



MAR 22 1999

Dear TANF Administrators, State Medicaid Directors, and CHIP Directors:

Through an ongoing strategy to reform welfare, the Administration has fought to continue efforts to support low-income families, especially those trying to make the transition from welfare to self-sufficiency. As part of these efforts, it is critical that progress is made towards increasing the number of Americans with health insurance. The delinkage of Medicaid from cash assistance and declining welfare caseloads have created both challenges and opportunities for providing this support for working families. It is important that we use effective strategies and find new ways to reach children and families outside, as well as through, the welfare system.

In order to help policy makers overcome these challenges, and to realize the potential of these opportunities, we have developed the enclosed guide, "Supporting Families in Transition: A Guide to Expanding Health Coverage in the Post-Welfare Reform World." This guide contains information regarding processes and procedures that will help ensure as many children and families as possible obtain health insurance.

In a letter we sent you on June 5, 1998 (<http://www.hcfa.gov/medicaid/wrdl605.htm>), we encouraged you to coordinate both the administration of and eligibility for your TANF and Medicaid programs. In that letter, we highlighted states' responsibilities to establish and maintain Medicaid eligibility for families and children affected by welfare reform, and we also outlined the broad flexibility the statute affords you to expand eligibility. Through the enclosed guide, we are providing additional information to help you accomplish these important goals.

In addition to explaining state options and suggesting appropriate strategies, the guide summarizes the application and enrollment requirements for the Medicaid program. Two of the most critical requirements are that States must:

- **Provide Medicaid applications upon request.** Based on Medicaid regulations (42 CFR 435.906), the Department of Health and Human Services (DHHS) has determined that states using joint TANF-Medicaid applications must furnish a Medicaid application immediately upon request and may not impose a waiting period before providing the application for Medicaid.
- **Process Medicaid applications without delay.** States must assure that an application for Medicaid is processed quickly and not delayed by any TANF requirement. In states where TANF application or eligibility is delayed (i.e., families receive diversionary assistance or face any other initial administrative steps), the state must process the joint application immediately to determine Medicaid eligibility.

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In addition to issuing the guide, we will be expanding our technical assistance efforts to states to ensure that TANF programs are designed and implemented so that children and their families are informed about Medicaid and CHIP and enrolled when eligible. To focus our efforts more effectively, we will work with states to review their welfare and Medicaid eligibility and enrollment procedures. This process will help us assist state agencies in improving their practices, it will further help us by identifying successful models of coordination that can be shared with other states.

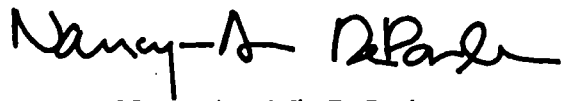
We recognize the new needs for outreach, accessibility, and coordination that have arisen from the delinkage of Medicaid from the welfare system, and the growing number of working families unlikely to enter the welfare office but likely to be eligible for Medicaid. In light of these new challenges, we are committed to working with you to establish the most effective Medicaid application and enrollment procedures for low-income families with children.

We look forward to continuing this very important work with you and to charting the gains we make together in improving the health coverage of all low-income children and families, and in supporting the transitions of families from welfare to self-sufficiency. In the meantime, please contact your HCFA or ACF Regional Administrator or your Regional Director with any questions or for additional information.

Sincerely,



Olivia Golden
Assistant Secretary
Administration for Children and
Families

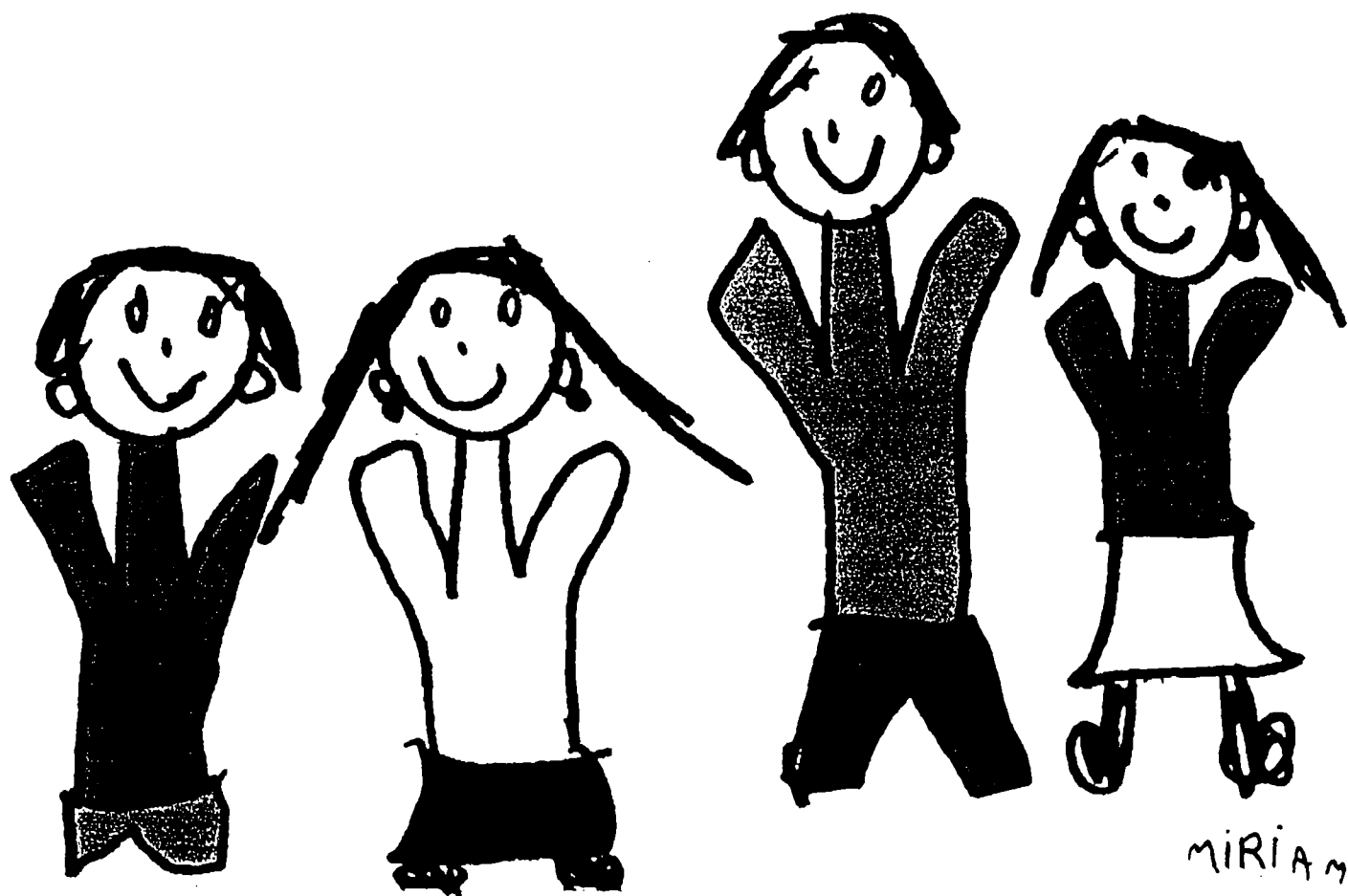


Nancy Ann Min DeParle
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Supporting Families in Transition

A Guide to
Expanding Health Coverage in
the Post-Welfare Reform World



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Introduction

The last two years have witnessed a profound transformation of the American welfare system. A booming national economy combined with innovative state policies and investments have helped millions of low-income Americans make the transition from dependency to work and self-sufficiency and resulted in steadily declining welfare caseloads. An essential pillar of family self-sufficiency is the ability to obtain and keep health insurance coverage.

Until recently, many low-income families obtained health insurance through their eligibility for cash assistance programs. Under the old Aid to Families with Dependent Children (AFDC) program, poor families automatically received Medicaid coverage when they qualified for cash assistance. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 replaced AFDC with a new state-run Temporary Assistance for Needy Families (TANF) program and ended the automatic link between eligibility for cash assistance and eligibility for Medicaid.

To preserve Medicaid coverage for low-income families with children, the welfare reform law created a new Medicaid eligibility category. Under the new "Section 1931" group, families who would have qualified for Medicaid under a state's AFDC program are generally eligible for Medicaid now, regardless of whether they receive TANF assistance. The law also made available to states \$500 million in enhanced matching funds to support the systems changes and outreach necessary to address the effects of "delinking" Medicaid from welfare.

Beyond preserving Medicaid eligibility as it was prior to welfare reform, new options have been created. Specifically, Congress provided states with broad flexibility under Section 1931 to expand Medicaid to cover more low-income families at their option. Also, as a result of regulations published in August 1998, states can expand coverage to more two-parent working families through Section 1931. Finally, seeking to extend free or affordable health coverage to uninsured children in low-income families, President Clinton and Congress created the Children's Health Insurance Program (CHIP).

The dramatic changes in welfare laws and policies, and the challenges and opportunities they continue to present, require that states establish new strategies and procedures to ensure that as many children and families as possible retain or obtain health care coverage under Medicaid or CHIP. To achieve this result, we need to find new ways to reach children and families with these health programs—outside as well as through the welfare system.

This guide serves three major purposes:

- ✓ First, it assists state policymakers and others in understanding what the Medicaid statute and regulations require of states in terms of Medicaid eligibility, enrollment, redetermination, notice and appeal rights, and other program and policy areas. These requirements apply generally in Medicaid, and also specifically to Medicaid applications and eligibility determinations in the welfare context — that is, when families seek or leave TANF assistance. The guide includes information on the ways in which states can work within the statute to strengthen their outreach efforts, simplify their application processes, and broaden Medicaid coverage to reach low-income families with children, independent of TANF.
- ✓ Second, it discusses the Medicaid requirements and options that apply in three common scenarios: 1) when families seek TANF assistance; 2) when families leave TANF assistance; and 3) when families have no contact with the TANF program.
- ✓ Third, it points the reader to the various sources of funding that are available to states to pay for outreach, training, and other activities to help states bring their systems into compliance with the law and increase health insurance coverage for low-income families with children.

