

## ALLIANCE FOR HEALTH REFORM

### WELFARE, WORK, AND HEALTH CARE: A LOOK AT TRANSITIONS AND THEIR EFFECT ON ACCESS TO CARE

JUNE 28, 2002

WASHINGTON, DC

**MR. ED HOWARD:** Good afternoon. I'm Ed Howard with the Alliance for Health Reform. On behalf of Senator Rockefeller, Senator Frist, and the rest of the Board of Directors of the Alliance, welcome to our program this afternoon.

We're pleased to have today the co-sponsorship and support of the Kaiser Commission on Medicaid and the Uninsured.

Be sure to thank Diane Rowland for the quality of the lunch, by the way, and remember it the next time you have a turkey sandwich from the Senate caterers at one of our briefings.

We're here today to examine a very important issue that's actually flown pretty much beneath the radar for most people this year, how we're going to get health coverage to low income families who are moving from welfare to work. Most of these people who get jobs find they don't carry health insurance with them, and the out of pocket cost is pretty daunting if they do.

So how to get and hang onto the public coverage that's available is an important piece of the welfare to work puzzle for the people themselves, and for the success of the welfare reform program as well.

This couldn't be a more timely discussion, I guess, unless you're working on prescription drugs on the House side, then nothing is timely, but a visit to the -- to your sack. But, absent that, the House has already passed it's version of Welfare Reform Extension. The Senate Finance Committee is ready to send it's version to the floor.

And today, we have a chance to ask the tough questions about how well the current programs are working and what changes might help. And to help us with that discussion, we have an excellent panel that includes top analysts and players, and people with people -- people with hands on experience in these programs.

Let me just do a couple of quick logistics things before we get to that. You see the microphones where you're going to be able to ask questions of the speakers once we've finished with the presentations. You also, as you know, have those green question cards that you can write something on and hold up, and somebody from the staff will come by and get it to us. And the blue evaluation forms are very important. We need them to get feedback from you to make these programs better as we go along.

And finally, those of you who aren't familiar with this before, ought to be. The cameras are indicative of a webcast of this event by KaiserNetwork.org which, within a couple of hours, will have the streaming video of this discussion. Within a day or two we'll have a transcript of this discussion. And most of the items in your information packets will be posted on the Web site as well. And those will also be available on the Alliance Web site, which is AllHealth.org.

So, without further delay, let us move on. Most of you know Diane Rowland, who's the Executive Director of the Kaiser Commission on Medicaid, our co-sponsors and supporters. And she's also the Executive Vice President at the Kaiser Family Foundation.

She's one of the country's leading experts in many areas of health policy, especially having to do with access to care for low-income people. She has held a range of important positions in both the executive and legislative branches. She's on the adjunct faculty at Johns Hopkins School of Hygiene and Public Health, and we're very pleased to have her as our leadoff speaker today.

Diane?

**MS. DIANE ROWLAND:** Thank you, Ed. And I'm very pleased to be co-sponsoring with the Alliance this briefing on Welfare Reform and Health.

When Welfare Reform passed in 1997, there was a great deal of discussion about the separation of the Medicaid program from Welfare and the disconnecting of the two, and Medicaid being established and reconfigured as a health program for children and their parents. And indeed, that is part of what has been happening in the Medicaid program, where we've seen the elimination of a lot of the rules that Medicaid inherited from welfare. We've seen a simplification of the process for both enrolling in Medicaid and staying on Medicaid. And we've seen a new imperative to try and do outreach to find eligibles and enroll them.

But despite the progress in Medicaid and the separation, healthcare issues and the role of Medicaid still remain entwined with welfare, and especially with the ability of people leaving welfare to maintain and obtain healthcare coverage. Our jobs for most of us in America come with health insurance, but that's not so for low-wage workers, and it's especially not so for welfare leavers.

So here, once again, we look at the Medicaid program as a way that can and does fill in many of the gaps in our employer-based health system, through both transitional Medicaid assistance initially, and then through broader health coverage reforms that help the low-income population obtain healthcare services.

What I'm going to do today is just very briefly review some of the health issues that remain entwined with the welfare issues, and then turn over to my speakers that follow me to really discuss the implications in the legislation before you.

In my first slide, what we've tried to show here is the kind of coverage that individuals who are working parents have with relationship to their income. And what you see is that, in more than half of the states, parents who earn \$7 an hour and work 35 hours a week or more are really not eligible for Medicaid coverage, and are often not getting the kind of coverage they need through their employment base.

Here 43 percent of working parents below the poverty level are without health insurance; only 28 percent receiving Medicaid and only 30 percent receiving private coverage.

If we look to the next slide, we see that one of the gaps here is caused by really the limited income eligibility levels for parents under the Medicaid program. Much progress has been made with Medicaid and then with the companion enactment in 1997 of SCHIP. But we see here that, while children tend on average to qualify for the program, which an average income of nearly \$30,000 for their employed parents, parents coverage comes at an average income of \$10,000 or less, and unemployed parents below that. And as we all should always remember, childless adults, no matter how poor, are typically ineligible for Medicaid and federal matching funds for services should the states elect to cover them.

So what we see is that we have a situation in which going to work doesn't necessarily translate into health insurance coverage or assistance from Medicaid. And in the next slide, we see the tremendous difference in terms of shift to employment and shifts in insurance coverage.

In 1994, 49 percent of single mothers were working who were poor. And in 2000, nearly two-thirds, 65 percent, are now employed. However, their insurance coverage, their likelihood of having either Medicaid or private insurance has decreased. And so we now have nearly a third of single mothers without health insurance coverage in the year 2000. So they're working more, but they're less likely to be insured.

