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STAYING EMPLOYED: TRENDS IN MEDICAID, CHILD CARE, AND HEAD START IN OHIO

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Executive Summary

Over the past two and a half decades in Ohio, more women have entered the labor force, and families have increased their work hours. Yet, job quality has often declined: wages for most workers have been stagnant, health insurance provision by employers has decreased, and Ohio remains nearly 264,000 jobs below its peak employment. The poor performance of Ohio's labor market coincided with the imposition of time limits for cash assistance under the federal Temporary Assistance for Needy Families (TANF) program. These broad trends mean that more women are paying for child care and health care while in low-wage jobs. This paper reviews changes in state child care and health care programs and discusses how such programs can help low-wage parents remain employed.

National studies show that health insurance and child care enable parents in low-wage jobs to remain employed. Of former welfare recipients, those with health insurance are more successful in staying off welfare than those without, according to an Urban Institute study. Working parents who have regular child care arrangements and those who receive help paying for child care are more likely to be employed, keep their jobs longer, and have higher earnings than other parents, according to studies by the Institute for Women's Policy Research, National Bureau of Economic Research, the Economic Policy Institute, and the National Poverty Center.

Like many states, Ohio expanded eligibility and expenditures for Medicaid, child care, and state-funded Head Start in the late 1990s to compensate for reduced cash support and to help low-income families survive on employment income. Recently, state fiscal problems have led to cutbacks in child care and Head Start, and Medicaid may be threatened in the upcoming budget process for state fiscal years (SFY) 2006 and 2007.

Medicaid

As a result of these eligibility changes and the economic downturn, Medicaid caseload and spending jumped in 2001 and 2002. The number of non-disabled children and families who were eligible for Medicaid was approximately 268,000 higher in SFY 2002 than in SFY 1997. Medicaid covers one in three births in Ohio, and one in four children. Despite this, most Medicaid spending is directed to persons who are in the aged, blind, or disabled (ABD) caseload category, even though this group is a minority of total caseload. This is because the medical treatments needed by those in the ABD category are more expensive, on average, than those needed by low-income children and adults.

In the debate over Medicaid, policymakers must recognize that trends toward reduced employer health care coverage are likely to continue, and that the program is a good investment for the state. The federal government pays for almost 60 percent of the cost of treatment for most individuals in the program, and 70 percent of the cost of treatment for children in families with incomes between 100 percent and 200 percent of the poverty line. A recent study estimated that the state would lose \$3.15 in economic activity for each dollar of Medicaid cuts.

Child Care

Child care eligibility was expanded in 1997 and 1998, so that by 2003 state-subsidized child care covered families with incomes up to 185 percent of the poverty level. Over the 1997 to 2003 period, program participation increased by 66 percent and spending increased by 91 percent in real terms. But changes made in June 2003 (effective October 2003) retightened eligibility, lowering income eligibility for continuing care to 165 percent. Also, excessive increases in co-payments made the program more expensive for parents. These changes reduced growth in subsidized childcare spending and participation to four percent in 2003. Lower eligibility ceilings increase turnover and can create perverse incentives for low-income families because small improvements in income can result in losses of large subsidies.

Head Start

Until the current budget biennium, Ohio's state-funded Head Start program was among the largest in the nation in funding and participation. Under former Governor George Voinovich (1991-1999), Head Start spending rose from \$18.4 million to \$181.2 million. By the end of this period, Head Start reached 90 percent of eligible Ohio children, at a time when the program reached just 40 percent of eligible children nationally.

Under the Taft administration, the state-funded part of the program has been severely curtailed. In the current budget biennium, funding shifted from historic use of state General Revenue Fund (GRF) resources to using federal funds from Ohio's TANF block grant. In the late 1990s the program served 22,000 children. The Taft administration created a new all-day program, called Head Start Plus, but provided for only 10,000 slots. Traditional half-day Head Start was reduced to a planned 4,000 slots. In practice, the program fell far short of serving even 14,000 children. Recently, the Ohio Department of Job and Family Services changed program rules to make the program more accessible. Nonetheless, these rule changes did not address unreasonably parental high co-payments for Head Start Plus or lowered income eligibility.

Policy Recommendations

Economic and policy changes are placing enormous stress on low-income families in Ohio. Work supports can help poor parents stay employed. We conclude with three recommendations to bolster such work supports:

1. Provide adequate Medicaid funding to maintain current services and eligibility.
2. Restore eligibility for child care assistance to 185 percent of the federal poverty level and address unreasonably high co-payments.
3. Allocate sufficient funding for Head Start, either through the GRF or TANF, to restore the state-funded portion of the program to previous levels of program participation.

Ohio's low-wage workers are doing their part to become self-sufficient and raise healthy children. With targeted help from Medicaid, child care, and Head Start programs, their prospects for success will be much brighter.

Introduction

Over the past two decades, several trends have collided in ways that have dramatic implications for public policy. More women entered the labor force,¹ and both single-parent and two-parent families increased their work hours. At the same time, wages for all but the highest-earning workers were stagnant, although wages at the bottom began to climb slightly in the late 1990s. Job creation shifted to the low-wage sector: half of all new jobs pay wages in the bottom quartile. The percentage of jobs that provide health insurance coverage decreased, even while the cost of medical care rose substantially.

These broad trends in the labor market mean that more women are working in low-wage jobs without access to health care coverage for their families. Moreover, the increase in parents' work hours requires more families to pay for child care – an expense that can easily absorb nearly one-third of a low-income mother's income.²

Public policy also contributed to increased labor force participation by women with young children. In 1996, Congress transformed the nation's welfare system to mandate higher workforce participation by program participants. The new program, named Temporary Assistance for Needy Families (TANF), imposed a maximum five-year limit for receiving cash benefits, but also permitted states to use federal funds for many types of assistance intended to aid a person in finding and keeping a job. Such assistance can include training, transportation, and child support functions. In response to the federal TANF program, Ohio initiated its Ohio Works First (OWF) Program, which set a three-year time limit on receiving cash assistance. The OWF program is managed on a day-to-day basis at the county level. Transitional assistance for persons leaving TANF is available through the Prevention, Retention, and Contingency (PRC) Program. Each county is required to establish a plan for its PRC program.