The guide is organized into four chapters:

Reaching Families Who Seek TANF Assistance. This chapter addresses the specific circumstances of families seeking TANF assistance. It outlines the Medicaid and CHIP requirements that states must meet when receiving and processing applications from these families, and identifies practices and techniques that states may wish to consider in designing their TANF programs and their application and enrollment processes to ensure maximum participation of families.

Maintaining Coverage for Families Who Leave TANF Assistance. This chapter focuses on the circumstances of families leaving the TANF system. It outlines applicable Medicaid legal requirements and options, and strategies and techniques that states may wish to consider in designing their Medicaid programs and the administration of their TANF programs to ensure maximum continued eligibility for Medicaid and CHIP.

Reaching Families Outside the TANF System. This chapter focuses on the ways in which states can help low-income families who are not seeking TANF assistance to obtain health insurance through Medicaid and/or CHIP. States have an opportunity here to capitalize on the delinkage of Medicaid from welfare eligibility by marketing

Medicaid as well as CHIP coverage as a freestanding support for working families — untied to TANF. This chapter also emphasizes the need to reach out to low-income families and inform them of the health coverage available to them under Medicaid and CHIP.

Funding Opportunities. The final chapter identifies sources of funds that are available to states to pay for outreach, training, and other activities critical to supporting compliance with Medicaid requirements and maximizing coverage of low-income families with children.

Reaching Families Who Seek TANF Assistance

Families seeking assistance under the Temporary Assistance for Needy Families (TANF) program typically first complete an application. All states currently report that they use joint applications for TANF and Medicaid. Therefore, the nature of coordination between the TANF and Medicaid agencies and their procedures has a critical impact on whether or not eligible low-income families obtain Medicaid coverage.

Not every person seeking TANF assistance actually completes the application process. In some states, for example, completion of an application is delayed until a parent conducts a job search. In other cases, an individual may decide not to apply for TANF after all because she secures employment, or for other reasons. Many parents do not realize that, regardless of their eligibility for or receipt of TANF assistance, they, or at least their children, may be eligible for Medicaid or CHIP. In such cases, TANF offices can be instrumental in ensuring that eligible families get enrolled in Medicaid or CHIP.

This chapter outlines the statutory and regulatory requirements under TANF and Medicaid that states must follow in establishing the eligibility rules for low-income families, as well as requirements concerning the Medicaid application and enrollment processes. To help state officials and others considering implementation issues, this chapter also identifies administrative steps and programmatic strategies designed to promote the maximum enrollment of families.

State Requirements and Options under Federal Medicaid Law

A. Mandatory Eligibility Policies

- ✓ **Section 1931 group.** Medicaid eligibility is no longer tied to or based on eligibility for welfare. Nor can states limit Medicaid eligibility only to families receiving TANF benefits. Section 1931 of the Social Security Act establishes rules for Medicaid eligibility for low-income families based on the income and resources of the family. Under Section 1931, states must provide Medicaid coverage to families who:

- ◆ have a dependent child living with them;
- ◆ have income and resources that would have qualified them for AFDC under the State plan in effect on July 16, 1996; and
- ◆ meet certain deprivation requirements (e.g., absent parent) that were in the state's AFDC plan as of July 16, 1996.

Most states have amended their Medicaid state plans to add the new Section 1931 eligibility group for low-income families to replace the former AFDC recipient eligibility group.

- ✓ **Comparable standards.** Section 1902 (a) (17) of the Social Security Act requires states to establish eligibility standards for a given Medicaid group that are the same for all members of that group. This means that, generally, the eligibility rules must be the same for all Medicaid applicants and recipients within the Section 1931 group.
- ✓ **Statewide application.** Medicaid statute requires states to apply their policies through all subdivisions of the state. Accordingly, a state's Section 1931 eligibility rules must be the same throughout the state.

B. Optional Eligibility Policies

Under Section 1931, states have the option to modify their July 16, 1996 AFDC state plan requirements by using the flexibilities outlined below¹. To exercise any of these flexibilities under Section 1931, a state must submit a Medicaid state plan amendment.

- ✓ **Use less restrictive financial methodologies.** States can use less restrictive income and/or resource methodologies to determine Medicaid eligibility than those in effect under the July 16, 1996 AFDC state plan. By doing so, states can expand coverage to more low-income families with children without obtaining a Federal waiver. For example, a number of states have chosen to disregard a car of any value, as well as interest income, under their TANF programs. Some of these states have adopted the same disregards for their Section 1931 group under Medicaid as they have in their TANF programs. (These types of disregards must be applied equally to all applicants and recipients under the Section 1931 group.)

In addition, some states have chosen to apply more generous *earned income* disregards under TANF and have adopted the same disregards for the Medicaid Section 1931 group. States can apply these disregards to applicants and recipients or, without violating comparability requirements, they can apply such disregards to Medicaid recipients but not applicants, by replacing the "\$30 and 1/3" disregards, which applied only to recipients under the AFDC program.

¹Note that, consistent with the requirement for comparable standards described above, the policies states adopt under the Section 1931 group must apply equally to families receiving and applying for Medicaid. Earned income disregards (see under Use less restrictive financial methodologies) constitute the sole exception to the comparable standards rule; that is, states can apply earned income disregards differently for Medicaid applicants and recipients under Section 1931, because the AFDC rules that underlie Section 1931 eligibility allowed AFDC applicants and recipients to be treated differently in this respect.

- ✓ **Ease deprivation requirements (repeal of the "100-hour" rule).** Under regulations published August 7, 1998, states have increased flexibility to define the deprivation requirements for Medicaid eligibility. Prior regulations prohibited states from providing Medicaid eligibility to two-parent families if the principal wage-earner worked more than 100 hours per month. The new regulation removes the 100-hour definition of deprivation and instead allows states to set a reasonable standard based on hours of work and/or dollar amounts that may take into account family size and/or time elements. This new flexibility allows states to treat one-parent and two-parent families the same under Medicaid even if a distinction existed under the states' 1996 AFDC and Medicaid state plans.
- ✓ **Use less restrictive financial standards.** States can raise their income and resource standards by as much as the rise in the Consumer Price Index (CPI) since July 16, 1996. (Section 1931 also allows states to use income standards that are lower than the July 16, 1996 AFDC standard, but no lower than those in place on May 1, 1988.) Exercising this flexibility, a state may, for example, pass legislation indexing the income and asset standards for its Section 1931 families² — without obtaining a Federal waiver and without regard to its policies under TANF.
- ✓ **Continue certain AFDC waivers.** Finally, states are allowed to continue AFDC waivers that were in effect as of July 16, 1996 that relate to income and resource methodologies, deprivation, and the requirement that a child live with a specified relative. Section 1931 provides that these waivers may be continued permanently for Medicaid purposes even after the date the AFDC waiver expires. However, any AFDC provisions that were more restrictive than those in place for Medicaid cannot be continued for Medicaid purposes beyond their expiration.

C. Mandatory Application and Enrollment Policies

- ✓ **Opportunity to apply.** Medicaid regulations (42 CFR 435.906) require states to provide the opportunity for families to apply for Medicaid *without delay*. When states use joint TANF-Medicaid applications or use the state TANF agency to make Medicaid eligibility determinations, the TANF office is considered a Medicaid office. Therefore, TANF offices in these states must furnish the joint application (or a separate Medicaid application) immediately upon request and may not impose a waiting period before providing the application for Medicaid or processing it. These Medicaid requirements also apply to CHIP programs that are Medicaid expansions, and states are encouraged to apply them in the same manner for non-Medicaid CHIP programs as well.

² Because of the CPI constraint, a state that has chosen to apply income standards under TANF that are significantly higher than those under its AFDC state plan in effect on July 16, 1996 may not be able to raise the standards for its Section 1931 group to the same level. However, such a state could effectively raise the income standard for its Section 1931 group by using the authority to liberalize its financial methodologies as explained above. For example, if a state raised the income standard under TANF from \$250 per month to \$500 per month and wanted to do the same under its Section 1931 group, the state could get the desired result by disregarding an additional \$250 of income (or disregarding "the difference between the AFDC standard and the TANF standard by family size") for purposes of Medicaid eligibility.

In states where the TANF application or eligibility is delayed (i.e., because families receive diversionary assistance, are required to conduct an up-front job search, or face any other initial administrative steps), the state must make a separate Medicaid application available immediately, or make the joint application available immediately for purposes of determining Medicaid eligibility. The evaluation of the Medicaid application and the Medicaid eligibility determination must be made by state personnel who are authorized to perform these functions.

- ✓ **Time frame for eligibility determination.** Federal regulations (42 CFR 435.911) require that Medicaid eligibility for most families and children must be determined within 45 days from the date of application. The date that a TANF-Medicaid application is filed begins the 45-day "clock" for Medicaid eligibility determination. While a few limited exceptions to the 45-day time frame are allowed, such as an administrative or other emergency beyond the state's control, a TANF requirement may not delay a Medicaid eligibility determination. For example, when a family applies for Medicaid and TANF through a joint application but does not qualify for TANF assistance because of a TANF requirement that does not relate to Medicaid (e.g., the living arrangements for teens), the state must make a timely determination of Medicaid eligibility based on the joint application.

States may grant Medicaid eligibility retroactive to the date of application, or to the first day of the month of application. Eligibility must be granted three months retroactive to the month of application if the applicant received services during that period and would have been eligible at the time the services were furnished.

- ✓ **Exhaust all avenues to eligibility before denial or termination.** Because Medicaid eligibility is not based on TANF eligibility, states may not deny Medicaid eligibility to a family or any family member simply because the family is ineligible for TANF due to employment, time limits, sanctions, or any other reason. Nor can a state deny Medicaid eligibility because a family member loses eligibility under a particular Medicaid eligibility category. Further, it is not acceptable for a state to deny joint applications and then advise families to reapply if they think they may be eligible under another Medicaid category. *States are prohibited from denying or terminating Medicaid eligibility unless all possible avenues to Medicaid eligibility have been affirmatively explored and exhausted.*

Since Medicaid eligibility for families no longer hinges on eligibility for welfare, and since Medicaid generally covers a broader group of children and families than may be eligible for TANF, some or all members of a family that fails to meet TANF eligibility criteria are likely to be eligible for Medicaid. There are many possible avenues to Medicaid eligibility for

family members denied or terminated from TANF assistance, including the Section 1931 group (depending on family income and other state eligibility rules for the group), poverty-level groups, and transitional Medicaid.