If we look at the next figure, we see how this really breaks down for working women by income. You see that those with wages less than \$7 an hour, which constitute 38 percent of the women who have recently left welfare, of those, 42 percent are uninsured, 42 percent have Medicaid, and only 16 percent can count on coverage from their employer.

As wages rise, the likelihood of employer-based coverage increases, so that 51 percent of women who recently left welfare who are earning \$10 or more an hour, are with employer-based coverage. However, that share of women only represents 15 percent of all of the women who left welfare.

So the bulk of women leaving welfare are going to lower income jobs and, in those lower income jobs, still heavily dependent on getting Medicaid assistance to remain insured. And if they don't get Medicaid assistance, very likely to be uninsured.

In the next slide, we look at women who have recently left welfare in a slightly different way to assess their health insurance coverage. We see that, for the 37 percent of women who have left welfare less than six months ago, Medicaid remains the major source of coverage, due mostly to transitional Medicaid assistance, which extends Medicaid coverage beyond leaving the official welfare roles.

Employer sponsored coverage for recent welfare leavers is only about 8 percent. However, by the time we get up to welfare leavers who have been gone for a year or more, employer-based coverage is beginning to kick in, Medicaid is dropping off, but we still see that 40 percent of these women remain uninsured. So that we really continue to look at the interaction between Medicaid, employer sponsored coverage, and uninsurance and see that, while employer sponsored coverage can help pick up some of the coverage that Medicaid has been providing, we are still leaving four in ten women who leave welfare without health insurance after a year's time.

And clearly, as the next slide shows, we care about getting healthcare coverage for these women, because it affects how they use the healthcare system and the services that they receive.

In this slide, we've looked at women who recently left welfare and their use of health services over the last year since leaving welfare. And you see that those with Medicaid or employer sponsored coverage are more likely to see a doctor, more likely to get preventive health services, such as a breast examine or a pap smear, than those who remain uninsured. Not different from any of the other statistics we constantly show you on the differences between those who have insurance and those who don't; but again, just a reinforcement of the need to bring healthcare coverage along with welfare reform to help the welfare leavers to be able to successfully enter the workforce.

And finally, one of the other issues that gets touched upon in the next slide -- it's part of this debate -- is that some of the lack of coverage that has been experienced is also due to changes in the immigration policy that were enacted as part of this, prohibiting federal funds for those entering the United States after August of 2002. What we've seen here is that 27 percent of citizens are uninsured, compared to 59 percent of non-citizens.

When we look at the next slide, we see that many states have tried to step up to the plate and fill in with state only funds to provide some coverage of the immigrant population. Nineteen states now provide Medicaid to pregnant woman, and 18 states provide Medicaid to the children of legal immigrants using state only funds.

But one of the concerns that many of us have is that, in this current environment in which state fiscal conditions have eroded, there may be less ability of many of the states to fill in those gaps and to continue to provide some coverage to their immigrant population.

And finally, in the next slide, I think it's important to recognize that not everyone who had welfare was in good health, and that healthcare is there for a very important source of supplemental coverage to people who are in need of assistance.

Thirty percent of those who left welfare and working report that they have poor health, either a physical or mental health problem. But 46 percent of those who left welfare, and have since returned to welfare, report health problems and health related problems.

So we really need to assess the need for assistance based on some kind of healthcare conditions, as well as just a need for cash assistance. And, in fact, health conditions may be impeding the ability of many individuals to be retained in the workforce.

And finally, in the next slide, many of the families who are receiving cash assistance and are now moving to work, may in fact be caregivers for individuals with severe disabilities. And we look here at the fact that, in many states, individuals with disabilities are not yet exempted for the care they have to provide to their children.

So, lack of adequate coverage for individuals who are caregivers, who are at home taking care of disabled children, can actually result in an increase in federal spending and state spending if one needs to replace the family caregiver with another caregiver.

So we really need to look throughout the debate at how to make sure the health issues are not being complicated by our welfare policy, and that our welfare policy is not being complicated by the lack of healthcare issues being attended to.

So in my final slide, I would just raise that the issues that need to be considered in the reauthorization of the welfare reform legislation, the need to look at this transitional medical assistance program that provides interim healthcare financing for the lowest income population as they shift off of the rolls and onto employer based coverage. That has been included in all of the bills. The issue there is can it be simplified, can it be improved, and how long should it be extended.

We need to, I think, also reassess the role that Medicaid plays for immigrant populations, and whether or not there should be some additional coverage there of at least pregnant women and children. We need to look at how health conditions for parents and children are being treated, and whether or not states can be given broader flexibility to exempt some of these parents from conditions.

But ultimately, we need to look at the fact that we need to fix our healthcare systems. We need to provide health insurance coverage for our lowest income populations. Here, we're asking the welfare systems to bare the burden of the flaws and gaps we have in our healthcare system.

Fixing healthcare coverage would remove an obstacle to successful implementation of welfare reform, and we wouldn't need to be talking about all of these issues in the context of welfare reform if we solved the problem of uninsured, low-income Americans.

Thank you.

**MR. HOWARD:** Thank you, Diane. Quite a good set up. And we're going to move right on to Ron Haskins.

If you've dealt with federal welfare policy in the last generation, you probably know, and you should respect, Ron Haskins. For 14 years, he was a welfare expert for the House Ways and Means Committee Republicans. He was on -- as the Subcommittee Staff Director during Welfare Reform.

He's now -- and this is quite a trifecta. He's President Bush's Special Advisor on Welfare Policy. When he's not doing that, he's a guest scholar at Brookings, and a Senior Special Advisor -- I'm sorry, a Senior Consultant at the Annie E. Casey Foundation. He told me before the briefing that he's not always welcome all three places at the same time.

But frankly, those of us who've been around for a while probably would think that his most impressive feat is the three times he was the editor of the Green Book which, if you've had the occasion to use it, you know is a virtual treasure-trove of information about every program that you care about in the Ways and Means Committee's very broad jurisdiction.