As a result of these changes in the economy and public policy, more low-income women are relying on employment to support their families. Between 1995 and 2000, the percentage of single mothers nationwide who were employed jumped from 61.7 percent to 73.0 percent.³ Recent job losses then pushed this rate back down to 69.8 percent in 2003.⁴ To help mothers afford and maintain work, most states and the federal government have increased their support for child care subsidies and have tried to make their Medicaid programs more compatible with the needs of low-income working families. Policy makers made these expansions to reflect a public sentiment that supported work over welfare, but that also recognized that many of the jobs available to low-income women do not provide health insurance or pay wages that make full-time child care affordable.

The Economy and Work Supports in Ohio

Ohio's experience reflected the nationwide trend on these issues. Eligibility for Medicaid, subsidized child care, and state-funded Head Start was expanded in the late 1990s, and expenditures for these programs increased accordingly. At the same time, the economic downturn created more need. Ohio began to lose jobs in 2000, before the U.S. economy

officially went into recession in March 2001. As of September 2004, the state still had approximately 264,000 fewer jobs than it had in the peak employment month of June 2000.⁵

The implementation of TANF in Ohio had a dramatic effect on cash assistance caseloads in the late 1990s. The statewide TANF caseload is now under 200,000 recipients, down from a peak of nearly 734,000 in 1992.⁶ The TANF caseload continued its decline between 2001 and 2003, in marked contrast to previous recessions in which the cash assistance caseload rose in tandem with unemployment rates.⁷ Ohio currently receives an annual TANF grant of \$727.9 million from the federal government.⁸ According to a recent article in the *Cleveland Plain Dealer*, approximately \$431 million of the state's TANF account has gone unused because "the state and counties haven't designed programs to spend it on."⁹

In the recessionary environment, the lack of increased TANF participation reflected the implementation of more stringent program rules rather than the needs of Ohio's low-income population; other types of assistance for economically distressed individuals, such as food stamps and food banks, showed significant increases in demand.¹⁰ A state-sponsored study of Ohio's TANF program uncovered significant concerns about the well-being of individuals leaving TANF in Ohio. Only 61 percent of those who were no longer receiving cash assistance were employed,¹¹ and just 19 percent of the employed individuals earned more than \$1,500 per month. These findings suggest that in the present economic context, it is highly unlikely that low-income women who leave TANF will be able to find a job that offers health insurance and sufficient income to afford child care.

As in other states, the recession and weak recovery of the past several years meant that state revenue grew very slowly in Ohio. At the same time, the need for many state services was increasing. In the last budget deliberation, some lawmakers proposed large cuts to Medicaid, child care, and Head Start. Human service advocates in Ohio successfully fought the most onerous of these proposals for Medicaid, but had less success in defending child care and the state Head Start program. Because these programs have been preserved, some lower-wage female workers have been able to stay employed. However, these programs might be on the chopping block again as another tight budget looms. In that context, it is important to understand the role that Medicaid, subsidized child care, and Head Start play in helping low-income women remain employed in Ohio. This paper is designed to add to that understanding.

The importance of work supports for low-income women

Parents working in low-wage, low-quality jobs often cannot reach economic stability without assistance. Health insurance and child care subsidies are two critical work supports that can mean the difference between keeping a job and being out of work.

Promoting Women's Employment through Good Health. Poor health creates serious barriers to finding and keeping a job for many low-income women. Low-income women

are in worse health overall than other women and have higher incidence rates of chronic health problems such as heart disease and diabetes.¹² They are also more likely to either have a disability themselves or have a child with a disability (or both).¹³ Research documents that these health deficits interfere with employment: Women who are in poor health or have multiple health issues are less likely to be employed,¹⁴ stay on their jobs for shorter periods of time,¹⁵ and are at substantially greater risk of losing a job than healthier women.¹⁶

Having health insurance is critical to individuals' ability to get needed health care. Among low-income women, those without health insurance are much more likely to delay or fail to receive needed health care than women with either Medicaid or private health insurance,¹⁷ and they more frequently forego buying prescriptions because they cannot afford them.¹⁸ Improved access to health care through better health insurance coverage can change employment outcomes: Of former welfare recipients, those with health insurance are more successful in staying off welfare than those without.¹⁹

Help with the High Cost of Child Care. Paying for care for one or more children can quickly absorb a substantial portion of a low-wage worker's earnings. Child care for a 4-year-old averages \$4,000 to \$6,000 a year – more than public college tuition in most states.²⁰ The U.S. Department of Health and Human Services reports that employed mothers with monthly family incomes under \$1,500 spend 32 percent of their incomes on child care, while child care takes only 7 percent of income for mothers in families with monthly incomes of \$4,500 or more.²¹ Without help, many workers simply cannot afford good child care.

Working parents who receive help paying for child care have better employment outcomes. They are more likely to be employed,²² keep their jobs longer,²³ and have higher earnings²⁴ than other parents. A recent study by the Institute for Women's Policy Research found that working mothers with regular child care arrangements were less likely to leave their jobs.²⁵ Welfare and employment programs that improve access to child care and increase affordability decrease reports of employment-related child care problems.²⁶ Individuals receiving child care subsidies when leaving public assistance have greater employment stability than those not being helped.²⁷

Ohio's Medicaid Program

How Medicaid Works. The federal government shares funding for Medicaid with the states. The U.S. Department of Health and Human Services establishes basic program regulations and oversees states' use of funds. States are allowed some discretion in choosing services and setting eligibility levels. The federal government establishes a cost-sharing rate, which is known as the "federal medical assistance percentage" or FMAP. In recent years, Ohio's contribution has been slightly over 40 percent for required Medicaid treatments. Recently, the FMAP for all states was temporarily increased by 2.95 percent as part of a federal fiscal aid package that expired on June 30, 2004.²⁸ The federal FMAP for Ohio rose to 62.2 percent under this provision, before

falling back to its current level of 59.7 percent. The increased FMAP translated into additional funding of over \$300 million for Ohio's Medicaid program.²⁹

A separate Medicaid funding stream is made available to states through the State Children's Health Insurance Program (SCHIP), which supports health insurance for children in families above the poverty line. SCHIP has a higher FMAP than regular Medicaid. Ohio contributes only about 30 percent of the cost of its SCHIP program.

