childless adults through Section 1115 waivers include Arizona, Delaware and Massachusetts. These states are not included in the chart because they do not have Medicaid asset limitations.

Appendix B: Resource Limitations in New York State's Medicaid and Medicaid Expansion Programs

MEDICAID CATEGORY	CASH RESOURCE TEST	RESOURCE DISREGARDS	AUTOMOBILE RESOURCE TEST (MRG 286*)
"Low-income Family" (LIF Household with children)	up to \$3,000 in cash <i>(Sources: NY Social Services Law §366; MRG 305)</i>	Aid to Families with Dependent Children (AFDC) related disregards** <i>(Source: 18 NYCRR §360-4.6(b))</i>	(1) at county's discretion, 1st or 2nd car is exempt if there is a "medical need," or if the car is needed for job activities, including child care; <i>otherwise:</i> (2) Fair Market Value ≤ \$4,650 or equity value ≤ \$1,500
"Singles and Childless Couples" (S/CC Household without children)	up to \$2,000 in cash (or \$3,000 if the recipient is ≥ 60 years old) <i>(Sources: NY Social Services Law §366; MRG 326)</i>	AFDC related disregards** <i>(Source: 18 NYCRR §360-4.6(b))</i>	(1) at county's discretion, 1st or 2nd car is exempt if there is a "medical need," or if the car is needed for job activities, including child care; <i>otherwise:</i> (2) Fair Market Value ≤ \$4,650
Supplemental Security Income (SSI) recipients	SSI individual: \$2,000 SSI couple: \$3,000	SSI-related Disregards*** <i>(Source: 18 NYCRR §360-4.6(b))</i>	1st car is exempt if used by a household member; 2nd car is exempt if there is a "medical need"
133% FPL Children	None	not applicable****	none
200% FPL Pregnant Women	None	not applicable****	none

AFDC-Related Medically Needy	<i>depends on household size:</i> 1 person: \$3,750 2 person: \$5,400 3 person: \$5,450 4 person: \$5,500 5 person: \$5,950 (Source: MRG 311)	AFDC-related disregards** (Source: 18 NYCRR §360-4.6(b))	1st car is exempt; 2nd car is exempt if there is a "medical need," or if the car is needed for job activities, including child care
SSI-Related Medically Needy	<i>depends on household size:</i> 1 person: \$3,750 2 person: \$5,400 3 person: \$5,450 4 person: \$5,500 5 person: \$5,950 (Source: MRG 311)	SSI-related Disregards*** (Source: 18 NYCRR §360-4.6(b))	1st car is exempt if used by a household member; 2nd car is exempt if there is a "medical need"
Child Health Plus	None	not applicable****	none
Family Health Plus	None	not applicable****	none

* "MRG" is the New York State Department of Health, *Medicaid Reference Guide* (August 1999).

**AFDC related disregards are detailed in 18 NYCRR Section 360-4.4.

*** SSI related disregards are detailed in 18 NYCRR Section 360-4.4.

****The asset disregards are not applicable because there is no asset limitation for this population.

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