So, a man of substantial accomplishments in many areas. We're very happy to have Ron Haskins with us.

**MR. RON HASKINS:** Let me begin with a slight correction in the introduction. I don't know that you noticed that you said this, but I want to point it out before Paul does, and that is, the last generation part that you -- he said I was from the last generation. Forgive me, I'm not quite that old. I'm getting there, but I'm still in this generation.

I was actually invited, I think, because I am not any kind of Medicaid expert, as Paul will attest. But I was around when the Welfare Reforms of 1996 were enacted, and there were some extremely important provisions in that legislation. And I got to go in and out of the room and listen to people yell at each other, including Laurie Rubiner, who was extremely aggressive on Senator Chafee's behalf.

So, let me make a few historical comments and then I want to talk about what happened in 1996, what has happened since, and what the situation today is. And I'll try to do all of this, out of sympathy with the audience, in less than four minutes.

First, TMA, Transitional Medicaid Assistance. This is really the most important topic, I think, before us here, and it's the most important topic that is before the Congress right now. There are many other having to do with Medicaid, but when it comes to Medicaid and Welfare and children, transitional Medicaid was really an important innovation. And it actually goes all of the way back to 1972, in the Social Security Amendments, was the first time that Congress actually made provision to provide Medicaid benefits to people who were not on welfare.

In my opinion, the original sin of American health policy was the link that was established, virtually unbreakable, between welfare programs on the one hand and Medicaid on the other. So, in the old days, if you wanted Medicaid coverage, you had to be on welfare. You either had to be on the old Aid to Families with Dependent Children program, or you had to be on Supplemental Security Income.

And if you think about this for just a minute, you can see that this is really an outrageously bad idea, because we would like people to leave welfare. Maybe SSI a little bit less than AFDC or cash welfare, but we certainly want people to leave welfare.

In the old days, that didn't make all that much difference. We talked a lot about it but nobody really did anything. But starting in 1988 with the Family Support Act, and then up with much greater intensity in 1996 with the Welfare Reforms of 1996, it did become extremely important to get people to leave welfare.

Now, we already had essentially the framework of TMA, Transitional Medicaid Assistance, established in 1998. And Paul Offner, I'm sure, played a very crucial role in that. And the general idea was that, if you left welfare because of increased income, that you had six months of -- both the mother and the children had six months of Medicaid coverage, and then there was another six months if you met an income criteria, which was 185 percent of poverty level. So, in today's dollars, that means, as long as you're below about \$28,000 you're eligible for coverage. And the 1996 legislation extended that provision and was not one of the more controversial parts.

However, there's another strand of Medicaid Reforms that goes back, actually, to 1986 and that was when Mr. Waxman, recognizing this serious flaw in our health policy, this connection with welfare and Medicaid, started to break that link.

And Congress began to enact policies that would provide coverages to children, and eventually to pregnant women, regardless of their welfare status. And this is extremely important for children. So that now we have several different coverages that children get Medicaid coverage regardless of their welfare status. They meet an income status and a few other less important conditions. But, roughly speaking, any kid under -- up to age six, under 133 percent of poverty, has to be covered.

States have the option of covering pregnant women and children up to age one all of the way up to 185 percent of the poverty level, and states now have to cover all children under 19 up to 100 percent of the poverty level.

And it took many, many pieces of legislation to get that far. To my thinking, it is one of the most brilliant examples of gradual policy making by a determined, in this case, individual who set -- Mr. Waxman -- who made this into a bipartisan issue and gradually built up these coverages, and I think went a long way towards solving one of the fundamental flaws of American Health Policy.

Now, with regard to this breaking this link between welfare and Medicaid, 1996 took what in some sense is the final step, and that is that we required that states basically could not change their income criteria for Medicaid eligibility. And this was extremely important because, at the time it was thought that the states, because they were given dramatic control over the welfare programs, that they would be likely to change the income criteria for welfare.

So what happen -- and this was really the part that was fought over and was extremely controversial -- the states could not go, except with a few minor exceptions, below their income qualifications for -- at that time the Aid to Families with Dependent Children Program in 1996 and, in the future, they could never change that level. No matter what they did to the program that replaced AFDC, the TANF, Temporary Assistance for Needy Family Programs. So what the states increased the income criteria for entry into TANF, they still had to cover -- offer coverage to those families that met the income criteria for AFDC. And that was an extremely controversial thing.

And I'll tell you a colorful story that was actually one of the worst experiences I think I ever had, except having to deal with Paul over and over again. But on the night before the final bill came to the House floor in July of 1996, Governor Engler of Michigan, who was strongly, and I use that word modestly, was strongly opposed to what he called "dual calculation of eligibility" because, if a State change its TANF qualification, they would have to compute an eligibility for TANF and they would have to compute an eligibility under the old AFDC income guidelines.

And he had been to Washington several times to oppose this. So, he was at a formal dinner and we were changing calls back and forth through his staff. And he was telling us that if we kept this provision in here, he was gonna call a press conference the next morning and denounce the Welfare Reform. Now, this is Governor Engler who was one of the real driving forces behind Welfare Reform.

So, it was a game of chicken, I'll tell you. And that is how that funny \$50 million provision got in the legislation that went to the states. The idea was it would go to the states that could show that they had additional expenses for calculating to dual eligibility.

But eventually -- I mean, that -- we kept it in there because there was, as Lori will tell you, the bill could not have passed unless that were in there because of a bipartisan agreement that it was definitely going to be in there. And as I said, Senator Chafee played a big role in that.

