



THE KAISER COMMISSION ON
Medicaid and the Uninsured

Welfare Reform and Transitional Medical Assistance

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For

**“Welfare Reform: A Review of Abstinence Education and
Transitional Medical Assistance”**

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Subcommittee on Health
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**Summary of Testimony
Of
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1. TMA provides critical support to low-income working families, primarily those who have left welfare for employment. TMA has enjoyed strong bipartisan support for many years. It assures that families do not immediately lose health care coverage if a parent who has been receiving regular Medicaid finds a job (or receives child support payments). TMA is currently set to expire in September 2002.

2. TMA addresses the anomaly that poor parents are more likely to be uninsured if they are employed than if they are unemployed.

- While most people receive health care coverage through the workplace, this is not the case for many poor and near-poor families. A third of low-income parents, including 4 out of 10 parents with incomes below poverty (\$15,000 for a family of three) are uninsured.
- Ironically, poor parents are more likely to be uninsured if they are employed than if they are not employed (43% v. 31%). This is because many poor working parents do not have employer-based coverage and yet parent eligibility levels for Medicaid are so low in most states that they are often not able to qualify for regular Medicaid. Without TMA, many more working parents would be uninsured.

3. TMA participation suffered after welfare reform due to state and local implementation problems that have been addressed in many states. Changes in some of the federal rules could further improve participation. These include:

- Allowing states to modify the federal requirement that families must have received regular Medicaid for at least three out of the prior six months in order to qualify for TMA. This rule can interfere with work-first welfare initiatives that emphasize quick attachment to the labor market.
- Allowing states to eliminate or modify prescriptive federal reporting requirements. The added paperwork required by the federal TMA rules creates administrative burdens for states and limits participation among eligible families.
- Allowing states to provide TMA for longer than 12 months.

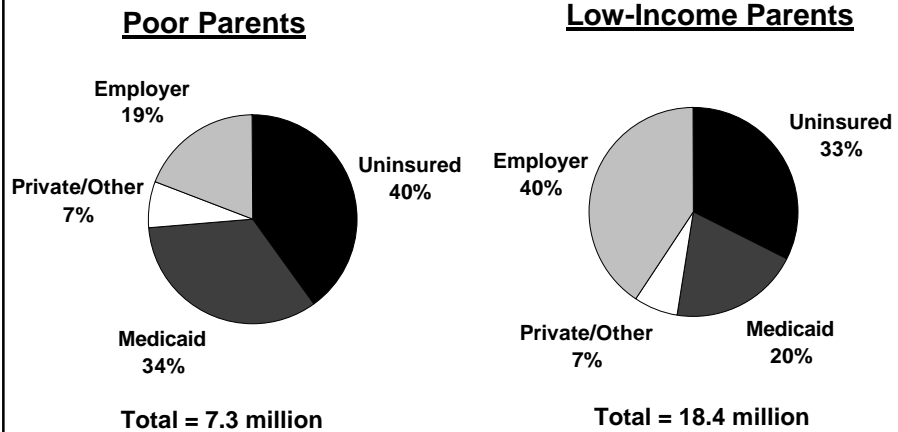
Thank you for the opportunity to offer testimony on Transitional Medical Assistance. I am Cindy Mann, Senior Fellow with the Kaiser Commission on Medicaid and the Uninsured. The national nonpartisan Commission services as a policy institute and forum for analyzing health care coverage and access for low-income populations and assessing options for reform. Before joining the Commission, I served as the Director of the Family and Children's Health Program Group at the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services) overseeing the administration of Medicaid for families and children, including Transitional Medical Assistance.

Low-income people (those with incomes below 200% of the federal poverty line, or \$30,040 for a family of three), including parents who have left welfare and are now employed, have a much higher risk than others of being uninsured. A third of low-income parents, including 40 percent of parents with incomes below poverty, lack health insurance coverage. (The poverty level is \$15,020 for a family of three.) Figure 1. Ironically, poor parents are more likely to be uninsured if they are employed than if they are not employed (43% uninsured v. 31% uninsured) because low-wage workers often do not have access to employer-based coverage and, in most states, Medicaid eligibility standards for parents are so low that even parents with very low wages are "over income" and cannot qualify for ongoing Medicaid coverage.