Medicaid Eligibility. In Ohio, Medicaid has three basic programs: Healthy Families, Healthy Start, (which includes SCHIP), and Aged, Blind and Disabled. The bulk of Medicaid spending is for individuals in the Aged, Blind, and Disabled category, who have high health-care costs, even though they are a minority of the total caseload.

The Healthy Start and Healthy Families programs provide health care to eligible low-income pregnant women, children (to age 19), and certain families. Families receiving cash assistance through Ohio Works First are also eligible for Medicaid, and transitional Medicaid is provided for some months for individuals leaving OWF for employment. The income eligibility level for Healthy Start was raised to 150 percent of the poverty level in 1998 and to 200 percent of the poverty level in 2000. Healthy Start now covers pregnant women with incomes up to 150 percent of the federal poverty level and children in families with incomes up to 200 percent of the poverty level.

In 2000, the Healthy Families program raised its family eligibility threshold to 100 percent of the poverty level.³⁰ That program now covers parents of Medicaid-enrolled children with incomes up to 100 percent of the poverty level and adults who receive cash assistance through the Ohio Works First program. Individuals who leave welfare are eligible for an initial six months of coverage, which can be extended another six months if income does not rise above 185 percent of the poverty level.³¹

Medicaid now covers one in three births in Ohio, and one in four children.³² In essence, Ohio's Medicaid income eligibility guidelines are more generous for children than for adults. In families with incomes between 100 percent and 200 percent of poverty level, children are covered while their parents generally are not.

Even after the Medicaid eligibility expansions of the late 1990s, the lack of health insurance for low-income women is a substantial problem in Ohio. The Kaiser Family Foundation estimates that 30.3 percent of working-age low-income women in Ohio – nearly 325,000 – lack health insurance.³³

Ohio's Medicaid Participation and Expenditures. In State Fiscal Year (SFY) 1997, those receiving Medicaid assistance through Ohio Works First (the precursor program to Healthy Families) and Healthy Start comprised 72 percent of the total Medicaid caseload, but required just 22 percent of total spending.³⁴ By SFY 2002, these percentages had increased only slightly, despite the dramatic declines in welfare caseloads that left more heads of household reliant on low-wage employment to support their families. In 2002,

the Healthy Start and Healthy Families programs accounted for a combined 74 percent of all individuals eligible for Medicaid, but only 26 percent of total spending.³⁵

Maintaining Medicaid eligibility helps keep low-income families in the workforce even when job quality declines. Caseload and spending increased significantly in 2001 and 2002 because of the combined effects of the weak economy and less restrictive eligibility guidelines. As shown in Table 1 below, the number of people eligible for Healthy Families and Healthy Start was approximately 268,000 higher in state fiscal year (SFY) 2002 than in SFY 1997, a 25 percent increase. Over this five-year period, real (inflation-adjusted) annual expenditures increased by roughly \$592 million, a 46 percent increase, reflecting the surging cost of medical care even for the healthier part of the Medicaid population.

SFY	Eligible Individuals*	Real Expenditures** (1997 dollars)
1997	1,070,389	\$1,286,672,966
1998	1,010,781	\$1,218,906,816
1999	999,058	\$1,233,173,121
2000	1,003,993	\$1,252,342,425
2001	1,268,342	\$1,573,398,081
2002	1,338,930	\$1,878,299,734

Source: Ohio Medicaid Reports for SFYs 1997 to 2002, Office of Ohio Health Plans, ODJFS; Policy Matters Ohio.
 * Data for SFY 1997 are for OWF/ADC and Healthy Start; data for 1997 and 1999 are approximations based on the percentage of total Medicaid caseload in this category.
 ** Includes state and federal expenditures adjusted using the U.S. Bureau of Labor Statistics Medical Care Inflation Index for the Cleveland-Akron, OH MSA.

Support for a Strong Medicaid Program. Since the onset of the national recession in 2001, Ohio has experienced recurring revenue shortfalls. Nonetheless, the Medicaid program was not affected by budget cuts until the SFY 2004-2005 budget biennium. Proposals that would have dramatically reduced Medicaid for tens of thousands of families were met with strong resistance by advocates for low-income families. As a result, cuts enacted did not affect basic eligibility requirements for programs required by federal law. Instead, the main operating budget bill for SFY 2004-2005 reduced eligibility and services for certain specific populations or needs.³⁶ Medicaid stopped funding chiropractic and independent psychological services for adults as of January 2004.³⁷ New enrollment in the Disability Assistance Medical program (funded solely by the state) was frozen as of July 2003.³⁸ Finally, since January 2004, some adults in non-institutional settings are required to make a \$3 co-payment for some prescription drugs, with several exceptions.³⁹ These cuts were far less damaging to low-income families than

the cutbacks considered during budget deliberations. In most other states the tight fiscal environment led to broader cuts in health insurance programs than were seen in Ohio.