Now, why is all of this so important? I'd like to show this slide. You can't see it very well. It's kind of complicated. What this does -- the idea of this chart is to show you that, as American policy shifted from an emphasis on welfare on the one hand to an emphasis on work with supplements from other public sources, so that people were encouraged to leave welfare and, where necessary, were forced sometimes with fairly -- Paul would say, and Paul's former boss, Senator Moynihan would say, was pretty tough on -- even on fair policies to force people to work. The idea was that our other policies needed to support this movement from off welfare to work so that it would become more profitable to work.

And the only thing I want to show you on the income in this chart, you can look at it at your leisure if you want to. In 1986, if a mom took a minimum wage job in a typical state, this is based on Pennsylvania -- by the way, these calculations were done by the Congressional Research Service. So, untouched by those biased Republican hands -- she would have \$3,600 dollars more in income as compared with her income under welfare. And that figure, I think, is really somewhat exaggerated

because it does not take into account childcare, and there were very, very few childcare coverages in 1986. And, she and the children would almost certainly lose their Medicaid once they left welfare.

So, if you look down here now, you will see that we changed the characteristics of the support system for people who left welfare and went to work. The biggest change by far was the earned income tax credit, but there were also very important changes in state welfare policy that allowed people to keep benefits when they went to work, and changed what are called the “income disregards,” and many other changes in several federal policies over a period of many years to expand the support to lower income families that worked, all because we had the vision that it was better for people to work than to be on welfare.

And, of course, Medicaid was a very important part of this. So as it turned out, the Waxman changes came into play and made it, certainly from a parents perspective, much better for the kids because the kids had coverages. And then, with the transitional Medicaid, also the mother had coverage’s.

So, those were maintained in 1996 and even expanded somewhat because they were tied to AFDC, to make sure that people below whatever income made you eligible for Medicaid in 1996 would not change.

So, by 1998 on this chart, you can see that when the mother left welfare, she would be assured of a year of Medicaid coverage. And the children basically would be covered until the mom made \$28,000 which, as you could tell by Diane’s charts, doesn’t happen very often.

So that’s why it’s important. It’s part of a bigger picture to make it useful, profitably, wise for someone to leave welfare and try to make it on their own.

Now, it turned out once we passed welfare, then unfortunately, as so often happens, with both food stamps and Medicaid, that even though people were eligible for the benefits -- so the statute is fine. The federal statute is good. But as it actually implemented out there in the countryside, a lot of people didn’t get the benefits, and that’s what Diane’s chart shows. And food stamps, we now have extremely good research on big samples to show that about half of the families that leave welfare and are eligible for food stamps don’t get it. And in some states, it’s at least half for Medicaid.

So this is a big problem. It’s not working out the way we planned it. What a shock that is. That almost never happens in the policy world.

So now the question before us is what can be done to extend these coverages? One answer is that states already have a lot of flexibility. If states are determined, they can make a big difference in the coverages, and how many actually receive the coverage using what’s already available in the federal statute.

We had a hearing about a year and a half ago before the Ways and Means Committee, and showed in Florida, Oklahoma, Ohio, that they -- what happened is that their coverage of children went down after

we passed the Welfare Reform Bill -- this is the problem that I was referring to -- and then, because they changed their policies, the coverage went up and, in Florida and several other states, they actually cover a higher percentage of children now than they did before Welfare Reform.

So, the federal policies are good, they're reasonable, they give flexibility to the states. And the states could cover a lot of these kids if they aggressively want to do it. Right now's probably the worst possible time to be talking about this because of the fiscal problem in the states, and states are not gonna be that aggressive for the next, you know, 12 months or whatever it is.

But, when we return to normal and the states have a pretty good history of trying to extend Medicaid, I think that there already flexibility under the federal statutes that states could do a much better job of covering these children and the mothers.

So I think the policies that we need are in place. They could be improved, that's for sure. But the states could do much better in solving this very, very important problem and making sure that people who leave welfare are covered by Medicaid.

Thank you.

**MR. HOWARD:** Thank you very much, Ron.

By the way, we didn't have Ron's slide in time to get it into your materials. We'll try to get it onto the Web site as soon as we possibly can.

We also didn't have time to distribute Laurie Rubiner's slides. If there is anybody who did not get a copy of them as they came in, if you'll hold up your hand -- that's what they look like -- if you'll hold up your hand, we'll get you one or you can get one on the way out if we've run out of copies up here.

As Ron noted, Laurie Rubiner also knows her way around the Hill, having served for almost a decade as the Legislative Assistant for Health and Welfare Issues to the late Senator John Chafee of Rhode Island.

I know many of my Republican colleagues speak wistfully of the Chafee Health Reform Bill from 1993 and 4, as in, "Why didn't we have the sense to take yes for an answer on the Chafee Bill?"

Now Laurie is the Vice President for Program and Public Policy for the National Partnership for Women and Families, where she's been doing work recently on how low income working families get health coverage. And that is precisely what we want to hear from her today.

Thanks for being with us, Laurie.

**MS. LAURIE RUBINER:** I'm happy to be here. Thanks, Ed.

I want to start off by just talking a little bit about why access to public health coverage for low income women and families is a key priority for our organization.

The National Partnership for Women and Families is a non-profit, non-partisan organization. We do a tremendous amount of work on both healthcare and low income issues affecting families. And I think that one thing that we need to remember when we're talking about both welfare and the Medicaid program is that we are talking primarily about women. And Ron used the word "mom" over and over again, and that is primarily what we're talking about. We're talking about single mothers with children.

Women are disproportionately represented on both the Medicaid and the TANF rolls. And so, for the National Partnership, and for many organizations across the country representing women, we see no more pressing issue facing us than the need of these low income families. And, in particular, the Medicaid coverage, we believe, should be a top priority as we move forward on the TANF Reauthorization.