Transitional Medical Assistance (TMA) is one policy that helps address this troubling dynamic. TMA offers critical support to many of the most vulnerable families in this nation. It provides temporary health care coverage to families with low wages, primarily those who have

Figure 1

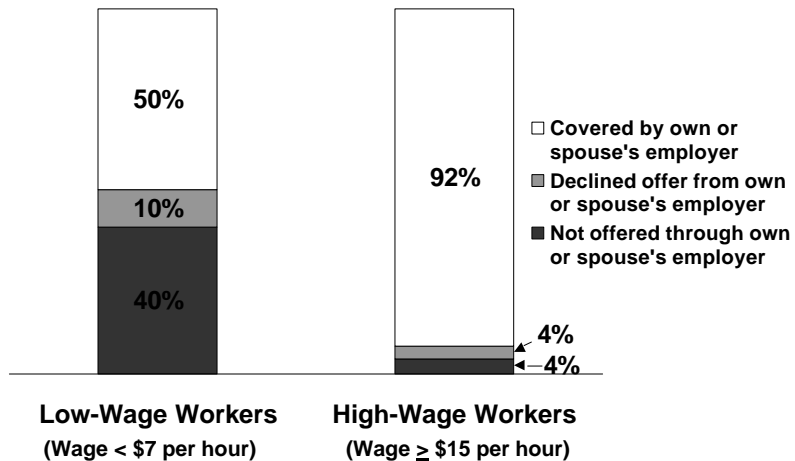
Health Insurance Coverage of Low-Income Parents, 2000



NOTE: Poor is defined as 100% of the federal poverty level and low-income includes those with incomes below 200% of the federal poverty line.
 SOURCE: Urban Institute and Kaiser Commission on Medicaid and the Uninsured, analysis of March 2001 Current Population Survey, 2001.

Figure 2

Access to Employer-Based Coverage for Low and High Wage Families, 1998



NOTE: Workers categorized by highest hourly wage in family.
 SOURCE: B. Garrett, unpublished analysis based on Garrett, Nichols, and Greenman, Urban Institute, 2001.

left welfare to take a job. TMA covers children and their parents, but it is particularly important for low-income working parents for whom TMA is often their only source of coverage. If TMA lapses at the end of this fiscal year, poor and near-poor parents will become uninsured, with adverse effects for their health, their ability to care for their children, and their capacity to retain employment and support their families. On the other hand, if TMA is extended and improved, even more low-income working parents will have a guarantee of coverage at least for a limited period of time.

TMA has been supported and expanded over the years

TMA is a common-sense “welfare-to-work” initiative that was created with strong bipartisan support years before the current era of welfare reform. It was first established in 1984 and was revised and expanded in 1988 as part of the Family Support Act of 1988. During this time, Medicaid eligibility for families with children was linked to welfare. In general, this meant that families that received welfare (Aid to Families with Dependent Children, or AFDC) were automatically enrolled in Medicaid and that when a family left welfare its Medicaid coverage would end. Congress recognized that parents leaving welfare for work are often not offered coverage at their workplace and was concerned that the loss of Medicaid coverage could discourage families from seeking jobs and make it difficult for them to retain employment. The 1987 Report of the House Energy and Commerce Committee accompanying the measure that broadened TMA noted that “(F)ormer AFDC families that work their way off welfare have the greatest need for health care coverage, because they are least able to pay for services out of pocket and because their health is more likely to be poor. Yet these are precisely the families

that are among those most likely to be uninsured.”¹ TMA assured that parents receiving welfare could take a job without losing Medicaid at least for a limited period of time.²