- ✓ **Medicaid denial notice and appeal rights.** Federal regulations (42 CFR, Part 431, Subpart E and 42 CFR 435.912) require that applicants who are denied Medicaid eligibility or individuals who are terminated from Medicaid receive timely notices informing them of the denial, the reasons for the denial, and their appeal rights. With very few exceptions Medicaid coverage for current recipients continues during an appeal. These rights apply to all Medicaid denials and terminations, including those that flow from joint TANF-Medicaid applications.

When a family applies for Medicaid and TANF through a joint application and the family does not qualify for TANF, the denial notice should inform the family that the TANF denial does not mean the family is ineligible for Medicaid.

D. Optional Application and Enrollment Policies

- ✓ **Facilitate Enrollment in Medicaid and CHIP.** Making both joint TANF-Medicaid applications and Medicaid-only applications available in TANF offices is an important step toward assuring that families get connected with Medicaid or CHIP, no matter what decision they ultimately make about seeking TANF assistance.

- ◆ **Use joint applications.** TANF offices are a critical site for reaching low-income families since, in most states, virtually all TANF recipients are likely to be eligible for Medicaid. In states that use a joint TANF-Medicaid application, the opportunity to apply for Medicaid must be provided without delay, whether the family applies for TANF or receives diversionary payments or any other assistance. The family cannot be told to come back another time or be sent elsewhere to obtain the application.

South Dakota uses a joint application for TANF and Medicaid. However, while both programs are supervised by the same operating division and the same case management staff administer the programs, the state's use of separate computer systems for TANF and Medicaid eligibility ensures that when a TANF case is denied, an independent Medicaid eligibility determination is made.

- ◆ **Use separate applications.** If a state does not use a joint application, it should ensure that Medicaid applications are available at all TANF sites. States with non-Medicaid CHIP programs should also ensure that CHIP applications are available at TANF sites.

- ◆ **Use both joint and separate applications.** An effective strategy for maximizing the Medicaid participation of families who come into TANF offices is for states to make both joint and Medicaid-only applications available. This way, no matter what course a family takes with regard to seeking TANF assistance, the family can apply for Medicaid easily.

Administrative Strategies and Considerations

Effective implementation of the new Medicaid rules requires procedures that ensure that eligibility for Medicaid is considered when TANF assistance is provided, denied, delayed, or terminated. State procedures should assure that caseworkers are proactive in offering families the opportunity to apply. Families should not be expected to take the initiative to ask about Medicaid. Rather, all those who come to TANF offices should be asked about their health coverage needs and informed of the process for applying for Medicaid and CHIP. Following are suggestions for how to assure such an outcome:

- ✓ **Provide Medicaid and CHIP outreach to families at TANF sites.** The key to any effort to identify and enroll eligible children and families is outreach. Success in outreach and enrollment requires the involvement of TANF offices and personnel. Families who inquire about or apply for TANF should also receive information about Medicaid and CHIP, including how to apply for these programs. TANF agency staff should be trained to conduct this outreach and education.
- ✓ **Place Medicaid/CHIP workers in TANF offices.** States are encouraged to place Medicaid and CHIP eligibility workers at TANF offices to take applications and assist in their preparation. This practice is especially important at sites where, by state or local policy, low-income people are often directed to job searches, receive diversion payments, or otherwise receive assistance that may result in their not filling out an application for TANF assistance.
- ✓ **Conduct staff training.** States can send a strong and clear message to their employees about the importance of Medicaid and CHIP eligibility through special staff training, supervisor reviews, and other mechanisms. Such efforts should call attention to the differences between the TANF rules and Medicaid and CHIP eligibility rules, and to the procedures necessary to ensure that Medicaid and CHIP eligibility are considered. States should consider offering similar training to hospitals, clinics, health providers, child care centers, Head Start programs, WIC offices, community-based organizations, and other programs that come into contact with low-income families and children.

- ✓ **Encourage Medicaid application when the TANF application process halts.** States should ensure that the Medicaid application process is completed when a family does not qualify for TANF-funded assistance or abandons the TANF application process. It is important to inform families early in the application process about the different eligibility rules for TANF and Medicaid. Otherwise, families may not understand that even if they don't qualify for TANF, their Medicaid application can and should be processed and could well be approved.

To give an example, a person who applies for TANF might be required to meet an up-front job search requirement before becoming eligible for cash assistance. Although that person's TANF application might be suspended, he or she should be guided to proceed with the application for Medicaid. As another illustration, a parent might not carry through with a joint application if he or she finds a job, thinking that the family is no longer eligible for Medicaid coverage. Rather than just accepting a withdrawal of a TANF-Medicaid application, a state should send a letter informing the family that all or some of its members might still be eligible for Medicaid, laying out the steps the family needs to take to complete the Medicaid aspects of the application, and urging them to pursue application.

- ✓ **Educate families.** Informing families early in the TANF application process and regularly thereafter about how the Medicaid and TANF rules differ, and reminding them that Medicaid eligibility is not tied to TANF receipt, can help encourage families to submit and complete Medicaid applications. One reason families may not sign up for Medicaid is that they are under the mistaken impression that Medicaid eligibility depends on welfare eligibility. Therefore, states should make clear in all of their informational materials about TANF that coverage under Medicaid and CHIP does not require welfare eligibility and that, no matter whether or not families apply for or receive TANF assistance, they are encouraged to apply for Medicaid and/or CHIP.

For individuals facing language barriers, states should consider developing culturally-appropriate materials in languages other than English.

- ✓ **Simplify application and enrollment.** States have considerable flexibility under Medicaid and CHIP to simplify the application and enrollment processes. HCFA has provided states with suggestions on how to do so in a letter to state health officials dated September 10, 1998, which can be found on the HCFA website (<http://www.hcfa.gov>).

Many states have simplified their application and enrollment processes for children under Medicaid and CHIP by shortening application forms, allowing the use of mail-in applications, reducing or eliminating verification and documentation requirements that go beyond Federal requirements, and speeding up processing of applications. States should consider taking similar steps to simplify the application process for low-income families.

- ✓ **Coordinate TANF and Medicaid Section 1931 eligibility.** The alignment of TANF and Medicaid eligibility requirements for low-income families can greatly facilitate families' participation in Medicaid. Medicaid and TANF requirements can be aligned by taking advantage of the flexibility to modify financial methodologies and standards under Section 1931, loosen the deprivation requirements for two-parent families, and continue certain AFDC waivers. By exercising these options, states can provide automatic Medicaid eligibility for TANF recipients as they did for AFDC recipients prior to the enactment of welfare reform.

States have begun to take advantage of the flexibility to harmonize TANF and Medicaid eligibility in several ways. For example, several states have adopted earnings disregards in their TANF programs that are more generous than the old AFDC earnings disregards. To ensure that TANF recipients also qualify for Medicaid, many of these states have adopted the same disregards under the Section 1931 eligibility group. With the exception of earned income disregards, the financial rules under the Section 1931 group must be applied to all members of the group, including those families who do not receive TANF benefits.

- ✓ **Eliminate or ease the Medicaid resource test.** Most states have dropped the Medicaid resource test for children and now, under Section 1931, states have the ability to drop or ease the resource test for parents as well. Taking this step makes it easier to establish Medicaid eligibility, and can also make Medicaid rules more compatible with welfare reform initiatives. Some states that have not dropped their resource requirements under Section 1931 have made their resource rules less restrictive, for example, by exempting the value of a car.

Maintaining Coverage for Families Who Leave TANF Assistance

This chapter focuses on the statutory and regulatory requirements with which states must comply in providing Medicaid to adults and children in families leaving the welfare rolls. This chapter also identifies administrative practices that can increase the likelihood that parents and children who leave welfare will continue to receive Medicaid and/or CHIP.

State Requirements and Options under Federal Medicaid Law

A. Mandatory Eligibility Policies

- ✓ **Exhaust all avenues to eligibility before denial or termination.** Because Medicaid eligibility is not based on TANF eligibility, states may not deny Medicaid eligibility to a family or any family member simply because the family is ineligible for TANF because of employment, time limits, sanctions, or for any other reason. Nor can a state deny Medicaid eligibility because a family member loses eligibility under a particular Medicaid eligibility category. Further, it is not acceptable for a state to deny a joint application and then advise families to reapply if they think they may be eligible under another Medicaid category. *States are prohibited from denying or terminating Medicaid eligibility unless all possible avenues to Medicaid eligibility have been affirmatively explored and exhausted.*

Since Medicaid eligibility for families no longer hinges on eligibility for welfare, and since Medicaid generally covers a broader group of children and families than may be eligible for TANF, some or all members of a family that fails to meet TANF eligibility criteria are likely to be eligible for Medicaid. There are many possible avenues to Medicaid eligibility for family members denied or terminated from TANF assistance, including the Section 1931 group (depending on family income and other state eligibility rules for the group), poverty-level groups, and transitional Medicaid.

- ✓ **Provide transitional Medicaid for families.** Under Section 1925 of the Social Security Act, states must provide extended Medicaid benefits ("transitional Medicaid") to families who, because of hours of work or income from employment (or loss of the earned income disregard), lose their

eligibility for Medicaid under the Section 1931 group. (States must also provide transitional Medicaid when eligibility would otherwise be lost due to child support income.) It is important to note that it is the loss of coverage under Section 1931 — not the loss of TANF assistance — that is now the trigger for transitional Medicaid.

States are required to provide an initial six-month period of transitional Medicaid and, subject to certain reporting requirements and the income limit explained below, can provide an additional six months of coverage. Some states provide a longer period of transitional Medicaid under Section 1115 waivers. (Four months of coverage are available when child support payments trigger eligibility.)

To be eligible for transitional Medicaid, a family must have received Medicaid under Section 1931 in three out of the preceding six months before becoming ineligible under this category. No income limit applies to families for the initial six-month period of transitional Medicaid. However, the optional second six-month period is limited to families whose earned income (less necessary child care expenses) does not exceed 185% of the Federal poverty level for the size of the family.