In the spring of 2004, when the state again faced a revenue shortfall, Governor Bob Taft ordered spending reductions at most state agencies for the remainder of SFY 2004 and for the upcoming SFY 2005. The Governor asked the Ohio Department of Job and Family Services (ODJFS) to reduce state Medicaid spending by \$50 million in SFY 2005. Advocates were again prepared to oppose any cuts, and in April 2004, the ODJFS announced a plan to save \$51 million without cuts in eligibility or coverage, by upwardly revising estimates of FMAP cost share and billing the federal government for reimbursement of disability assistance recipients who later become eligible for Medicaid.⁴⁰

The next budget cycle could see further proposals to slice Medicaid services, according to Cathy Levine, Executive Director of Universal Health Care Advocates Network-Ohio. Levine sees parental coverage as particularly vulnerable. The dental, podiatric, and vision services that were threatened during the 2003 budget negotiations are likely to be targeted again because the federal government picks up a lower percentage of the cost for these items than for other essential medical procedures, making them relatively more expensive for the state. Lawmakers have also discussed requiring poor families to make co-payments for their care, and reducing allotments for hospitalization. Many legislative initiatives are likely to be drawn from the conclusions reached by the Ohio Commission to Reform Medicaid, an organization created by the most recent budget bill. The Commission is due to report to the Governor no later than January 1, 2005.⁴¹

Ohio Child Care Trends

In the late 1990s, as part of welfare changes that mandated workforce participation for many low-income single parents seeking income supports, the state expanded eligibility for subsidized child care, providing assistance to families with slightly higher incomes. Public opinion supported work requirements and reduced cash assistance, but most polls also showed great concern for child well-being when single mothers were pushed into the workforce. One poll of 1,000 Ohio voters taken by the AARP Ohio in early 2003 determined that “72% of voters would be very likely or somewhat likely to accept an increase in taxes or other fees in order to maintain the current funding level for helping low-income working families pay for childcare.”⁴² The expansion of child care reflected an attempt to respond to those concerns.

To support families with new work activities, assistance for continued care is available to families with slightly higher incomes than those eligible for initial care. Until 1997, children were eligible only if their families were at or below the federal poverty line. In 1997, the state expanded eligibility for child care programs to families earning 150 percent of the poverty level, or \$28,275 for a family of 4 (in 2004 dollars) (see Table 2, below). In late 1998, eligibility for continuing care was further expanded to families with incomes up to 185 percent of the poverty level.

Year	Eligibility Level for Initial Care (as percent of federal poverty level)	Eligibility for Continued Care
Pre-1997	100 percent of federal poverty level	150 percent of poverty level
1997	100 percent, 105 percent, 135 percent	150 percent
1998	150 percent	150 percent
1999 – early 2003	150 percent	185 percent
Since October 2003	150 percent	150 percent for transitional 165 percent for employment, training

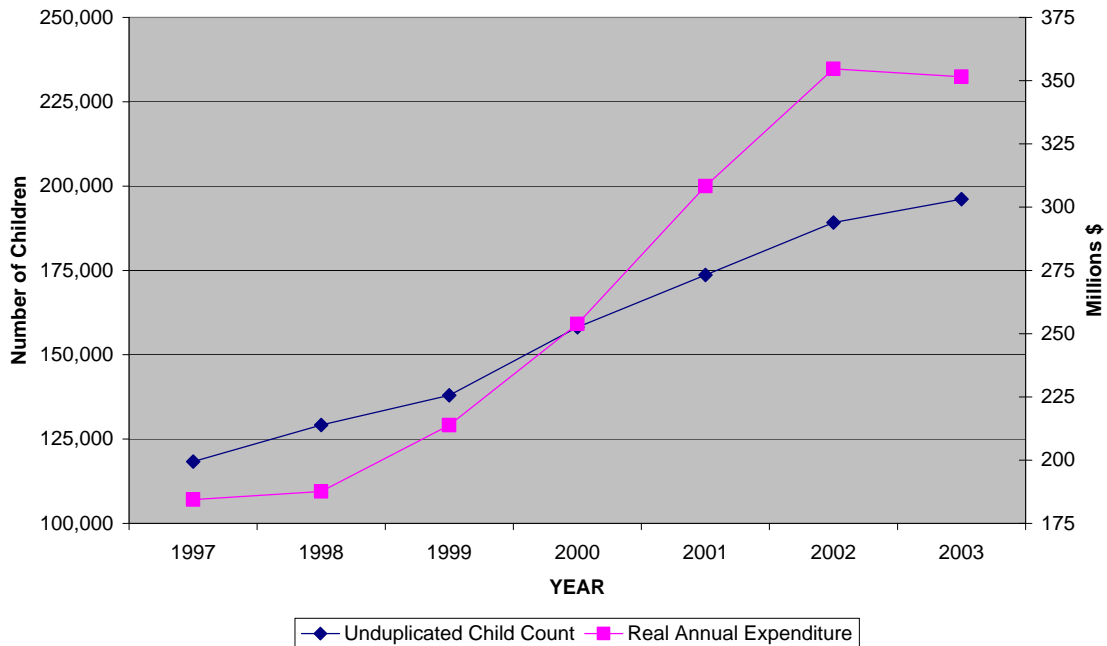
Changes made in June 2003 (effective October 2003), however, retightened eligibility requirements, lowering the income eligibility for continuing care to 165 percent of the federal poverty level.⁴³ This eligibility level continued in 2004. In addition to this, an increase in parental co-pays has made it even more difficult to provide assistance for children in need. An Ohio family of three with an income at 100 percent of the federal poverty level and one child in care must pay a fee of \$127 per month. Data from 2004 show that only four other states have a higher child care parent co-payment than Ohio for a family with these characteristics. Between 2001 and 2004, only two other states increased their parent co-pays more than the state of Ohio did in terms of actual dollar amounts.⁴⁴ In addition, the state has frozen its reimbursement rates for providers for four years.⁴⁵

These changes have greatly reduced the growth of subsidized child care (both in the number of children served and in the amount spent), to only four percent in 2003. Nearly 200,000 Ohio children received child care subsidies in 2003, but the typical month saw an average of only 104,000 served.⁴⁶

The lower eligibility ceilings result in greater turnover in the programs. If a family of four manages to raise its income above \$31,102, it is no longer eligible to receive any subsidized child care.⁴⁷ This can create perverse incentives for low-income families, where small improvements in income can result in large losses of subsidies.