In 1996, when Congress drafted the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) to replace AFDC with the Temporary Assistance to Needy Families (TANF) block grant, it revisited Medicaid coverage rules, including TMA. Welfare reform underscored the important role Medicaid plays for low-income families, including those who may not be receiving welfare. PRWORA broke the historic link between Medicaid and welfare and created in its place a new Medicaid eligibility category for families with children. Under these new rules, families qualify for Medicaid based on their income, not based on their status as welfare recipients. PRWORA also extended TMA to 2001, demonstrating Congress’ continued commitment to assuring that families would not immediately lose health care coverage if they left welfare because a parent in the family found employment. The TMA sunset date was extended for one more year in legislation enacted in 2000.³

Under current law, states must provide TMA to families who otherwise would become ineligible for ongoing Medicaid coverage under the new family coverage category (“section 1931”) created by PRWORA.⁴ TMA is available if the family was receiving Medicaid for three out of the prior six months and is losing regular Medicaid because of earnings or child support payments. If the receipt of child support triggers TMA coverage, the family is eligible for four months of coverage. If TMA is based on earnings, the family is eligible for six months of coverage, plus an additional six months if family income, less child care expenses, stays below 185 percent of the poverty level (\$27,787 for a family of three) and the family complies with

federal reporting requirements. Families with access to employer-based coverage can combine this coverage with Medicaid. TMA would cover some medical services not covered by the employer plan, and help pay premiums and cost sharing imposed by the employer plan.

Employer-based coverage is often not available to parents leaving welfare

While most Americans receive their health care coverage through employer-subsidized plans, low-wage workers are substantially less likely to have job-based coverage. In 1998, only half of the workers earnings less than \$7 an hour (which is close to the average wage earned by those leaving welfare who are employed) were covered by plans offered either by their employers or their spouses' employer. Forty percent were not offered health insurance and an additional 10 percent declined an offer of coverage, largely as a result of costs. Figure 2. Even without considering deductibles and co-payments, the average cost of maintaining coverage offered through the work place is often well beyond the reach of parents leaving welfare. The average employee contribution for family coverage in 2001 would consume 11 percent of the average gross earnings reported by families leaving welfare for employment (\$1,360 a month).⁵ Individual coverage is less costly but still difficult for many families living below or close to the poverty level to afford, and premium costs are rising rapidly.

Other factors that typify the circumstances of many of the families leaving welfare also contribute to low rates of employer-based coverage among TANF leavers. Parents leaving welfare are often new employees both because they may be entering the labor market for the first

time and because they change jobs often due to the dynamics of the low-wage labor market and the challenges of maintaining child care and reliable transportation. New employees are often not offered employer-based coverage even in firms that offer longer-term employees coverage. In addition, women leaving welfare frequently find work at retail or service firms where employer-based coverage is less prevalent.

For all these reasons, only a small portion of families leaving welfare have employer-based coverage. The Urban Institute found that, in 1999, on average, only one out of five parents had employer-based coverage in the first year after leaving welfare. Employer-based coverage picked up substantially after one year, but still, even at a time when the economy was particularly strong, only a minority (44%) of parents had employer-based coverage more than one year after leaving welfare.⁶