B. Optional Eligibility Policies

- ✓ **Provide continuous eligibility for children.** Under Section 1902(e)(12) of the Social Security Act, states may grant continuous Medicaid eligibility to children under age 19 for up to 12 months, even if there is a change in family income, assets, or composition. Such eligibility must end when the child reaches age 19. By granting children eligibility for up to one year without regard to changes in circumstances, states can minimize the burden on families seeking to maintain coverage for their children. Most importantly, continuous eligibility can minimize coverage losses among children that occur because families are in financial transition and because of the barriers to continued participation that recertification requirements impose. To adopt the continuous eligibility option, states must amend their Medicaid state plans. States may also grant continuous eligibility under CHIP.
- ✓ **Termination for failure to meet TANF work requirements.** States can terminate Medicaid coverage for a TANF recipient (excluding pregnant women and children eligible under a poverty-level group and minor children who are not heads-of-household under TANF) if the recipient's TANF assistance is terminated because of a refusal to cooperate with TANF work requirements. This sanction extends only to the person violating the TANF work requirement, in most cases the adult head-of-household. A state cannot terminate Medicaid benefits for other family members, including the chil-

dren of an adult who fails to meet a TANF work requirement. States that wish to adopt this option to terminate Medicaid for refusal to cooperate with work requirements must submit a Medicaid state plan amendment.

- ✓ **Medicaid payment of premiums and cost-sharing for employer-based health coverage.** Under Section 1906 of the Social Security Act, states have the option of paying a low-income worker's share of the premium for employer-sponsored health insurance along with any cost-sharing, if such action would be cost-effective relative to providing Medicaid for that person. That is, the cost to the state of the premiums and cost-sharing must not exceed the cost to the state of providing Medicaid benefits. The family or individual must be otherwise eligible for Medicaid and agree to enroll in the employer-based health insurance as a condition of Medicaid eligibility. Under Section 1925, states have the option of requiring that individuals receiving transitional Medicaid enroll in employer-sponsored insurance, whether or not it is cost-effective.

Administrative Strategies and Considerations

States may want to consider the following administrative strategies to maximize enrollment in Medicaid and CHIP:

- ✓ **Prevent inappropriate Medicaid denials and terminations.** The key to states ensuring that Medicaid-eligible families continue to receive Medicaid after their TANF benefits have been terminated is the set of procedures they use to prevent inappropriate Medicaid eligibility terminations. In no event should closure of a TANF case automatically result in closure of a Medicaid case.

In many situations in which a TANF case is closed, the state will have all the information it needs to determine whether Medicaid eligibility for a family should continue; in these cases, the state must make the Medicaid redetermination without seeking additional information from the family. In other situations, families will need to be informed that they must provide additional information to allow the state to evaluate their ongoing Medicaid eligibility. One way states can help families understand that their Medicaid benefits are not affected by the actions taken in their TANF case is to make sure that TANF case-closing notices state this fact very clearly.

- ✓ **Educate families about transitional Medicaid.** To maximize the participation of families in transitional Medicaid, it is critical that states educate families about this benefit and the steps they need to take — such as reporting earnings, rather than closing their cases — to safeguard and facilitate their Medicaid eligibility when they leave TANF assistance.

- ✓ **Delink Medicaid and TANF redeterminations.** To avoid inappropriate Medicaid termination, states can establish different redetermination periods for Medicaid and TANF, thereby delinking Medicaid and TANF eligibility reviews. Under Medicaid regulations, states must conduct redeterminations at least every 12 months, or promptly upon notification of a change in the family's or child's circumstances that may affect eligibility (unless the state has adopted the 12-month continuous eligibility option for children, as described next).
- ✓ **Adopt continuous eligibility for children.** Under Section 1902(e)(12) of the Social Security Act, states may grant continuous Medicaid eligibility to children under age 19 for up to 12 months, even if there is a change in family income, assets, or composition. Such eligibility must end when the child reaches age 19. By granting children eligibility for up to one year without regard to changes in circumstances, states can minimize the burden on families seeking to maintain coverage for their children. Most importantly, continuous eligibility can minimize coverage losses among children that occur because families are in financial transition and because recertification requirements impose barriers to continued participation.
- ✓ **Simplify redeterminations.** Eligibility reviews can be simplified. To avoid time-consuming face-to-face meetings and help working parents avoid missing work, states can be kept informed of changes in family circumstances by telephone or mail. States can respond to requests for eligibility reviews by simplifying the review process, much as they have simplified their Medicaid applications for children. Redetermination forms can be shortened, most of the necessary information can be filled in by the state based on the information on hand, and the family can be asked to send in the signed form with any changes noted.
- ✓ **Review closed TANF cases.** A state review of TANF cases that have been closed and in which Medicaid was not continued may identify families likely to be eligible for Medicaid. States have the authority to re-open erroneously closed cases on their own motion, and should, at a minimum, conduct aggressive outreach to families in this situation.
- ✓ **Expand Medicaid coverage for low-income working families.** States have the flexibility to use less restrictive financial methodologies and standards under the Section 1931 group, as well as authority to loosen deprivation requirements, in order to expand Medicaid to cover more working families (see pages 6-7 for a detailed discussion of state flexibility). States adopting such policies provide health security — a critical support — to families who have made or are making the transition to self-sufficiency. When states take this route to broadening eligibility for Medicaid, families at the higher income levels remain eligible as long as their income does not exceed the Medicaid income threshold and they continue to meet other applicable requirements.

- ✓ **Improve the reach of transitional Medicaid.** To be eligible for transitional Medicaid, a family must have received Medicaid under Section 1931 in three out of the preceding six months before becoming ineligible under this category. The same flexibility under Section 1931 that states can use to expand coverage quite broadly (e.g., via income and asset disregards) can also be used for the narrower purpose of increasing access to transitional Medicaid for working families who may be diverted from TANF or leave TANF assistance in less than the three months typically required to trigger transitional Medicaid.

For example, states that offer lump-sum "diversion" payments in lieu of recurring cash assistance can prevent these lump-sum payments from making the family ineligible for Medicaid by disregarding them as either income or resources when they determine eligibility under Section 1931. To give another example, a state can disregard all earnings below the poverty level for 12 months; this way, a low-income working family can obtain Medicaid eligibility under the Section 1931 group for 12 months; and subsequently qualify for transitional Medicaid for up to an additional 12 months. Alternatively, a state can adopt a more limited disregard of all earned income for three months, enabling families to obtain Medicaid eligibility under Section 1931 for the three-month period necessary for the family to qualify for transitional Medicaid.

As the illustrations make clear, limited changes in Medicaid rules can ensure that families in the earliest stages of their connection to the workforce do not lose their Medicaid coverage. Such programmatic coordination is key to the development of a coherent state strategy for supporting families in transition.

- ✓ **Pay private health insurance premiums and cost-sharing.** States' use of the option to cover Medicaid-eligible working families by paying the family's share of premiums for employer-sponsored health insurance, along with deductibles, coinsurance, and other cost-sharing, gives families an incentive not to drop employer-sponsored insurance, preserving continuity in their health coverage and supporting their employment. The approach also builds on the private insurance system, and may result in savings to the state.

Reaching Families Outside the TANF System

This chapter deals with ways to ensure coverage for low-income families who do not come in contact with the TANF system. As states succeed in helping families move to self-sufficiency, more families will remain outside the welfare system. Thus, it is critical that new strategies for reaching families outside the TANF system be developed and implemented.

The longstanding linkage between cash assistance and Medicaid was often seen as an inequitable and counter-productive feature of the old system. When families learn that they can receive Medicaid coverage without having to receive welfare, they may be less likely to turn to welfare in the first place or to return to the welfare system in the event that they have significant health care needs. This chapter highlights the historic opportunity that the delinkage of Medicaid from welfare presents to promote Medicaid and CHIP coverage as a freestanding support for low-income families with children, and outlines approaches states can take toward this goal.

This chapter also emphasizes the importance of information and outreach efforts, and of simplifying the application and enrollment processes, as means of identifying and enrolling low-income families and children in Medicaid and CHIP.

State Requirements and Options under Federal Medicaid Law

A. Mandatory Eligibility Policies

- ✓ **Outstation eligibility workers.** Medicaid law and regulations require that states provide an opportunity for children under age 19 and pregnant women to apply for Medicaid at locations other than welfare offices. States are required to have outstationing arrangements at facilities designated as "disproportionate share hospitals" and Federally Qualified Health Centers (FQHCs). HCFA regulations (42 CFR 435.904) permit alternative outstationing arrangements under certain limited conditions, and allow states to use additional sites where children and pregnant women receive services. States are free to station Medicaid eligibility workers at any location to take applications, provide assistance, and, if authorized, evaluate applications and make eligibility determinations.

B. Optional Eligibility Policies

- ✓ **Expand coverage for families under Section 1931.** Section 1931 authorizes states to use financial standards and methodologies for low-income families that are more generous than the standards and methodologies in AFDC state plans in effect on July 16, 1996. Together with the new flexibility to define deprivation (e.g., by substituting another definition of unemployment for the 100-hour rule), states can use Section 1931 to take two significant policy actions. (See pages 6-7 for a detailed discussion of state flexibility.) First, they can equalize their treatment of single- and two-parent families for Medicaid purposes. Second, they can expand coverage of families as far as state budget and policy preferences permit. States can accomplish these policy changes through amendments to their Medicaid state plan; they do not need to obtain Federal waivers.