The expanded eligibility in the late 1990s led to higher combined state and federal spending and higher program participation, as Figure 1 shows. The number of children in the program grew by 66 percent, from 118,328 in 1997 to 196,148 in 2003 (shown on the left-side axis). As measured in 1997 dollars, program spending for direct (non-administrative) child care subsidies grew by 91 percent in real terms, from \$184 million in SFY 1997 to \$351 million in 2003 (shown on the right-side axis).⁴⁸

Figure 1. Trends in Child Care: Real Expenditures and Children Served, 1997-2003 (1997 dollars)



Source: Ohio Department of Job and Family Services, Bureau of Child Care and Development; Spending amounts are in 1997 dollars, adjusted for inflation by Policy Matters Ohio using the U.S. Department of Labor, Bureau of Labor Statistics’ Child Care and Nursery School consumer price inflation index (U.S. City Average).

Growth and Contraction of Ohio’s Head Start Program

Although conceived as a program to improve children’s school readiness and encourage family stability and well-being, the federally funded Head Start program provides a form of subsidized child care for many families. Its preschool programming for low-income children has been widely praised as a highly successful model for early intervention and future academic success. Two distinct Head Start programs have operated in Ohio. One program is completely funded by the federal government, with the federal government giving funding directly to grantees. A second, state-administered program has received significant amounts of state general revenue in combination with federal funds. Until the current budget biennium, Ohio’s Head Start program was among the best in the nation in terms of the number of children served and overall funding levels. Under former Governor George Voinovich (1991-1999), spending on Head Start rose sharply, from \$18.4 million to \$181.2 million. By the end of this period, Head Start reached 90 percent of eligible Ohio children, at a time when just 40 percent of eligible children participated nationally.⁴⁹

Ohio’s federally funded Head Start program is now the eighth largest in the nation in terms of federal funding, receiving \$239,770,120, and fifth largest in terms of children served, with 38,017.⁵⁰ Ohio’s \$6,307 in annual funding for each child, however, ranks forty-ninth of the fifty-six bodies receiving funding, and is \$785 below the national

average of \$7,092. Ohio spends the least per child of the five states in its federal administrative program region.⁵¹

Under the current administration, the state-funded part of the program has been severely curtailed. Planned Head Start participation was reduced first from 22,000 slots to 18,000 slots, and then even further, to only 11,600. This planned reduction was due in part to an effort to transition to a “Head Start Plus” program that would provide full day care to a smaller number of children as opposed to part-day care to a larger population.

Although full day care can be of greater assistance to working parents, Head Start advocates worried that program quality was being compromised. The Head Start Partnership Study Council, which included state legislators, state agency staff, county officials and representatives from the Head Start and child care provider communities, examined some of the Taft administration’s changes in a 2003 report. Among other things, the Council concluded that calling the new program Head Start Plus was inappropriate because the new program does not meet the comprehensive standards set out by the national Head Start program.⁵² Nonetheless, a majority of the committee agreed with the Administration’s full day concept.⁵³ A minority report by the Ohio Head Start Association and some advocates for low-income families was more critical, condemning a change in governance from the ODJFS to the Ohio Department of Education and asserting that the program modifications mean that low-income families “will be forced to accept less, yet survive in a society that demands more from them.”⁵⁴

The administration’s plans for further restructuring were included in the most recent biennial budget.⁵⁵ In prior years, the state-administered Head Start program was funded mainly from the state’s General Revenue Fund (GRF), not by federal funds. Actual state spending amounted to over \$88 million in SFY 2003, having fallen from over \$100 million in SFY 2001.⁵⁶ Under the current funding scheme, however, the state will use only federal funds from Ohio’s TANF block grant allotment for the program. Small amounts of GRF resources will be advanced to grantees at the beginning of each fiscal year, but these amounts will later be reimbursed with federal funds. In fiscal year 2004, \$68.2 million was appropriated for Head Start by the Ohio legislature.⁵⁷

In FY 2005, Ohio fully implemented the Head Start Plus program, which merges child care and some educational services. Head Start Plus will receive \$113.2 million, only \$5 million of which will come from the state GRF (on a reimbursable basis). The new program will support 10,000 slots for low-income children. Traditional Head Start programs will be reduced to 4,000 slots. In essence, the withdrawal of state funding from the program resulted in a planned reduction of 8,000 Head Start slots while raising serious questions about the quality of service delivery. Income eligibility for Head Start Plus and Head Start are the same as for the subsidized child care program. Head Start Plus uses the same family co-payment structure as subsidized child care, but the traditional Head Start program does not require a co-payment.

Unfortunately, actual enrollment has been far below the reduced number of available slots. As of September 9, 2004, only 2,774 children were enrolled in the Head Start Plus

Program, rather than the planned 10,000.⁵⁸ The Ohio Department of Education and the ODJFS (which continues to set eligibility levels) have announced a dramatic overhaul of the program's administrative rules to increase utilization. Among these changes are: the removal of a minimum parental work requirement; encouraging providers to provide care on second shifts and weekends; and modifying reimbursement policies.⁵⁹ The state also acknowledged that the traditional Head Start programs were having trouble filling all of their anticipated 4,000 slots. To address this situation, new program rules will subsidize day care for the hours that a child is not in Head Start. Still, none of these regulatory changes address the issue of parental co-payments or lower income eligibility, despite the state's admission that these issues are among the "key reasons for low enrollment."⁶⁰

Administrative Funding for County Job and Family Services

In July, 2004, the ODJFS acknowledged that significant budgetary mismanagement had taken place with regard to TANF funds distributed to county governments for program administration.⁶¹ Since Ohio's welfare reform in 1997, funds for TANF administration had been mingled with funds for food stamp and Medicaid administration in "consolidated allocation" grants to the counties. A total of \$536.9 million was distributed to the counties in SFY 2004.⁶² As the need for food stamps and Medicaid services grew, some counties utilized TANF administrative funds to cover expenses in these programs. The ODJFS failed to replace these TANF funds as required by federal law. Consequently, Ohio will have to repay \$133 million for fiscal years 2000 through 2003.⁶³ The amount of shortfall for SFY 2004 is unknown. The ODJFS has begun to shift funds to maintain services and bring the system into compliance for SFY 2005, but addressing the accumulated funding gap will require legislative action. The ODJFS has changed its county grant allocation system to separate funding streams for program administration, but whether adequate revenue can be found to maintain current levels of administrative services for Medicaid and food stamps during the upcoming SFY 2006-2007 budget biennium is an open question.