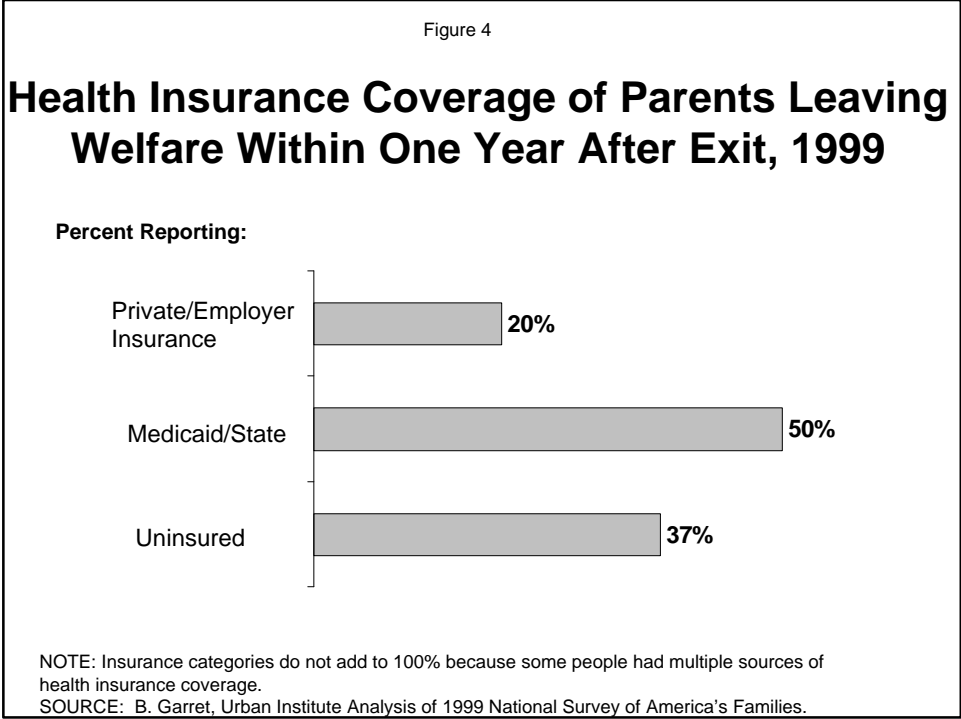
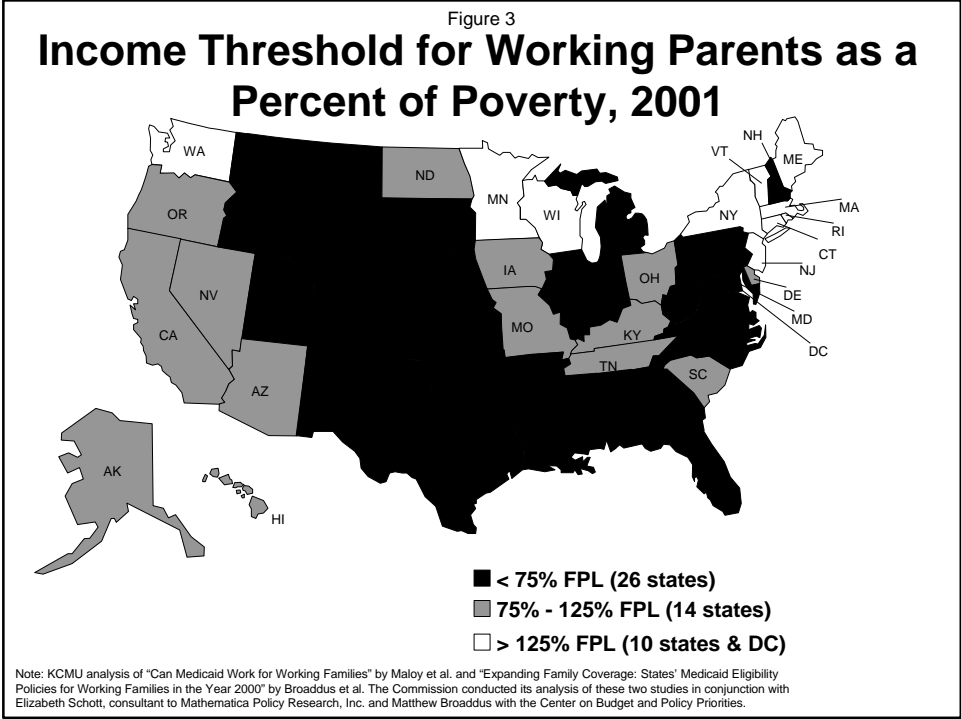
For parents, regular Medicaid often does not fill the gap left by employer-based coverage