Recognizing that Section 1931 coverage expansions will require additional state expenditures to draw down Federal matching payments (see under **Cover children under CHIP** regarding enhanced Federal match for uninsured children in families covered under a Section 1931 expansion), it should be noted that states' expansions of coverage to low-income families under Section 1931 can be as broad or as narrow as state resources and other considerations permit. For example, states can:

- ◆ ***Expand Medicaid to cover all families up to a specified income level.*** By using more generous financial methodologies and standards, states can expand coverage under Section 1931 to reach single- and two-parent families with more income than Medicaid has traditionally covered. Such expansions present an opportunity for states to recast and market Medicaid as a freestanding health insurance program for low-income families, improving the possibility of de-stigmatizing Medicaid and enhancing the potential of the program to reach families who do not come into contact with the TANF system. The law leaves states free to raise their effective income eligibility thresholds for Section 1931 to whatever level they wish.
- ◆ ***Phase in expansions.*** States can expand coverage under Section 1931 more narrowly initially and, based on their evaluation of the expansion and its success in meeting state welfare reform and health coverage objectives, consider broadening those expansions further to include families with more income and/or resources.
- ◆ ***Improve the reach of transitional Medicaid.*** The same flexibility under Section 1931 (e.g., income and asset disregards) that states can use to achieve a broad expansion of coverage can also be used for the narrower purpose of increasing access to transitional Medicaid for

families who do not come into contact with the TANF system. States can extend Medicaid to working families temporarily, by using income and asset disregards that permit families to obtain Medicaid eligibility for at least three months, and thus give them access to up to 12 months of transitional Medicaid as well. Such limited changes in Medicaid rules can ensure that families' success in attaining self-sufficiency does not preclude their qualifying for health coverage — a coherent result that supports the twin goals of reducing the numbers of people without insurance and supporting state welfare reform initiatives.

- ◆ **Expand coverage to two-parent families.** States can expand Medicaid to cover more two-parent families by replacing the 100-hour rule with a broader definition of unemployment.
- ✓ **Cover children under CHIP.** Under CHIP, enhanced matching funds are available to states to provide coverage for uninsured children who are not otherwise eligible for Medicaid. Coverage can be provided through a Medicaid expansion, a separate CHIP program, or a combination of both. Under Medicaid expansions, the usual Medicaid eligibility rules apply. Under a separate CHIP program, states have flexibility to establish eligibility requirements.

Nearly all states have approved CHIP plans and are implementing their programs. States should consider further expansions of coverage for uninsured children; such expansions promote both health care coverage and welfare reform goals by improving health security and providing needed support to low-income working families.

States implementing CHIP through a Medicaid expansion can claim enhanced Federal matching funds under Title XIX (section 1905(u)(2)(B)) for children who become eligible for coverage as a result of an expansion of family coverage under Section 1931. The enhanced match can be claimed only for uninsured children who would not have qualified for Medicaid coverage under the Medicaid state plan in effect on March 31, 1997. The funds claimed for CHIP-eligible children under Section 1931 would count against the state's CHIP allotment. To claim the enhanced match, states must have a means of identifying children who are uninsured and otherwise qualify for enhanced Federal matching payments for the medical assistance they receive. For children who do not meet the criteria for the enhanced match, the state may continue to claim its regular Medicaid match.

- ✓ **Cover families under CHIP.** CHIP also grants states the authority to obtain a "variance" to purchase family coverage that includes coverage of CHIP children if the state can demonstrate that the cost to the CHIP program of purchasing the family coverage does not exceed the cost of obtaining CHIP

coverage for the children alone, and that the family coverage will not otherwise substitute for other health insurance coverage for the children. While these statutory constraints limit use of the family coverage option under CHIP, a few states, including Massachusetts, have utilized this option to extend coverage to poor working families.

It should be noted that a CHIP family coverage program would not extend coverage to the parents of children who are eligible for Medicaid. To avoid an anomalous result in which higher income families are covered under CHIP, but the parents of lower-income children lack coverage, states would also need to implement a Medicaid expansion under Section 1931.

- ✓ **Presumptive eligibility for children and pregnant women.** States have the option to provide presumptive Medicaid eligibility to children and to pregnant women. Under Section 1920A of the Social Security Act, certain entities can determine, based on preliminary information, whether the family income of a child is within the state's income eligibility limits for Medicaid. If it is, the child (or, under Section 1920 the pregnant woman) can be granted temporary eligibility for Medicaid and has until the end of the following month to submit a full Medicaid application. A similar approach may be used under a separate CHIP program. It should be noted that states that use a simplified Medicaid application can also use this form to establish presumptive eligibility, eliminating the need for a two-step application. As always, however, an authorized state employee must make the Medicaid eligibility determination.

Presumptive eligibility provides the opportunity to grant immediate health care coverage without first requiring a full Medicaid eligibility determination. This option also offers the advantage of providing additional "entry points" into the Medicaid system because health care providers and others can grant temporary coverage on the spot when children and pregnant women go to receive health care services and other forms of assistance.

Under the law, the entities that can establish presumptive eligibility for children include: Medicaid providers, entities that determine eligibility for Head Start, WIC, and child care subsidies under the Child Care and Development Block Grant, and other entities designated by the state. Presumptive eligibility for pregnant women can be established by specified entities likely to have contact with pregnant women seeking pregnancy-related services. While TANF offices are not specifically mentioned in the statute, TANF offices can establish presumptive eligibility if they determine eligibility for one of the programs listed.

- ✓ **Continuous eligibility for children.** Under Section 1902(e)(12) of the Social Security Act, states may grant continuous Medicaid eligibility to children under age 19 for up to 12 months, even if there is a change in family income, assets, or composition. Such eligibility must end when the child reaches age 19. By granting children eligibility for up to one year without regard to changes in circumstances, states can minimize the burden on families seeking to maintain coverage for their children. Most importantly, continuous eligibility can minimize coverage losses among children that occur because families are in financial transition and because recertification requirements impose barriers to continued participation.

Administrative Strategies and Considerations

States may want to consider some or all of the following administrative strategies and other measures to improve outreach and increase coverage of low-income families with children:

- ✓ **Create application sites outside the welfare office.** States may make Medicaid applications regularly available at sites outside of welfare offices. For example, sites can be established at state or county offices that handle child care subsidies or at "Medicaid-only" offices. States may also place eligibility workers at locations that provide services to low-income families (see just below) subject to the regulations on outstationing cited on page 19. Federal law does not limit states' options along these lines as long as all final eligibility determinations are performed by state personnel who are authorized by the state to perform these functions. This approach can help promote the program as one that offers health insurance coverage to low-income families, generally, and not just to families receiving TANF.
- ✓ **Place Medicaid and CHIP eligibility workers in communities.** The opportunity to apply for Medicaid or CHIP can be enhanced by placing outreach and eligibility workers in locations where they are likely to interact with low-income families who are eligible for those programs (e.g., hospitals, community and migrant health centers, community action agencies, schools, community colleges, Head Start programs, and one-stop career centers).

Medicaid permits only authorized state eligibility workers to evaluate the information on the application and supporting documentation and to make eligibility determinations. But other individuals, including volunteers, provider and contractor employees and TANF workers may take applications at the outstation locations described on page 19, and perform initial processing activities, including interactions with applicants. The regulations on outstationing do not prohibit the use of volunteers to help appli-

cants complete applications at sites other than outstation locations. Therefore, states can work with a very broad range of public and private organizations to identify eligible families, educate them about Medicaid and CHIP, and have them complete applications for health insurance. Again, the evaluation of Medicaid application information and the eligibility determination itself must be performed by state personnel who are authorized by the state to perform these functions.

States have greater flexibility to determine the sites where non-Medicaid CHIP applications may be taken and who may conduct initial application processing activities and make eligibility determinations.

- ✓ **Improve the availability of application sites.** It is important that states make it easy for low-income families, including working families, to apply for Medicaid and CHIP. Keeping application sites open during evening hours and on weekends makes it more convenient for working families to apply.
- ✓ **Simplify the application and enrollment processes.** Application and enrollment processes should not be a barrier to low-income families applying for Medicaid. As noted earlier, states have taken several steps to simplify the application and enrollment process for children under Medicaid and CHIP, including simplifying application forms, reducing documentation requirements, allowing mail-in applications, and expediting processing of applications. States also should consider allowing families who are not applying for TANF to use simplified Medicaid and CHIP applications and application processes. This approach would facilitate Medicaid and CHIP participation among these families. (HCFA's guidance on simplifying the Medicaid and CHIP application and enrollment processes was provided in a letter to state health officials dated September 10, 1998, which can be found on the HCFA website (<http://www.hcfa.gov>).)
- ✓ **Educate families.** It is important that low-income families understand that the coverage available under Medicaid and CHIP for families and children is not linked to receipt of TANF assistance. The misconception that Medicaid eligibility is linked to TANF is widespread. Vigorous educational efforts are needed to correct this belief so that enrollment in Medicaid and CHIP can be maximized.
- ✓ **Conduct outreach.** It is critical that aggressive outreach be conducted to provide Medicaid and CHIP information to low-income families. States have used a variety of valuable approaches to help them locate children and facilitate their enrollment in Medicaid and CHIP, which should also be used to reach out to low-income families as a whole. They include:

- ◆ implementing a toll-free telephone hotline for enrollment information;
- ◆ placing billboards and posters in places frequented by low-income families;
- ◆ producing public service announcements for radio and television;
- ◆ distributing information through other public and private programs designed for low-income families (e.g., child care, Head Start, food pantries, one-stop centers, and community-based organizations);
- ◆ stationing state eligibility workers in places frequented by low-income families, such as TANF offices, WIC offices, hospitals, and one-stop centers); and,
- ◆ working with local community-based organizations to develop creative outreach programs.

States should also maximize publication of the national toll-free number that automatically connects callers with the CHIP program in their state. The number is 1-877-KIDS-NOW.

- ✓ **Integrate health and social service systems.** States should aim to integrate their programs to ensure that low-income families receiving any of an array of services learn about and apply for Medicaid and CHIP. The recently enacted Workforce Investment Act (WIA) promoted this concept by establishing an innovative "one-stop" system designed to provide a comprehensive array of job training, education, and employment services at a single neighborhood center. The WIA specifies several Federal programs and activities that must participate in each local one-stop system. Although not required partners, the TANF and Medicaid programs can link up with one-stop systems as optional partners, enhancing the support available to low-income working families and families making the transition from welfare to self-sufficiency.

Several states have taken advantage of this new opportunity. For example, the Kenosha County Job Center in Wisconsin has combined services, including Medicaid, at its job center. Although the one-stop center was initially designed to include services fairly directly related to job training, job-seeking, and education, it evolved to include Medicaid, child support, child care, and Head Start.