The positive outcome of this situation is that more TANF funds will be available in the future because they will not be used to administer other programs. This, combined with the state's large TANF reserves, should create more flexibility in funding Head Start and other TANF-eligible activities. In addition, policy makers could increase allocations for work supports such as transportation and training for TANF-leavers. This must be done carefully because TANF funds that are carried over from prior years can only be spent on cash assistance.⁶⁴ Appropriations for non-assistance activities would have to be made from current year federal grants.

Conclusions and Policy Recommendations

Increased parental employment, declining job quality, and a very slow economic recovery are placing enormous stress on low-income families in Ohio. Strong and stable work supports are essential to keeping low-wage workers in jobs and to maintaining their families' economic security and basic health.

Because of growing health care expenses and a lack of health insurance coverage through work, the Healthy Start and Healthy Families programs are likely to continue to play a crucial role in helping Ohio residents receive medical care. With the federal government bearing almost 60 percent of the overall cost of Medicaid, and 70 percent of the cost of insuring children under Healthy Start, the state receives an excellent return on its investment for this program. Reductions in state funding would be multiplied by lost federal revenue. A recent study estimated that Ohio would see a reduction of \$3.15 in the state's economic activity for each dollar cut in state Medicaid expenditures.⁶⁵ Cuts to this program would reduce insurance levels, leading to gaps in medical care for poor children. In some cases, preventive care would be foregone, with more expensive emergency treatment taking its place. Despite the difficult fiscal environment Ohio faces, the legislature should recognize the value and cost effectiveness of this program.

- Medicaid funding must be adequate to maintain current services and eligibility ceilings.

Low-wage working parents face an enormous challenge in finding and paying for quality child care. State programs that help defray the expense of caring for children while parents work can make employment more worthwhile.

- Eligibility for child care assistance should be restored to 185 percent of the federal poverty level. Parental co-payments should be lowered to more realistic levels.

Head Start has been an important source of early education for low-income children, helping to reduce some of the gaps in preparedness that low-income children typically face when entering kindergarten. Ohio, once a pioneer in ensuring access to Head Start programming, should continue to provide this important program to needy children in the state.

- In spite of the difficult budgetary situation, the state should examine ways to restore Head Start program participation to previous levels. In the report, *“Ohio’s Early Care and Education System Falls Short: What’s Wrong and How We Can Fix It,”* The Center for Community Solutions suggests using Ohio’s federal TANF funds to pay for cash assistance, while reserving the state’s general fund to pay for expanded child care or state Head Start services.⁶⁶ Alternatively, TANF funds that become available due to changes in the county administrative allocation system could be used for Head Start.

Ohio’s low-wage workers are doing their part to become self-sufficient and raise healthy kids. With targeted help from Medicaid, child care, and Head Start programs, their prospects for success will be much brighter.

¹ The employment-to-population ratio for women age 16 and over increased from 48.0 percent in 1981 to 57.0 percent in 2002. Labor Force Statistics from the Current Population Survey, U.S. Department of Labor, Bureau of Labor Statistics <<http://data.bls.gov>>.

² U.S Department of Health and Human Services. 2003. *Who's Minding the Kids? Child Care Arrangements: Spring 1999 Detailed Tables (PPL-168)*, Table 6. Washington, DC: U.S. Department of Health and Human Services, <<http://www.census.gov/population/www/socdemo/child/ppl-168.html>> (August 30, 2004).

³ Sherman, Arloc, Shawn Fermstad, and Sharon Parrot. 2004. *Employment Rates for Single Mothers Fell Substantially During Recent Recession*, Table 2. Washington, DC: Center on Budget and Policy Priorities.

⁴ Ibid.

⁵ Calculated using seasonally adjusted data on Ohio's total non-farm wage and salary employment in June 2000 and September 2004 as estimated through Current Employment Statistics from the *Ohio Workforce Informer* website of the Ohio Department of Job and Family Services' Bureau of Labor Market Information (www.ohioworkforceinformer.org).

⁶ Between calendar year 2001 and calendar year 2003 there was a 3.3 percent **decline** in the number of Ohio Works First recipients, from 201,009 to 194,429 (<http://jfs.ohio.gov/pams/Reports/SFY2003.pdf>). This was despite the fact that this recovery was much weaker than the one in the 1990s. Ohio lost more than 130,000 jobs between November 2001 when the recession ended and December 2003 (25 months later), about 2.4 percent of total jobs in the state. The state lost 68,200 jobs between March 1991 when the previous recession ended and April 1993 (25 months later), about 1.4 percent of total jobs.

⁷ Ohio Association of Community Action Agencies. 2004. *The State of Poverty in Ohio 2004*. Cleveland, OH: The Ohio Association of Community Action Agencies. <<http://www.oacaa.org/uploads/docs/REP2004j.pdf>> (September 14, 2004).

⁸ Corlett, John, and Lori McClung. 2004. *Ohio's Early Care and Education System Falls Short: What's Wrong and How Can We Fix It*. Cleveland, OH: Center for Community Solutions, August 2004.

⁹ "Money for poor not spent; sparks fly – County, state officials clash over millions" by Ted Wendling. *The Plain Dealer*, Wednesday, September 29, 2004. online source: <http://www.cleveland.com/printer/printer.ssf?/base/news/109645038637253>

¹⁰ The number of food stamp recipients increased by 33.2 percent (from 660,446 to 879,775) between calendar years 2001 and 2003.