Medicaid and now the State Children's Health Insurance Program (SCHIP) fill in much of the gap in coverage for children left by relatively low rates of job-based coverage among low-income workers and their dependents. Under federal minimum eligibility standards, all states must provide Medicaid coverage to children under age six if their incomes are below 133 percent of the federal poverty line (\$19,977 for a family of three). Older children must be covered if their income is below the poverty level. Options available to states to receiving federal matching funds to cover children at higher levels have prompted most states to expand coverage through Medicaid and SCHIP beyond these minimum levels. As of January 2002, every state covered

children with incomes up to at least 140 percent of the poverty line, and all but 11 states covered children with incomes up to 200 percent of FPL. As a result, most (83%) low-income children are now eligible for Medicaid or SCHIP.⁷ Many immigrant children are still left out of coverage, but for most other children the primary challenge is to improve participation rates in Medicaid and SCHIP.

The story is far different for the parents of these children. There is no uniform national minimum eligibility standard applicable to parents under Medicaid; the federal minimum standard varies by state pegged to the state's 1996 AFDC income standard. States have options to broaden their family coverage to reach more low-income working parents, but to date, only 18 states cover parents with incomes at 100 percent of the poverty level through regular Medicaid (or through a waiver). In seven states the income eligibility standard for a parent with earnings is *below* 33 percent of the poverty line (\$4,957 for a family of three). Figure 3.

As a result of these low eligibility standards, in most states low-income working parents, including many of those leaving welfare, have too much income to qualify for regular Medicaid. The earnings of those who leave welfare and find jobs average \$1,360 a month.⁸ This is below the poverty level for a family of three, yet in 39 states a parent with two children earning this amount will be “over income” for regular Medicaid.⁹ In the absence of TMA, most parents at these wage levels would not have any route to Medicaid coverage unless they are pregnant or disabled. Given limited access to employer-based coverage, parents moving into the labor market earning these wages would be at great risk of being uninsured if TMA were not available.



TMA implementation issues

While TMA has been a valuable source of coverage for millions of people in low-income working families, TMA has not always operated smoothly for either families or for states. Some problems have arisen as a result of implementation problems at the state and local level. In addition, some families do not take advantage of TMA because they are unaware of the coverage it offers. Families often close their Medicaid case when someone in the household finds employment, unaware that they may continue to be eligible for Medicaid. Many families wrongly assume that they have to be receiving welfare in order to qualify for Medicaid.¹⁰

Implementation problems were identified following the enactment of the federal welfare law in 1996. The welfare rolls plummeted, and, in many states, Medicaid enrollment dropped sharply as well even though most families leaving welfare should have been eligible for Medicaid at least for a temporary period of time.¹¹ Some of the decline occurred because state and local procedures and computer systems did not ensure that families who were leaving welfare were being properly evaluated for continuing Medicaid eligibility, including TMA. Studies have found that only one third to one half of the adults leaving welfare had Medicaid coverage following their TANF exit. According to an analysis by the Urban Institute relying on 1999 data, half of the women leaving welfare had Medicaid coverage during the year after leaving TANF. More than one-third (37%) percent were uninsured.¹² Figure 4. TANF “leavers” studies funded by the Department of Health and Human Services had similar findings.¹³

As a result of the unanticipated drop in Medicaid enrollment following welfare reform, many states began to focus in on the problem and make corrections, sometimes as a result of litigation or the threat of litigation.¹⁴ In 1999 through 2000, the Centers for Medicare and Medicaid Services (formerly HCFA) visited each of the 50 states and issued reports on state and local policies and procedures, and in April of 2000, CMS instructed all states to take steps to address any problems that might continue to exist and to restore coverage to children and parents who had been terminated from coverage improperly.¹⁵

Partly as a result of these state and federal efforts, Medicaid enrollment began to rebound in 1998, although enrollment trends varied significantly across states. Indiana's experience is instructive. The state identified implementation problems and outreach needs and took a number of steps to improve policies and procedures so that families moving in and out of the welfare system as well as those who did not apply for welfare did not lose out on Medicaid coverage. After three years of enrollment declines, Indiana saw its family caseload in Medicaid rise by 40 percent between May 1998 and April 2000. TMA enrollment quadrupled during this period.¹⁶ Indiana's experience shows that proper implementation coupled with aggressive outreach can make a substantial difference in the extent to which Medicaid generally and TMA specifically live up to their potential for covering low-income working families.