Funding Opportunities

This chapter sets out the funding sources available under Medicaid, CHIP, and TANF for outreach activities, systems changes, training, and other investments critical to supporting compliance with Medicaid requirements in the new welfare context and to maximizing health care coverage of low-income families with children. States have several options for claiming Federal matching funds for their spending on efforts to find and enroll families and children in Medicaid and CHIP. The Medicaid and CHIP funds for outreach were described in detail in a January 23, 1998 letter to state health officials (available at <http://www.hcfa.gov>) highlighting new and existing opportunities for outreach to uninsured children. In addition, options to receive Federal funds for outreach spending are available under TANF. These options are described below.

Medicaid Funds

Medicaid law does not limit the amount of money a state can spend on outreach efforts to enroll people in Medicaid. The Federal government will match such spending dollar for dollar. In addition, a special \$500 million Medicaid fund was created under the welfare reform law to help states with the additional administrative costs of eligibility determinations resulting from the delinkage of Medicaid from welfare eligibility and the establishment of Section 1931. These funds are available for matching certain allowable administrative expenditures incurred by states during the first three years in which the states' TANF programs are in effect. State spending is matched by the Federal government at either a 90 percent or a 75 percent rate. (For more details, see the notice published in the Federal Register on May 14, 1997, Vol. 62, No. 93, pages 26545-26550.)

Each state has an allocation from the \$500 million fund from which it can claim matching funds. Each state's allocation is composed of a "base allocation" and a "secondary allocation." The base allocation for each state is \$2 million; the secondary allocation varies by state based on state-specific factors. Federal matching funds are available from the base allocation at the enhanced matching rate of 90 percent for allowable administrative activities (including outreach), regardless of the type of activity. Federal matching funds are available from the secondary allocation at enhanced matching rates of either 90 percent or 75 percent, depending on the type of activity. Activities whose costs are claimable from the secondary allocation at the enhanced rate of 90 percent include: educational activities, public service announcements, outstationing of eligibility workers, training, outreach, developing and disseminating new publications, and local community activities. Activities whose costs

are claimable from the secondary allocation at the enhanced rate of 75 percent include: hiring new eligibility workers, designing new eligibility forms, identifying at-risk TANF recipients, intergovernmental activities, and eligibility systems changes.

In order to be allowable, activities must be attributable to administrative costs of eligibility determinations that are incurred due to the enactment of Section 1931. However, it is clear that outreach efforts conducted by states to implement the provisions of Section 1931 may also result in Medicaid eligibility determination activities for individuals covered under other groups. It is neither administratively efficient nor practical, with respect to claims for Section 1931 outreach activities, to distinguish between activities resulting in eligibility determination under Section 1931 and activities related to Medicaid eligibility under other statutory authorities. Therefore, so long as the outreach activities are designed principally to address the eligibility determinations related to Section 1931, states may claim the costs of such activities at the enhanced Federal matching rate.

CHIP Funds

State spending on CHIP-related outreach activities is matched from the state's CHIP allotment. States may spend up to 10 percent of their total CHIP expenditures (Federal and state) on non-benefit activities, including outreach. These expenditures are matched at the enhanced CHIP matching rate. At state option, outreach activities related to a CHIP Medicaid expansion can be matched either from the state's CHIP allotment (at the CHIP enhanced matching rate) or at the regular Medicaid administrative matching rate. If a state elects to claim the CHIP match rate for outreach expenditures related to the CHIP Medicaid expansion, then the Federal matching payments count against 10 percent limit and the CHIP allotment. If the state exceeds either limit, it may claim matching for the additional costs of these activities at the regular administrative matching rate under the Medicaid program.

TANF Funds

States can also use their Federal TANF or state maintenance-of-effort (MOE) funds for outreach and training activities for Medicaid and CHIP. However, MOE funds cannot be used as state Medicaid matching funds. While Section 408(a)(6) of the Social Security Act prohibits the use of Federal TANF funds to provide medical services (except for pre-pregnancy family planning services), TANF funds can be used for non-medical services, such as outreach to ensure medical coverage.

file health care
Coverage

THE WHITE HOUSE

WASHINGTON

November 24, 1998

MEMORANDUM TO THE FIRST LADY

FROM: Chris Jennings, Jennifer Klein, Jeanne Lambrew^{JL}

SUBJECT: Response to Questions about Coverage Expansions

cc: Melanne Verveer, Neera Tanden, Nicole Rabner

In a recent discussion of the uninsured, you asked about several coverage expansion proposals, including a 55 to 65 coverage option, a Medicaid buy-in, a Federal Employees Health Benefit Plan (FEHBP) buy-in, and a new health insurance option for young adults. This memo summarizes these proposals, discusses their rationale, and provides you with a budget and Congressional status update. As was discussed in the memo to the President on the uninsured, the absence of substantial subsidies and the omission of an individual or employer mandate significantly limits the number of Americans who will be newly insured as a result of these policies. Having said this, each of these options (or modifications to them) can improve access to needed health insurance and are being considered for the FY2000 budget.

Medicare Buy-In / Health Insurance Options for People Ages 55 to 65

Policy. In our FY 1999 budget, we proposed three policies: (1) a Medicare buy-in for people ages 62 to 65 that is fully self-financed through an unsubsidized, two-part premium (an up-front premium plus a smaller, post-65 premium to compensate for any risk selection); (2) a similar Medicare buy-in for displaced workers ages 55 and over who have involuntarily lost their jobs and health care coverage; and (3) guaranteed access to former employers' insurance for retirees age 55 and over whose retiree health benefits have been ended. According to CBO, this entire initiative costs about \$1.5 billion over 5 years (mostly a temporary cost until the participants begin contributing their post-65 premium) and would assist about 300,000 people.

Rationale. This initiative, according to the latest data, is needed more than ever. Although still low, the number of uninsured people ages 55 to 65 grew the fastest in 1997 -- and will grow exponentially in the future since the number of people in this age cohort is projected to rise by over 60 percent by 2010. Moreover, we have increasing evidence that the individual insurance market -- relied on by this age group more than any other -- is raising its rates dramatically. Kaiser Permanente, for example, will double its individual insurance premiums for its older enrollees on January 1. This initiative gives people in this age group options to purchase insurance that they might not otherwise have. It also would be the bare minimum policy needed if the age eligibility for Medicare were raised -- an idea seriously being contemplated by the Medicare Commission.

Issues. Despite the need, this initiative was victimized by conflicting “too much - too little” criticisms. Republicans (and some conservative Democrats) claimed that the buy-in creates a huge loophole in Medicare that will ultimately lead to large costs. In part, this reflects a disbelief in our technical ability to set premiums that are self-financing in the long run. But mostly, it results from a strong belief that, even if the premium estimates are accurate, we will eventually succumb to the pressure to subsidize these premiums to make them more affordable for the lower income uninsured. In contrast, a number of traditionally liberal advocates and academics criticized the policy for helping too few people to justify the political capital that would be necessary to expend to get the proposal any serious attention by the Republican Congress.

Regardless of its political viability in this Congress, this proposal addresses a population in need, remains generally popular outside the beltway, and will continue to be seriously considered for inclusion in the FY 2000 budget. It is unclear whether it will make the final cut, however. The short-term savings needed to finance this initiative are controversial and/or likely to be used for other priorities (such as for underwriting the costs of the Jeffords/Kennedy disability coverage expansion bill). Also, there is concern about putting this proposal out so close to the final report released by the Medicare Commission this March. No matter how we resolve the budget question, however, we expect Senators Moynihan and Daschle as well as Congressman Gephardt to introduce this bill at the beginning of the next Congress.

Medicaid Buy-In

Policy. A Medicaid buy-in would allow states to charge income-related premiums for people in optional eligibility groups with income above 150 percent of poverty (the level at which states may charge cost sharing under the Children’s Health Insurance Program (CHIP)). This proposal could be broadened to allow all people below a fixed income level -- not just those in current optional eligibility groups -- to buy into Medicaid.

Currently, states cannot charge premiums to Medicaid beneficiaries. A lesser known fact is that Medicaid law limits who can be covered as well. Historically, adults were eligible for Medicaid only if they were: (a) single parents, or married but unemployed parents, who receive welfare; (b) low-income elderly or people with disabilities who receive SSI; or (c) nursing home residents. During this Administration, however, new Medicaid eligibility options have been created. Welfare reform gave states the option to cover higher income single parents and unemployed married parents. The exclusion of married employed parents -- which is anti-work and anti-family -- was changed last summer with “100-hour rule” regulation. This lets states define “unemployed” as working more than 100 hours a month -- meaning that they may cover parents working 40-hour weeks if they so choose. And, in the Balanced Budget Act, we created a Medicaid buy-in for people with disabilities with incomes below 250 percent of poverty.

Rationale. A Medicaid buy-in could be an incentive for states to expand coverage to working adults, since even small family contributions improve the acceptance of such expansions. It also gives all states the flexibility that we have permitted through Medicaid waivers and supported in CHIP, as well as in the Medicaid buy-in for workers with disabilities.

Issues. Despite its sound policy basis, the likelihood that a Medicaid buy-in will significantly reduce the uninsured is low. Since large subsidies are required to encourage low-income, uninsured people to purchase health insurance, states would have to charge the families low premiums and pay for most of the costs themselves in order to get meaningful participation. Moreover, only states that have already expanded coverage to 150 percent of poverty could charge premiums to all new participants. Unfortunately, states typically cover few adults with incomes above 50 percent of poverty. Thus, premiums collected through a Medicaid buy-in would not come close to offsetting the large Federal and state costs. Additionally, while allowing premium payments from beneficiaries may be attractive to states, Republicans, and moderate Democrats, it would be vehemently opposed by advocates and liberal Democrats who believe that this opens the door to high premiums for lower-income Medicaid beneficiaries.

One idea that could possibly address the financial limitations of this proposal is to link the Medicaid buy-in proposal to a tobacco recoupment bill. The recent state tobacco settlement will likely lead to legislation about whether and under what terms states may keep the Federal share of that settlement. In such legislation, we could make expansion through a Medicaid buy-in one of the uses (or the sole use) of the Federal share. Congressional Democrats and advocates have long argued that tobacco settlements should be directly linked to health care, health insurance expansions, and Medicaid. It is possible they would accept a buy-in in a recoupment bill that assures Medicaid expansions. States, obviously, do not want any strings on the uses of the Federal share of the settlement, but may have the hardest time arguing against Medicaid investments since the settlement itself is premised on Medicaid costs resulting from tobacco use. The clear downside to this option is that money spent on expansions would limit the money used for other priorities like child care. This issue will be debated in our budget process.