But before I go into some of the background on it, I want to just put a face on Medicaid for you a little bit, just to sort of give you a sense of who is it that we're talking about.

A woman -- women and girls make up nearly six in ten Medicaid enrollees. Among adults, women are twice as likely to be covered under Medicaid than men are. Medicaid beneficiaries are primarily white. White women are likely to receive coverage under Medicaid than any other racial or ethnic group. They make up over 52 percent of Medicaid enrollees, followed by African-Americans at 26 percent, and Latinas at 17 percent.

They are young. More than half, 57 percent of women on Medicaid are between 18 and 44 years old. And most of the women on Medicaid are under the age of 30.

They are more likely to be a single parent. This is a stunning statistic. Twenty-five percent, one quarter of all the single women with children in our country are covered under Medicaid, as are their children. They're less likely to have finished high school. Among women, four in ten Medicaid enrollees have not finished high school.

And they are living well, well below the federal poverty level. The median income threshold for Medicaid enrollees across the country is 45 percent of the federal poverty level. That's about \$544 a month for a family of three for unemployed families, or \$836 per month for employed families of three.

As Ron said, there is a very important connection between Medicaid and Welfare. Historically, Medicaid eligibility was always linked to eligibility for welfare assistance under the Aid for Families with Dependent Children. So if you were eligible for welfare, you were automatically eligible for Medicaid.

And as we began to consider the Welfare Reform Authorization in 1996, one of the things that we were faced with was the reality that many, many women stayed on welfare because it was the only way for

them to keep their Medicaid. And Ron alluded to this. It was a linkage that kept women on welfare and it was certainly counter to good public policy.

And so, as part of the Welfare Reform Bill in 1996, Congress moved forward to firmly de-link Medicaid and welfare eligibility. This meant that families no longer had to be on TANF, or cash assistance, in order to be eligible for Medicaid.

But we also realized at that time, in order for the Welfare Reform Authorization Bill to be successful, if we really wanted to get people to be economically independent and move into the workforce, that we couldn't push people into losing, not only their cash assistance -- which many women were going to lose their cash assistance under the new 1996 law -- but we couldn't also at the same time take away their healthcare coverage.

And so, to protect families from having this wholesale removal of all of their support, we enacted new eligibility rules for Medicaid, and Ron alluded to it. I would put it in a somewhat more positive light, which is that we wanted to insure that people who left the welfare rolls were able to continue to keep their Medicaid eligibility.

And the way that we saw -- the best way we saw to do that was to grandfather in the existing standard. To say to those women, if you would have been eligible for Medicaid under the old system, you're going to remain eligible, as are your children.

We also had a very important provision in there which remains in the law, which is this Transitional Medicaid Assistance. This is for people who, going to work, they would normally lose their Medicaid coverage. We provide them with six months to one year of transitional coverage to help them ease their way into the workforce. And then, hopefully what will happen, is that they will get private coverage through their employer.

The new rules are really intended to preserve Medicaid coverage and provide more security for families transitioning from welfare to work. I think the question before us today is whether this system has worked.

Unfortunately, what we see is that more low income parents are working, but many, many workers transitioning to work are losing their coverage. Between 1994 and 2000, the number of all low income parents working increased from 53 percent to 61 percent, which is good, while the number of working single mothers rose by more than a quarter, from 49 percent to 65 percent. But, during that same period, the number of uninsured parents grew, and it rose by a quarter for all parents, and 65 percent for all single mothers.

Parents are especially at risk. Low income parents are significantly more likely to be uninsured than their children. While CHIP, the law enacted in 1997 to provide coverage for children who are slightly above the Medicaid eligibility level, and the CHIP program has made tremendous inroads in providing

coverage for income individual living below 200 percent of poverty, the parents of these children are still left behind.

Parents leaving welfare after one year are most likely to either be covered under Medicaid or to become uninsured. Only one in five leaving the welfare rolls is likely to be covered under private or employer sponsored insurance. And many parents who are eligible for Medicaid remain unenrolled on the program.

Even working at very low wage jobs can make parents ineligible for coverage. In 28 states, a working mother with two children, who makes \$7 an hour will be ineligible for coverage if she works 35 hours or more per week. In Alabama -- I hate to always single out the southern states. In Alabama, earning as little as \$254 per month would make a working parent in a family of three ineligible for Medicaid.

Thanks to support from the Kaiser Family Foundation, we have started to do some research on "What are the Coverage Gaps and Problems Facing Working Women?" And while we haven't released the study yet, I wanted to preview it a little bit for you.

We surveyed 1,200 low wage employers across the nation to learn more about what was happening to workers transitioning from welfare to work, and what these new workers' experiences with private health coverage were. Our findings demonstrate that many, many low wage workers, especially women, face significant barriers to obtaining health coverage when they transition from welfare to work.

Low wage, part time women workers are less likely to be offered coverage in the private insurance market. Overall, low wage employers are less likely to offer health coverage than their higher paying counterparts.

Part time, low wage workers are less likely to be offered coverage. In smaller firms, only one in ten employers offers coverage to these low wage workers who enter the workforce. Women are more likely to work part time, and they're -- and to lose out on access to health insurance because they are part time workers.

Smaller, low wage employers are far less likely to offer health coverage to their workers. Only half of small low wage firms that employ 200 or less employees offer coverage. Women especially are affected by small firms' decisions not to offer coverage. The more women workers a small firm employs, the less likelihood that the firm will offer coverage.

Firms in the sales and service industries, which are disproportionately represented by female employees, are also the least likely to offer coverage. But if you look at the firms -- similar firms of low wage workers who employ men in the manufacturing, in the farming industry, they're much more likely to offer coverage to those low wage workers. And if the health coverage is offered, it often comes with more limits and may be very expensive and out of reach of the average low wage workers.