TMA design issues

There appears to be broad consensus that TMA is an important component of the Medicaid program and state and federal welfare-to-work initiatives. Some changes in the federal

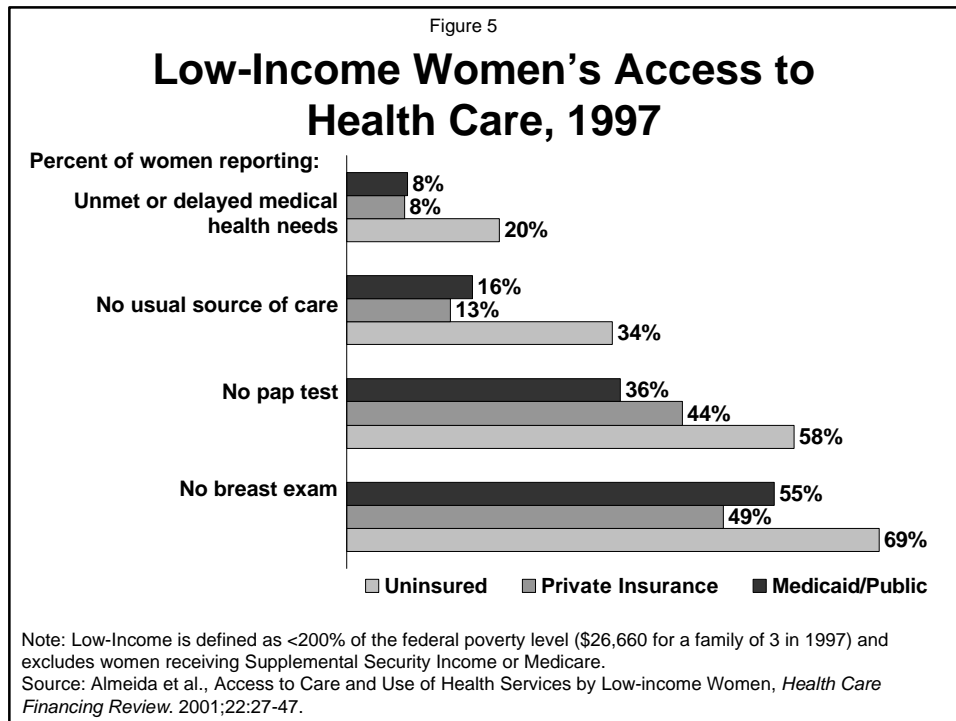
design of TMA could, however, boost participation. Some of these changes have been proposed in pending legislation.¹⁷

- Currently, TMA is available only to families that have been enrolled in regular Medicaid for at least three out of the last six months. Some states have noted that this requirement is not consistent with their welfare program’s “work first” approach, which stresses a quick attachment to the labor market. If a family begins receiving welfare and Medicaid in January and the parent finds a job in February with wages that would make the family ineligible for regular Medicaid, that family would not be eligible for TMA because it would not have satisfied the “three out of six months” requirement.
- The federal law includes prescriptive TMA reporting requirements. In order to retain eligibility throughout the full 12-month period, families must submit written reports of their earnings and child care expenses in the 4th, 7th, and 10th months. These reporting requirements create administrative burdens for states and can cause coverage problems for families. The GAO has recommended that Congress consider allowing states flexibility to change or eliminate these reporting requirements.¹⁸
- Some states have been interested in extending TMA beyond the 12 months allowed under the law. A few states have waivers extending TMA, but these waivers are generally no longer available due to budget neutrality rules.¹⁹ A legislative change would be necessary to allow states the option to provide TMA for longer periods of time.