¹¹ ORC Macro. 2003. *The Ohio Works First Evaluation: Findings From a Longitudinal Survey of Participants*. Calverton, MD: ORC MACRO. Prepared for the Ohio Department of Job and Family Services, June 2003. See page iii of the Executive Summary. The study followed a cohort of individuals who were receiving cash assistance in June, 2000, and were "work required." These findings are based on weighted responses from "wave 2" interviews conducted between May 2001 and February 2002.

¹² Mead, Holly, Kristine Witkowski, Barbara Gault, and Heidi Hartmann. 2001. "The Influence of Income, Education, and Work Status on Women's Well Being." *Women's Health Issues* 11(May/June): 160-172.

¹³ Lee, Sunhwa, Melissa Sills, and Gi-Taik Oh. 2002. *Disabilities Among Children and Mothers in Low-Income Families*. Washington, DC: Institute for Women's Policy Research.

¹⁴ Polit, Denise F., Andrew S. London, and John M. Martinez. 2001. *The Health of Poor Urban Women: Findings from the Project on Devolution and Urban Change*. New York, NY: Manpower Demonstration Research Corporation. <<http://www.mdrc.org/publications/77/report.html>> (August 28, 2004).

¹⁵ Lee, Sunhwa. 2004. *Women's Work Supports, Job Retention, and Job Mobility: Child Care and Employer-Provided Health Insurance Help Women Stay on Jobs*. Washington, DC: Institute for Women's Policy Research.

¹⁶ Earle, Alison, and S. Jody Heymann. 2002. "What Causes Job Loss Among Former Welfare Recipients: The Role of Family Health Problems." *Journal of the American Medical Women's Association* 57(1): 5-10.

¹⁷ Mann, Cindy, Julie Hudman, Alina Salganicoff, and Amanda Folsom. 2002. "Five Years Later: Poor Women's Health Care Coverage After Welfare Reform." *Journal of the American Medical Women's Association* 57(1):16-22.

¹⁸ Wyn, Roberta, Victoria Ojeda, Usha Ranji, and Alina Salganicoff. 2004. *Health Coverage and Access Challenges for Low-Income Women*. Washington, DC: The Henry J. Kaiser Family Foundation.

¹⁹ Loprest, Pamela. 2002. *Who Returns to Welfare?* Washington, DC: Urban Institute.

- ²⁰ Schulman, Karen. 2000. *The High Cost of Child Care Puts Quality Care Out of Reach of Many Families*. Washington, DC: Children's Defense Fund.
- ²¹ U.S. Department of Health and Human Services, op. cit.
- ²² Tekin, Erdal. 2004. *Child Care Subsidy Receipt, Employment, and Child Care Choices of Single Mothers*. NBER Working Paper 10459. Cambridge, MA: National Bureau of Economic Research.
- ²³ Boushey, Heather. 2002. *Staying Employed After Welfare*. Washington, DC: Economic Policy Institute.
- ²⁴ Danzinger, Sandra K., Elizabeth Oltmans Ananat, and Kimberly G. Browning. 2003. *Childcare Subsidies and the Transition from Welfare to Work*. NPC Working Paper #03-11. Ann Arbor, MI: National Poverty Center Working Paper Series. <http://www.npc.umich.edu/publications/working_papers/paper11/index.shtml> (August 30, 2004).
- ²⁵ Lee, Sunhwa. Forthcoming. *Work Supports, Job Retention, and Job Mobility Among Low-Income Mothers*. Washington, DC: Institute for Women's Policy Research.
- ²⁶ Gennetian, Lisa A., Danielle A. Crosby, Aletha C. Huston, and Edward D. Lowe. 2002. *How Child Care Assistance in Welfare and Employment Programs Can Support the Employment of Low-Income Families*. The Next Generation Working Paper Series No. 11. New York, NY: Manpower Demonstration Research Corporation.
- ²⁷ Loprest, Pamela. 2003. *Use of Government Benefits Increases Among Families Leaving Welfare*. Washington, DC: Urban Institute.
- ²⁸ The Jobs and Growth Tax Relief Reconciliation Act of 2003 (PL 108-27, 108th Congress) provided \$10 billion in increased Medicaid funds for the states over the five fiscal quarters ending June 30, 2004. Vernon Smith et al., *States Respond to Fiscal Pressure: A 50-State Update of State Medicaid Spending Growth and Cost Containment Actions* (Kaiser Commission on Medicaid and the Uninsured, January 2004).
- ²⁹ The American Health Care Association estimated that Ohio would receive an additional \$366.4 million from the increased FMAP. ("\$8.9 billion in Medicaid Funding Lost Nationally From Today's Phase Out of Federal State Fiscal Relief," AHCA News and Information July 1, 2004, www.ahca.org/news/nr040701.htm.)
- ³⁰ ODJFS, Office of Ohio Health Plans. 2003. *Update of the Ohio Medicaid Report (SFY 2001)*.
- ³¹ ODJFS, Office of Ohio Health Plans. 2004. "Fact Sheet 2.1: Medicaid Programs."
- ³² Coulter, Barbara. 2004. "Ohio Medicaid Reform: What's on the Horizon for 2004 and Beyond?" Presentation by Barbara Coulter Edwards, Deputy Director, Office of Ohio Health Plans, to the Ohio Osteopathic Association Teleconference. January 26, 2004.
- ³³ Working-age low-income women are defined as women with family incomes below 200 percent of poverty level. The Henry J. Kaiser Family Foundation. 2003. *Fact Sheet: Women's Health Policy Facts. Health Insurance Coverage of Low-Income Women Ages 18 to 64, by State, 2001-2002*. Washington, DC: The Henry J. Kaiser Family Foundation.
- ³⁴ ODJFS, Office of Ohio Health Plans. 1998. *Ohio Medicaid Report, SFY 1997*, ODJFS (December).
- ³⁵ ODJFS, Office of Ohio Health Plans. 2004. *Ohio Medicaid Report, SFY 2002*, ODJFS (January).
- ³⁶ Am. Sub. H.B. 95, 125th General Assembly. Summary information from ODJFS, "The State of Ohio Medicaid: State Budget Outcomes, State Fiscal Years 2004 & 2005." Office of Ohio Health Plans, July 2003.
- ³⁷ Medicaid continues to pay for certain psychological services offered through local Alcohol, Drug Addiction, and Mental Health Boards.
- ³⁸ The DA medical program is funded solely through state funds, although some individuals later qualify for federal Supplemental Security Income (SSI), and thereby become eligible for Medicaid.
- ³⁹ The copayment does not apply to birth control or family planning devices and is waived for pregnant women and women who have given birth within the previous 90 days. ODJFS, Office of Ohio Health Plans. 2004 "Fact Sheet 5.1: Prescription Co-payment for Medicaid Consumers."
- ⁴⁰ ODJFS. 2004. "Press Release: Medicaid Budget Savings – State Fiscal Year 2005."
- ⁴¹ The Commission has nine members. Three were appointed by the Governor, three by the Ohio Senate, and three by the Ohio House of Representatives.
- ⁴² Corlett and McClung, op. cit., p. 7.
- ⁴³ Child Care Transmittal Letter No. 55B, <<http://www.odjfs.state.oh.us/lpc/mtl/CCMTL55b.pdf>>.
- ⁴⁴ Schulman, Karen, and Helen Blank. 2004. *Child Care Assistance Policies 2001-2004: Families Struggling to Move Forward, States Going Backward*, Table 3. Washington, DC: National Women's Law Center.