Low wage firms, particularly small firms, are more likely to contribute less than half of the premium for coverage than firms over all. Low wage workers who enroll in their employer's coverage will have to wait for up to three months and, in some cases, much longer than three months, six months to a year, for their coverage to begin.

Now, just think about that for a minute. You're a woman transitioning off of welfare. You're a new entrant to the workforce. You go into your job, you're new to the job. You can't get the health insurance because there's a waiting period for you.

Without the Transitional Medicaid Assistance to help you through that period, you would be uninsured. And that is why the Transitional Medicaid Assistance is so vitally important to the overall success of the Welfare Bill.

Low wage workers who enroll in their employer's coverage will likely have to wait for up to three months. And this gap in coverage can have very serious health consequences.

So, why is coverage so important? Why do we care about women getting health coverage and children getting health coverage?

People who don't have health coverage often have serious health risks. Those without health coverage are more likely to delay care or be denied when they need it. And we all know that delaying going to the doctor makes your -- whatever illness you have worse and, ultimately, may make you spend more money on your health coverage and less time at work, and more money staying home trying to get better.

A recent Institute of Medicine report found that 18,000 adults die prematurely every year because of medical care delays or denials resulting from lack of insurance. Lack of insurance can also lead to increased health complications and poorer health complications over time. Uninsured women are at the highest risk for not receiving critical preventive services, such as mammograms and pap smears, which puts them at risk for illness and death.

Health risks associated with lack of coverage can really undermine worker productivity. And, after all, that's what's at the heart of the Welfare Reform Bill. We are trying to get people into the workforce, become economically independent. If they're not healthy, they're not gonna be able to work.

These are people who also, when they get sick, often don't have any leave to take from their jobs. They don't have any leave offered to them, paid or unpaid. So, if they get sick, if their child gets sick, they lose their job. That undermines the Welfare Reform Bill and that's why it's so vitally important that we insure that all of these women and their children have the health coverage they need to make them productive workers.

With regard to future initiatives, there are a couple of things that I think are really important, and all of my colleagues, I think we're all in agreement here.

The reauthorization of the Transitional Medical Assistance is a really critical component. There's a five year provision in the Senate passed bill We're thrilled about that and we hope that that will be retained.

We also should provide an increase in federal funding for state Medicaid, to help them in the Federal Matching Assistance Percentage, the FMAP. I'm sure a lot of you have heard about increasing the federal contribution to states' coverage to help them through this economically troubling period.

The state budgets are in crisis. They need help to continue and support Medicaid program at the current eligibility levels. And this should be another key priority this year.

Thank you.

**MR. HOWARD:** Thank you very much, Laurie.

Our clean-up hitter is Paul Offner. Paul's career combines experience in public policy from almost every conceivable vantage point. He ran the D.C. Medicaid Program, he was Deputy Director of the Ohio Department of Human Services. He was the principal Human Services staffer for the Senate Finance Committee and Senator Moynihan, as Ron noted. He was elected to each of the Houses of the Wisconsin Legislature in his own right. I guess that was at separate times, right?

Now, he's a very thoughtful analyst of public policy at Georgetown's Institute for Healthcare Research and Policy, where he's a Research Professor. And we've asked him to share some of his real world experiences with us trying to deliver healthcare coverage to low income families.

Paul, thanks for being with us.

**MR. PAUL OFFNER:** Thank you very much.

I spent a fair amount of time with the Senate Finance Committee and Senator Moynihan, but I think if I can do anything useful on this panel, it is to give you a little bit of the local perspective on all of this, because I am probably the only living human who has actually run two state Medicaid programs and helped guide a third.

I think the important proposition that I want to put before you is that Congress and federal -- people in Washington have had this sort of love-hate relationship with respect to getting poor people onto Medicaid. When I was the Ohio Medicaid Director, the total thrust of federal policy was to make sure that we didn't let people get onto Medicaid who weren't eligible and who didn't belong there. To prevent fraud.

The message that was sent out to state administrators was that you should be careful and not make mistakes. That's also, I might say, been sort of the historic focus on welfare policy.

Then along comes the CHIP program and, all of a sudden, everything changed. You know, everyone loves children. And so all of a sudden now, we're to rush out there and find every kid and, if you don't, you know, there's all sort of criticism about why the states are not more aggressively enrolling all these kids.

This is -- these are the same bureaucracies that were being told a few months earlier that, if they let anybody on the rolls who weren't supposed to be there, there would be bad, bad consequences.

I think it's important for you to understand this because welfare departments, and lets be honest. In most places, it is welfare departments that are doing all this stuff. Welfare departments are not sophisticated places and they're not staffed in general by very sophisticated people.

You have got to make sure that the messages that are sent out there are simple and straight forward, and not enormously complicated. There is nothing more complicated in the free world than Medicaid. That's why we have to have these periodic sessions in big rooms like this and invite all these people. Because Medicaid is so complicated, the eligibility is so tortuous that, unless you spend your full time following it, like Diane Rowland and seven other people, you're never gonna figure it out.

It is really -- and the importance of that is that, here we're now asking local -- in many cases county welfare departments -- to run these programs and to run these programs in a way that will change behavior and it's a mess. It's such a complicated message that goes out there, that there's no way in the world the average -- I mean, put yourself in the shoes of the average poor mother than Laurie was talking about. She is supposed to understand what it is that Congress intended with all this. It ain't gonna happen. No way.

And the reason that's a problem is that we're asking that woman to get her life together, to get organized, to get off welfare. And, you know, it's very difficult for her to do that if she doesn't understand what it is that this -- all these policies are intended to accomplish.