Health Coverage Makes a Difference

With or without improvements in the way TMA operates, there is nearly universal agreement that TMA plays an important role promoting welfare-to-work efforts and providing health care coverage to some of the most vulnerable families. Health care coverage alone does not guarantee quality health care, but coverage makes it much more likely that people will get the health care they need. A recent study showed that low-income adults are almost three times more likely to have an unmet medical need if they are uninsured.²⁰ Those with Medicaid coverage do not report these same levels of unmet needs. For example, a study found that low-income women are 2.5 times more likely to report unmet or delayed health care needs than are low-income women with either Medicaid or private coverage.²¹ Figure 5.

As the Congress recognized when it expanded TMA in the Family Support Act of 1988, parents relying on welfare and those leaving welfare for work are often in poor health. Poor health status is generally correlated with low incomes.²² Health-related problems take their toll on poor women's ability to care for their families and to work and retain employment. The National Governors Association has identified health-related problems as a key barrier to work and a challenge to state welfare-to-work initiatives.²³ Recent reports have highlighted the importance of quality coverage as a means of decreasing absenteeism and increasing productivity at work.²⁴ While coverage does not assure good health, it affords individuals access to health care, which can help them manage and address health problems and better care for their children and participate in the work force.



TMA is a critical component of the labyrinth of mechanisms by which some of the people who do not have access to employer-based coverage can obtain health care coverage. It has a limited reach both because it is a targeted program and because it provides time-limited coverage. Even with TMA, four out of ten poor parents are uninsured, and with a souring economy, rising health costs, and state budget cutbacks, the number of low-income people who lack health insurance coverage is expecting to rise. By extending TMA and perhaps improving how it works, Congress will be assuring that some of America's hardest working families do not join the ranks of the uninsured.

¹ H.R. Rep. No. 159, 100th Congress, 1st Sess., Part 3, at 12.

² TMA was also extended to families who might otherwise lose Medicaid due to child support income so that successful efforts to increase child support payments from absent parents did not result in the immediate loss of health care coverage.

³ Congress extended the sunset date to September 30, 2002 in P.L. 106-554, section 707(a).

⁴ Technically this means that a family does not have to be receiving welfare in order to qualify for TMA, since welfare receipt is no longer an eligibility requirement for Medicaid. However, as explained below, in most states the income standards for the family coverage category are so low that in those states TMA still largely functions as a welfare-to-work initiative.

⁵ Data on average premium costs for employees are from Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits, 2001 Annual Survey*, 2001; data on average wages of parents leaving welfare are from P. Loprest, *How are Families That Left Welfare Doing? A Comparison of Early and Recent Welfare Leavers*, New Federalism Policy Brief, Urban Institute, April 2001.

⁶ Urban Institute analysis of 1999 National Survey of America's Families.

⁷ L. Dubay, J. Haley, G. Kenney, *Children's Eligibility for Medicaid and SCHIP: A View from 2000*, Urban Institute, January 2002. These figures take into account restrictions in Medicaid and CHIP based on immigration status. About eight percent of low-income children are not eligible for coverage based on federal Medicaid immigration-related eligibility restrictions.

⁸ P. Loprest, *How are Families That Left Welfare Doing? A Comparison of Early and Recent Welfare Leavers*, New Federalism Policy Brief, Urban Institute, April 2001.

⁹ KCMU analysis of K. Maloy et al, *Can Medicaid Work for Working Families*, George Washington University, and M. Broaddus et al, *Expanding Family Coverage: States' Medicaid Eligibility Policies for Working Families in the Year 2000*, Center on Budget and Policy Priorities. In some states, a parent receiving Medicaid who finds a job may be able to receive Medicaid at somewhat higher income levels for a limited period of time due to earning disregards that are available to persons already receiving Medicaid.