FEHBP Buy-In

Policy. Another proposal for expanding coverage is opening up the Federal Employees Health Benefits Plan (FEHBP) to various groups of people (e.g., workers in small businesses, people ages 55 to 65 years old). In order to participate in FEHBP, health plans would have to offer health insurance to the designated group of eligibles. There are two options for how premiums would be set: first, new participants could be charged the same premiums as Federal employees; second, new participants could be charged premiums separately, depending on their own costs.

Rationale. The FEHBP buy-in would give certain groups of uninsured people the benefit of accessing the health plan options, information and possibly premiums that Federal government negotiates for its employees. It also reinforces our support for group health insurance purchasing, plan choices, and adequate information with which to make such choices.

Issues. Depending on how premiums are set, the FEHBP buy-in would either be costly to new participants or affect the premiums and choices of all Federal employees. Because newly eligible people who wish to purchase insurance who are healthy can likely find individual insurance that is cheaper, the population that decides to go into FEHBP is likely to be sicker. This will increase premiums of all current Federal employees if they are charged the same premium. It could also reduce plans participating in FEHBP if their enrollees include more costly, new participants than

Federal employees (which could happen in rural areas). As a consequence, most FEBHP buy-in proposals assume a risk pool separate from that of Federal employees for setting premiums. But because this pool would be a smaller and include less healthy people, premiums would be more expensive than FEHBP. As a consequence, most analysts project a relatively small effect on coverage. The only way to address this would be subsidies which carry significant cost implications. These complexities explain why there have been few FEHBP buy-in bills.

Given concerns about its use as a source of coverage, FEHBP may be better used as a model for other coverage expansion proposals. What makes FEHBP successful -- purchasing power for a large group of people; consumer information; plan choices -- could be incorporated into small businesses purchasing coalitions. These coalitions, promoted in previous budgets, provide any small business in the area with a set of plan choices and more affordable premiums. This year, we are examining options to aggressively encourage their development. For example, FEHBP managers could provide technical assistance in establishing these coalitions. They could also be granted non-profit status to facilitate private foundation support.

Catastrophic Coverage for Young Adults

Proposal. You mentioned an interest in policy options that would provide catastrophic coverage for young adults. Medicare, Medicaid, and FEHBP all provide comprehensive coverage, although we could conceivably develop a special program for catastrophic coverage. It is also possible through regulation to require individual insurers to offer such coverage to young adults.

Rationale. Young adults are more likely than any other age group to be uninsured -- nearly one in three 18 to 24 year olds lacks insurance. In part, this problem results because young adults are usually healthy and do not think that their need justifies the cost of comprehensive coverage. Thus, catastrophic coverage may be the best option for young adults since it is cheaper and protects them from the real risk of illness or injury that can be financially devastating.

Issues. Catastrophic coverage options probably would not insure many young adults. Few young adults would purchase even the lowest-cost catastrophic coverage without significant subsidies. In fact, some analysts believe that only an individual mandate will make young adults pay any level of premium for health insurance. This is because they rarely recognize their financial risk (e.g., one in four young adults sustains major injuries in a year and one in 20 is hospitalized). Second, while catastrophic coverage makes economic sense, people interested in insurance do not appear to like it. The lack of interest in the medical savings account (MSA) demonstration has shown that people prefer lower cost sharing and coverage of primary care.

Recognizing these challenges, we continue to examine policies to allow young adults to buy into Medicaid. Some of the most needing of insurance in this age group are foster care children who have aged past their 18th birthday (and thus last year of Medicaid eligibility.) We are working with OMB to provide a new state option for those Governors interested in expanding Medicaid coverage to this population. We believe it will be affordable (about \$50 million over 5), sound policy that a number of states will pick up. As of this writing, the chances of this proposal being included in the budget appear to be quite good.

THE WHITE HOUSE

WASHINGTON

November 13, 1998

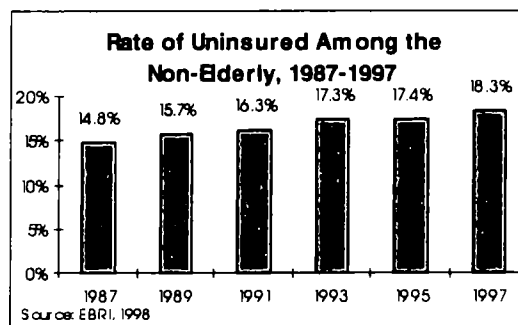
INFORMATIONAL MEMORANDUM TO THE PRESIDENT

FROM: Chris Jennings and Jeanne Lambrew ^{mc}

THROUGH: Bruce Reed, Gene Sperling

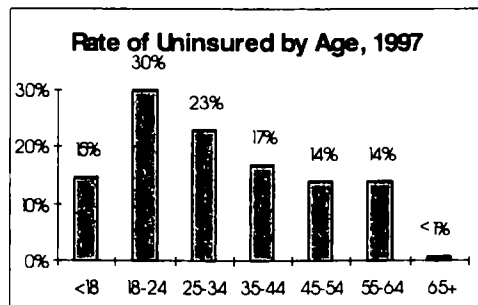
SUBJECT: Recent Uninsured Trends and Analyses

As you know, the Census Bureau recently estimated that 43.7 million Americans are uninsured -- an increase of 1.7 million from 1996 and nearly 5 million from 1992. Insurance coverage is one of the few social indicators that has not improved in the last several years. This contradicts the theory that a strong economy with low unemployment yields a high demand for workers, and thus better benefits like health insurance. It is even more disappointing given record-low health care cost growth in the last several years, which should make insurance more affordable and thus more common. This increase has important consequences since the uninsured are four times more likely to not receive needed health care, have hospitalization rates for preventable conditions that are 50 to 75 percent higher, and place growing uncompensated care burdens on the nation's providers.



Because of the importance of this problem and your expressed interest in these data, we are providing you an analysis of the numbers and recent insurance coverage trends, as well as a summary of their policy implications.

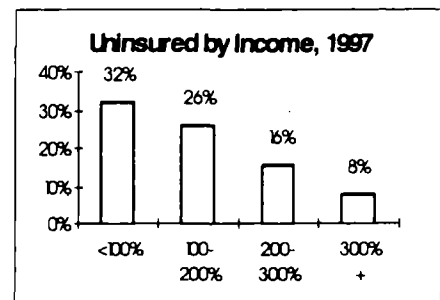
Uninsured by age: Most of the uninsured in America are young; over 80 percent are under age 45 (35.2 million). These uninsured are disproportionately ages 18 to 24 -- 30 percent of whom are uninsured compared to 15 percent of children. The number of uninsured children did not increase in 1997, remaining at 10.7 million. This contrasts dramatically with last year's data that showed that 800,000 of the 1.1 million additional people who were uninsured were children. The change



appears to be the result of the unprecedented focus on children's health in 1997. Beginning with the State of the Union and ending with the establishment of your Children's Health Insurance Program (CHIP), the Federal Government and the states started taking actions to address this serious problem. Next year, after Census' data reflects a full year's operation of CHIP, we would expect the number of uninsured children to fall.

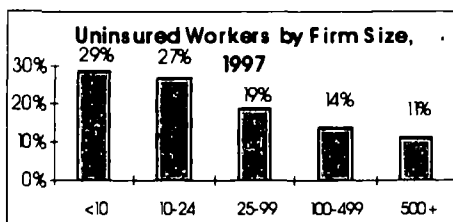
While the likelihood of being uninsured is higher among younger adults, the number of uninsured is growing faster among older adults. One million of the additional 1.7 million uninsured people in 1997 were age 35 or older. The increase is particularly concentrated among people ages 55 to 65; the number of uninsured people in this age group grew faster than all other age groups (7 percent growth). This trend is cause for concern because people ages 55 to 65 become more likely to develop a health problem and less likely to have employer insurance (because their spouses retire and join Medicare, they move to part-time or self-employment which typically does not offer insurance, or they retire). As a result, this age group is disproportionately relies on individual health insurance -- where premiums have been skyrocketing in recent years and underwriting practices remain prevalent. Because of the demographics, there is no doubt that the coverage problem will increase exponentially as the number of people in this age cohort is projected to rise by over 60 percent by 2010.

Uninsured by income: Not surprisingly, people with less income are less likely to have health insurance. Although only 13 percent of the U.S. population, poor Americans (with income less than \$16,000 for a family of 4) represent 26 percent of the uninsured -- fully one-third have no insurance. However, reflecting the strong economy, the poverty rate continues to fall and the number of uninsured below 100 percent of poverty did not increase between 1996 and 1997.



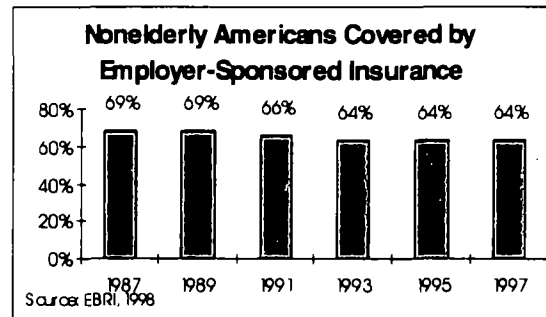
Despite the link between lack of insurance and low income, over 80 percent of the uninsured are in working families. The lack of insurance is growing among the middle class; all of last year's additional 1.7 million uninsured had income above the poverty level, with the greatest concentration of people between 100 and 200 percent of poverty. Inexplicably, although still small in number, the uninsured with income above 500 percent of poverty (over \$80,000 for a family of 4) rose at an extraordinary 20 percent growth rate in 1997.

Job characteristics and the uninsured: Workers in small firms are less likely to have access to affordable, job-based health insurance. Nearly half of uninsured workers are in firms with fewer than 25 employees. Compared to over 95 percent of large firms, about half of firms with fewer than 10 employees and three-fourths of firms with 10 to 24 employees offer coverage. These facts underscore the need to find better ways for small businesses to pool resources and leverage to bargain for more affordable benefits.