Now, the other point that relates to this is maybe to ask you to put yourself in the shoes of local administrators. Local administrators, of which whom I was one for quite awhile. The thing you dread as a local welfare administrator -- I was at the state level and most of them are at the county level -- but the thing you dread is to wake up in the morning and to read in the newspaper that there are 2,000 people on Medicaid in your state who are -- who don't belong there, or who are ineligible. And there are plenty of people who have lost their jobs because of that kind of headline. And again, this gets back to this problem of mixed message.

Now, when I was involved -- I was running the sort of healthcare finance in the district when CHIP came along. In the District now, and I don't think we're by any means unique, the District has a two-page application form for the Child Health Insurance Program. And you can pick up applications at your corner drug store. You never have to go anywhere near the vaunted welfare department. You fill out this little form, you attach a stamp to it, and you send it in the mail and you're eligible. I mean, that's what we can do when we're serious about trying to enroll people.

Meanwhile, in more than half the states today, if you're a mother of one of these CHIP kids, when I'm - let's say in Ohio, we had a 37-page form which asked every detail -- I mean, excruciating information about everything you owned, information that I imagine most of us would not want to divulge to a close friend, if we have any.

So the point I'm trying to make is that we have this totally disparate treatment. And if we really want to use Medicaid as a vehicle to buttress welfare reform and to help these low income women understand that if they get a job they're not gonna lose their health insurance, we've gotta change the whole way we look at this. We've gotta make it easy for local, small, unsophisticated local bureaucracies to find these people and to encourage them to sign up. And, in most places today, we are now doing that.

One sort of parallel thing that I would just add to this point about the state bureaucracies. You know, I think there's an attitude in too much of Washington that, if we don't write these rules very tightly and constrain everything these state and local officials can do, they're gonna let everybody and his brother on the rolls and there'll be all sorts of fraud and all sorts of ineligibles will be on the rolls.

It is -- I don't know how many of you have worked in a state or local bureaucracy, but it is -- it is really dreaming. My experience, and I've worked both at the federal level and at the state level, the state people are a whole lot more concerned about wasting money and letting ineligible people on the rolls than federal people.

I don't know if any of you have noticed. If you read the newspaper, states are about to go through a hell of a fiscal crunch. The District of Columbia in the next three or four months is gonna have furloughs I predict -- it was in the paper this morning -- because income tax revenues are down. I mean, we're under the gun fiscally in a way that the federal government never is.

And the notion that the states -- I mean, states after all pay for a good chunk of Medicaid. And the notion that we have to have all these controls at the federal level or the states will let everybody on is, I think, a myth.

A second problem is this notion that again is reflected in the Medicaid statute which -- it has been for many years -- kids are good, adults are bad. It is absolutely incredible how quickly everybody in Washington, you know, went with the notion that covering all these children was a terrific idea. The CHIPS program became the closest thing to "motherhood and apple pie." But to cover those poor kids' mother is somehow regarded as a radical proposition.

Now, you know, in the District of Columbia, and I guess we're not necessarily typical, but certainly this is typical of African-American families. The average family, more than half the Black kids in the United States today are living in a family headed by a single adult.

Now, we're apparently concerned about the healthcare of those kids, but we're not concerned about the healthcare of the adult. What happens to those kids if the health of that adult is compromised? It

makes no sense. And yet that is sort of philosophically the attitude I think that has dominated in Washington for too long.

I -- just another aspect of this is that -- and this was more true about ten years ago than it is today. But in the average family, when I was running the welfare system in Ohio, in the average family, let's say you have a mother, maybe a couple of children. One of the children maybe is disabled. Maybe the grandmother is in the house, too. You literally would have a different eligibility level for every single member of the family.

Again, the notion that poor people, poor family -- or any family could follow that is -- it blows your mind. There -- it's so complicated that it's impossible to follow. We ought to try to make this program simpler so that local bureaucracies can implement it, and so local welfare families can understand it.

My final point. As we get closer to, you know, half of the welfare case load, as you know, has now left the rolls because of welfare problems. As we -- we're getting now to harder and harder cases. And it is more and more important that we have a reliable, straight-forward, explainable healthcare policy for people on welfare. In other words, welfare insurance that seems to me is now gonna become more important if we want to get these more difficult cases to go to work, to get off welfare. So the discussion I think we're having here is enormously timely.

Thank you.

**MR. HOWARD:** Thank you very much, Paul.

Once again, fill out those green question cards if you have something or, more to the point, if you want to go to the microphone, you can be sure that your question will be asked. We have some of you who have submitted these questions in advance, and we'll start with one of those while you're getting yourselves organized. Just hold up those green cards when you fill them out and somebody from the staff will pick them up.

Ron, this one is directed to you. It's sort of a chance to respond to Laurie who said, "I'm sure everybody on the panel will agree with this."

The Administration had proposed Transitional Medical Assistance be extended for one year, which is the -- I gather what the House version of the bill would do. The Senate Finance Committee has, in its version of the bill, extended it for five years, which is the same length as the TANF extension.

Do you want to talk about the rationale behind the Administration's position? Or whether it's adjusted?

**MR. HASKINS:** Let me begin by talking about the rationale behind the Finance Committee provision, and that is, if you don't have to finance it, you can finance it -- you can approve it for a decade or a century.

Everything in the President's Welfare Reform Bill was financed and as -- there's a, I think -- was the Ku paper in your background material? Leighton Ku?

**MR. HOWARD:** Yes.

**MR. HASKINS:** Anyway, there's a paper by Leighton Ku. I guess it is in your background material. If you read that, there is just, I think, no question that there's vast bipartisan agreement, including the Administration, that Transitional Medicaid Assistance will never last.

It will be funded, whether it's on a year to year basis, or five years at a time, or ten years at a time. But if you're trying to do a budget in a responsible way, you'd have to finance every single part of your program, and that is -- in fact, Ku said this in the paper that's in your materials, that the main consideration is a budget consideration.