⁴⁵ Corlett, John, and Lori McClung. 2004. "Response to ODJFS TANF Transfer Memo." (Cleveland, OH: Center for Community Solutions). Distributed via email to the Have-a-Heart Ohio advocacy network October, 2004. The Center for Community Solutions reports that "we have heard numerous reports of Ohio's child care providers either going out of business or eliminating quality components of their services" (p. 2).

⁴⁶ Data requested from ODJFS, Bureau of Child Care and Development.

⁴⁷ According to the Ohio Department of Job and Family Services, eligibility is checked by the county departments every twelve months after initial eligibility is determined.

<<http://jfs.ohio.gov/factsheets/ChildCare.pdf>>.

⁴⁸ The table does not include amounts transferred to county governments to administer the program. These amounts are significant. In SFY 2003, direct subsidies for child care were \$471.1 million, but the total program cost was \$541.2 million.

⁴⁹ O'Neill, Tom. 2002. "Voinovich Seeks Support for Early Education Bill." *The Cincinnati Enquirer*, July, 16, 2004, <http://www.enquirer.com/editions/2002/07/16/loc_voinovich_seeks.html> (September 13, 2004).

⁵⁰ Haxton, Barbara. 2004. *Statistical Fact Sheet*. Ohio Head Start Bureau.

⁵¹ Illinois, Indiana, Michigan, Minnesota, Ohio and Wisconsin, all of which are under the regional office in Chicago. Only Michigan and Ohio are in the fourth quartile in per capita spending.

⁵² <<http://www.lsc.state.oh.us/legreports/headstart.pdf>>, chapter 3.

⁵³ Corlett and McClung, *Ohio's Early Care and Education System Falls Short* (op. cit.), p. 4.

⁵⁴ Ohio Head Start Partnership Study Council (OHSPSC). December 31, 2003. *Report & Recommendation*, p. 28. <<http://www.lsc.state.oh.us/legreports/headstart.pdf>>.

⁵⁵ Legislative Service Commission Final Analysis Am. Sun. H.B. 95, 125th General Assembly, available through <<http://lsc.state.oh.us/analyses/analysis125.nsf/>>.

⁵⁶ *Catalog of Budget Line Items – Ohio Department of Education*, p. 2. Ohio Legislative Service Commission. Available at <www.lbo.state.oh.us/fiscal/budget/FY2005-2005Budget/COBLI/EDU.pdf>.

⁵⁷ OHSPSC. December 31, 2003. *Report & Recommendations*, p. 6.

<<http://www.lsc.state.oh.us/legreports/headstart.pdf>>

⁵⁸ *Strategies to Improve Implementation of Title IV-A Head Start & Head Start Plus*. Rick Smith (Ohio Department of Jobs and Family Services) and Jane Wiechel (Ohio Department of Education), September 10, 2004.

⁵⁹ *Ibid.*, pp. 1-2.

⁶⁰ *Ibid.*

⁶¹ Moore, Theresa. 2004. "State Snafu Could Cost County DJFS." *The Ironton Tribune*, July 23, 2004.

⁶² "Welfare Fund Shortage has ODJFS Reconsidering County Payment Methods," *Gongwer News Service—Ohio Report*, August 2, 2004. See also "A Run on Ohio's Grant Account," *The Plain Dealer*, August 1, 2004, available at www.cleveland.com.

⁶³ "State announces short-term fix in welfare funding flap; more budget challenges loom in long-term," *Gongwer News Service – Ohio Report*, August 19, 2004; "Controlling board transfers \$46 million within ODJFS budget to avoid 'substantial' reduction in funds for counties," *Gongwer News Service – Ohio Report*, August 23, 2004.

⁶⁴ Administration for Children and Families, U.S. Department of Health and Human Services. Policy Questions and Answers on the Use of Funds. See # 11.

<<http://www.acf.hhs.gov/programs/ofa/polquest/usefunds.htm>>

⁶⁵ Greenbaum, Robert, and Anand Desai. 2003. *County Level Analysis of the Effects of Medicaid Cutbacks in Ohio*. Columbus, OH: Ohio State University – School of Public Policy and Management.

<<http://www.ppm.ohio-state.edu/pdf/medicaid.pdf>>.

⁶⁶ Corlett and McClung, *Ohio's Early Care and Education System Falls Short* (op. cit.), p. 9.

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