¹⁰ M. Perry, Kannel, S., Valdez, R.B., Chang, C. *Medicaid and Children: Overcoming Barriers to Enrollment*, Kaiser Commission on Medicaid and the Uninsured, January 2000.

¹¹ GAO, *Medicaid Enrollment: Amid Declines, State Efforts to Ensure Coverage After Welfare Reform Vary*, GAO HEHS-99-163, September 1999.

¹² Urban Institute analysis of 1999 National Survey of America's Families, April 2002. These figures do not add up to 100 percent because some people have both private coverage and Medicaid.

¹³ G. Acs, P. Loprest, T. Roberts, *Final Synthesis Report of Findings from ASPE "Leavers" Grants*, Urban Institute, December 2001, Chapter IV, <http://aspe.hhs.gov/hsp/leavers99/synthesis02/index.htm>.

¹⁴ Efforts taken by Washington state and Pennsylvania and Maryland are described at <http://www.hcfa.gov/medicaid/wrmdpawa.htm>. See also, *Adjusting Computer Systems for the TANF De-link*, prepared by C. Gerhardt, State of Maryland, Department of Health and Mental Hygiene, hcfa.gov/med/mmis/927mann.pdf.

¹⁵ CMS, Letter to State Medicaid Directors, April 7, 2000; <http://www.hcfa.gov/medicaid/letters/smd40700.htm>.

¹⁶ Statement of Kathleen Gifford, Assistant Secretary, Office of Medicaid Policy and Planning, Indiana Family and Social Services Administration, House Ways and Means Committee, Subcommittee on Human Resources on Health Coverage for Families Leaving Welfare, May 16, 2000.

¹⁷ HR 2630, HR 2775, and S.1269.

¹⁸ GAO, *Medicaid Enrollment: Amid Declines, State Efforts to Ensure Coverage After Welfare Reform Vary*, GAO HEHS-99-163, September 1999.

¹⁹ According to CMS, 11 states had waivers to extend TMA beyond 12 months, but only 6 of these waivers are currently in effect and 3 will expire in 2002. In the past, states were able to show that these waivers would not add to federal costs because they would lower AFDC costs by preventing some families from having to fall back on welfare because they lacked health coverage while they were working. Now that AFDC has been replaced by the TANF block grant, a decline in the welfare caseload due to extended TMA would not reduce federal expenditures.

²⁰ B. Strunk, P. Cunningham, *Treading Water: American's Access to Needed Medical Care, 1997 – 2001*, Health Systems Change Tracking Report, Results from the Community Tracking Study, No. 1, March 2002.

²¹ R. Almeida, L. Dubay, G.Ko, “Access to Care and Use of Health Services by Low-income Women”, *Health Care Financing Review*, 2001; 22:27-47.

²² See, for example, H. Mead, K. Witkowski, B.Gault, H. Hartmann, “The Influence of Income, Education and Work Status on Women’s Well-being”, *Womens Health Issues*, 2001; 11:160-172, comparing the health status of poor women with that of women with incomes above 200 percent of the poverty level. The study found that poor women were more than three times as likely as nonpoor women to report fair or poor health (34% v. 9%). The GAO has found that a significant portion of TANF recipients are disabled have poor mental and physical health, suffer from substance abuse and have experienced domestic violence. GAO, *Welfare Reform: Moving Hard-to-Employ Recipients Into the Workforce 2001*, GAO-01-368. Other studies have found that many current and former TANF recipients have mental health problems, including depression. Lennon, Blome, English, *Depression and Low-Income Women: Challenges for TANF and Welfare-to-Work Policies and Programs*, Research Forum on Children, Families and the New Federalism, National Centers for Children in Poverty, 2001.

²³ S. Callahan, *Understanding Health-Status Barriers that Hinder Transition from Welfare to Work*, National Governors Association, 1999.

²⁴ TC Buchmueller, *The Business Case for Employer-Provided Health Benefits: A Review of the Relevant Literature*, California Health Care Foundation, 2000.