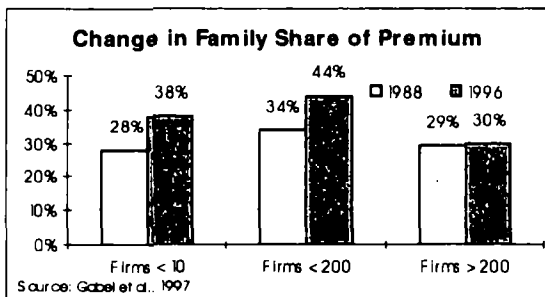


The rate of being uninsured is also high among people who work full time but only for part of the year, most likely due to job change or loss (27 percent). A recent Census study found that over 40 percent of workers with at least one job interruption had a gap in coverage. Because most people are insured through work, insurance coverage often ends with employment changes -- underscoring the importance of the Kassebaum-Kennedy portability and COBRA protections.

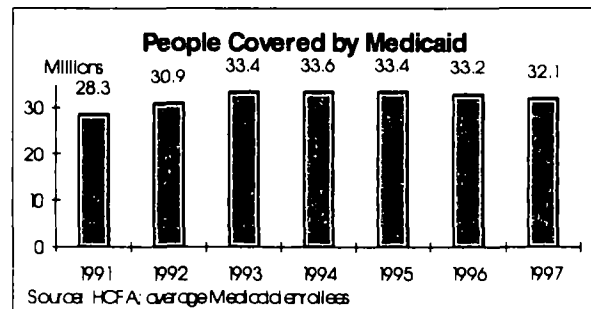
TRENDS IN EMPLOYER-SPONSORED INSURANCE. On the face of it, it does not appear that the increase in the uninsured is directly linked to a decline in employer-sponsored health insurance (ESI). The erosion that occurred in the late 1980s and early 1990s has ended. About 64 percent of nonelderly Americans had employer-based insurance in 1997, virtually unchanged from 1995 and 1996. In recent years, access to job-based health insurance has actually increased, even among small businesses. However, this has not translated into increased ESI coverage because a smaller proportion of people with access to ESI are purchasing it.



Even though more employers are offering health insurance, fewer employees are taking this coverage, primarily because they have to pay more of the premiums. The employee share of premiums has risen, especially in smaller firms. As a result, fewer employees are purchasing this coverage. For example, in 1987, 90 percent of workers in firms with fewer than 10 workers who had access to employer-based coverage took it, compared to 85 percent in 1996. These take-up rates drop as the share of the premium paid by the employee increases. This trend clearly affirms that health insurance affordability plays the most significant role in people's likelihood of buying health insurance.



TRENDS IN MEDICAID. The most notable drop in insurance coverage in 1997, reported by both the Census Bureau and HCFA, appears to come from the number of people covered by Medicaid. There are three possible explanations for this trend. The first and likely most significant factor is that, as the economy has strengthened, fewer people are eligible for Medicaid. This is supported by the fact that the poverty rate has declined, the number of poor covered by ESI has increased, and there was no increase in the number of uninsured children eligible for Medicaid (still 4.7 million). Second, there may be fewer people aware of their continuing Medicaid eligibility in the wake of state and Federal welfare reform. Third, it is becoming more likely that Medicaid beneficiaries misreport that they are covered by private insurance in the Census survey. States have been taking actions to "destigmatize" Medicaid by changing the name of their programs (e.g., TennCare, MinnesotaCare). Also, about 50 percent of Medicaid beneficiaries are enrolled in managed care plans, which are usually private plans. Thus, beneficiaries can easily mistake their coverage for private coverage.



FUTURE TRENDS IN THE UNINSURED. Given the complexity of these trends, it is unclear whether the rise in the number of uninsured will continue. Several compelling factors suggest that it will not and may actually decrease modestly. The Office of National Health Statistics projects that the proportion of Americans covered by employment-based insurance will rise as continued low unemployment will make employers more likely to use insurance to attract workers. Medicaid coverage may increase as well as additional low-income parents become eligible because of the "100-hour rule" welfare-to-work regulation you instituted this past summer and/or due to the states' continued use of Medicaid waivers, which have already covered over one million Americans. We also expect to see a decrease in the number of uninsured children beginning to showing up in next year's Census Report as the effects of CHIP take hold.

As the baby boom generation ages, however, more people will move into the 55 to 65 year old age bracket -- where the proportion of people with ESI is declining and uninsured is increasing. Furthermore, significant premium increases for next year, as some recent reports have projected, may make insurance unaffordable to greater numbers of Americans. While these conflicting trends make it extremely difficult to predict the future with any sense of confidence, it seems unlikely that we will see another significant increase in the uninsured next year.

IMPACT OF ECONOMIC AND EDUCATION SUCCESSES ON THE NATION'S HEALTH. This problem of the uninsured contrasts with tremendous improvements in other national health indicators. Your impressive economic accomplishments have had an impact on the costs of health insurance. For the first time in well over 30 years, health inflation was below general inflation in 1995 and 1996, thus actually reducing the real costs of health insurance. Moreover, gains in education, income and employment have contributed towards record high life expectancy (76.5 years for those born in 1997), a record low infant mortality rate (7.1 deaths per 1,000 live births), an AIDS death rate that is half of what it was in 1992, and a record-high immunization rates. And, historic increases in the investment in biomedical research during your Administration offer real hope for new (and hopefully cost-effective) treatments and cures for the diseases that will otherwise place unprecedented burdens on the nation's economy and health care system when the baby boom retires.

POLICY IMPLICATIONS. The uninsured in America remains one of the most challenging domestic social problems. Not only is the problem large in size, it is complex, crossing income, age and geographic boundaries. Despite its complexity, one fact is clear: making health insurance affordable is and always will be the key to significantly expanding coverage. Even for an employee whose employer pays for 80 percent of the premium, the family share of the premium is typically over \$1,100 per year -- more than one out of every \$10 of income for a minimum-wage worker. This cost is obviously much higher for people without access to employer-based insurance, especially if they have a history of illness. While traditional insurance regulation can help reduce insurance premium variation and discrimination, independent analysts will not project any substantial coverage expansions resulting from these interventions. In a non-mandate environment, they believe that only significant subsidies can induce a substantial reduction in the uninsured.

Ironically, our ability to propose policies to make insurance more affordable is limited by our success in reducing national health spending. In the last 5 years, hundreds of billions of dollars in excess Medicare and Medicaid spending have been squeezed out of these programs and used productively to help eliminate the deficit, finance children's health coverage, extend the life of the Medicare Trust Fund, and to make the Medicaid program a much more predictable and affordable safety net. However, substantial reductions in Medicare and Medicaid mean that these traditionally utilized funding sources cannot be relied on as offsets for major coverage expansions, let alone long-term Medicare reforms. With this in mind, outside funding sources from the tax code, tobacco, or elsewhere would be needed for a significant coverage expansion.

Administration & Republican coverage expansion ideas. The range of coverage options, currently being prepared through the traditional NEC/DPC/OMB budget process, will include some previous and new targeted coverage expansions. As this memo has documented, the most recent data validate the case for coverage expansions to the pre-65 and "workers-in between-jobs" populations. We also will continue to focus on administrative and possibly legislative outreach policies to encourage enrollment in CHIP and Medicaid to ensure your children's health initiative is a success. However, recognizing the questionable political and budgetary viability of these proposals, we are also reviewing options more likely to be well received in this Congress.

First, we are contemplating policies to encourage states to expand using existing options. With the 100-hour rule regulation, all states can now cover parents of children on Medicaid. Other states have used Medicaid 1115 waivers to cover all people up to certain income levels. Because this would likely require greater financial incentives, one option is making coverage expansions a priority on a short list of acceptable uses for the Federal share of state tobacco settlements.

As an alternative to coverage expansion options, we expect Secretary Shalala to advocate for a significant investment in public health infrastructure. This investment would be used to adapt the safety net to the rapidly changing health system. This idea would likely be better received than a coverage expansion by Republicans. However, if not a capped mandatory grant program, it would either require raising the discretionary caps or place a major strain on the current caps. Also, it would likely be perceived by some Democrats as giving up on coverage expansions.

Since there is bipartisan concern about small businesses' problem in accessing insurance, we are also considering enhancing our previously-proposed small business purchasing coalition grant initiative. We could more aggressively encourage these coalitions by directing OPM to provide technical advice for their establishment and operation, so that they more closely resemble FEHBP. We are also examining granting them non-profit status, to facilitate foundation support.

In 1999, Republicans, too, may consider small business group purchasing policies (although in the past, their versions have been significantly flawed). It is more likely, however, that, if Republicans decide to address the coverage issue at all, they will focus on the use of tax incentives for the purchase of individual health insurance. Encouraging individual insurance is intriguing because nation's reliance on voluntary, employer-based coverage has clearly not been an unqualified success. Moreover, if there is to be any significant investment in health care that the Republicans could possibly support, it would almost inevitably come from the tax code.

While acknowledging that tax credits are at least initially appealing, they are no panacea. They are extremely inefficient and expensive, as many of the assumed recipients would already have coverage. For independent experts to validate that the previously uninsured would take advantage of this policy, the credit would have to be quite large. In addition, if used for individual (rather than employer-based) insurance, they would require the type of major insurance reforms that have been historically opposed by Republicans. The individual market is the least regulated, most expensive, most "cherry-picked" and most unstable insurance market.

Notwithstanding legitimate concerns, we believe that tax credits may be the only health coverage expansion vehicle that could be produced by this Congress. As such, we are reviewing possible options for your consideration. For example, it might be possible to merge policies to promote small group purchasing coalitions with tax credits for participating employers or employees. Limiting the tax credit to such entities could further encourage a long-overdue expansion of small business coops. However, such approaches also raise equity concerns (e.g., why discriminate against an employee/employer who does not have access to, or does not want to be in, a purchasing coop) and political arguments (e.g., isn't this too similar to the Health Security Act). DPC, NEC, OMB, Treasury and HHS are reviewing this purchasing coalition/tax credit idea and other tax incentive approaches. We will keep you apprised of developments in this area, as well as other coverage options, as the budget process unfolds.