And that was a consideration the Finance Committee didn't have to worry about because the Senate doesn't have a budget and, you know, their total spending on their bill is probably \$12 billion over 5 years. And the House bill, which is financed because the House has a budget, is \$1 billion over 5 years. But, the bottom line here is, in our lifetime, Transitional Medicaid Assistance is not gonna expire.

**MR. OFFNER:** The question of whether it's one year or two --.

**MR. HOWARD:** -- Paul --.

**MR. OFFNER:** -- Years.

**MR. HOWARD:** Or five or whatever.

**MR. OFFNER:** No, I meant the important question, or one important question is whether we're gonna provide Transitional Medicaid for one year or two years. I mean, it's the same issue of how much is it gonna cost, but that's an important policy question that is not automatically answered.

**MR. HOWARD:** Let me clarify -- go ahead.

**MR. HASKINS:** Can I expand it just a little bit? That I think there are at least four -- someone may want to add to this -- but there are several issues, and we all suggested them one way or another, especially Diane, about Transitional Medicaid Assistance.

First of all, this requirement that you have to have been on welfare three of the previous six months is clearly a problem. Especially since a lot of states have what are called diversion programs and they try to get people off welfare before they ever come on.

In a lot of states -- in fact, I believe virtually every state has a program where they try to get people off. It's called "Work First Right Away." And they are successful in getting people off welfare who sometimes have been on a month or two. And they also would not qualify.

So that -- I mean, this is an issue that you need to look at. It would cost more if you did away with that criteria so there's gonna be -- CBO has not computed a cost for it, because I called them this morning and asked them. But there would be a cost associated with it.

Secondly, the -- to remain eligible for the full one year of coverage for the mother, the mother has to report income at three, seven and ten months I believe. Well, that is really -- that fits right into Paul's presentation. Because when you ask people to report their income, it's often very difficult for them to do it. And we don't always make it real easy for them to report the income either.

And then Paul's issue, of course, which is whether the one year of coverage for the mother is enough, maybe it should be two years of coverage for the mother.

And I would add an unpleasant thought to this, and I hope someone tells me I'm wrong about this and there's good research. But it seems to me to pop up again and again and again that, if a mother is covered, then the kids are more likely to be covered. If the mother is not covered, then the kids are less likely to be covered. So, if you want to cover the kids, cover the mother. I mean, that's maybe not a very generous interpretation of maternal motivation, but there you have it.

And so those are -- I think those are big questions. They all would impose additional expenses on the system. And if we get to a final negotiation in Welfare Reform, these will be up for grabs, and I think that one or more of them will be included in the final bill.

**MR. HOWARD:** Laurie?

**MS. RUBINER:** I guess I would just -- I would respond to Ron by just saying that I don't think it's so much a question of financing as it is a question of priorities. I don't want to get too into the weeds too much, but I do think that, if the five year reauthorization were a priority for the Administration or for the House Republicans, they would put it in there.

It's hard for me to understand how you can put a -- how you can reauthorize a five-year welfare program, acknowledge that Transitional Medicaid Assistance is critical to the success of women transitioning off of welfare, yet not guarantee that that Transitional Medicaid Assistance benefit will be there.

And I firmly believe that, if the Administration were committed to it, they would put it in there. And it's not a question of financing, it's a question of what the Administration's priorities are.

**MR. HOWARD:** Okay.

Yeah, go ahead, Diane.

**MS. ROWLAND:** I also think it's important, when you think about this from a health perspective instead of from a welfare perspective, that if Medicaid were broadened to extend coverage to the parents of the Waxman kids that Ron talked about earlier, then you wouldn't need some of the kind of Transitional Medical Assistance provisions we're talking about today, because they would automatically be eligible as the children are today.

And one of the reasons you see that the children are less likely to be uninsured as a result of welfare reform, is that the broader coverage under Medicaid is available. So what we're really talking about here is the gap in what Medicaid is able to do today in most states for coverage of working parents. And raising those levels is another way of getting at providing the support that working parents need, in addition to TMA.

**MR. HOWARD:** Yes. You want to identify yourself?

**MR. RYAN COOPER:** Yeah, my name's Ryan Cooper (sp). I'm with the Men's Health Network. My question's actually for Dr. Haskins. As was pointed out numerous times, men are less likely than women to have health insurance and to qualify for Medicaid because they're considered a family of one. Men who do not live with their children do not qualify for benefits available to many residential parents, even though they're financial responsible for the children.

Now, my question is, will the Administration extend to non-residential fathers the same medical benefits that will be available to residential mothers, and would it do so using a formula that is based on the size of the father's biological family?

**MR. HASKINS:** The -- I think the answer's no. The inequity here is much less than you might think. If the father were the custodial parent, then the father, too, would have the same coverages that mothers now have. It's not that it's a mother or father, it's that it's the custodial parent that gets the coverage.

The second thing is that single women who live alone also don't have coverages, the same way that men do not have coverages.

And the third point is that I think -- normally, when we make big policy switches in Washington, there's a gradual period of a growing support for the idea. And the idea that we would support single males or single females with health coverage, working age males and females, I think is something that has not even made small steps here in Washington. So I would say it's very unlikely that, in the foreseeable future, that there would be coverages of the type you mentioned.

**MR. OFFNER:** Can I just make one --?

**MR. HOWARD:** -- Paul?

**MR. OFFNER:** I mean, it seems to me one thing we maybe ought to think about though, Ron, is saying that non-custodial parents, particularly fathers who are up to date and are paying their child support maybe ought to be eligible for coverage. I mean, I'm just saying that that seems to me to be a direction that's consistent with everything we've done with encouraging child support enforcement and -

**MR. HASKINS:** But I think the con argument is that men that are meeting their financial responsibilities, therefore, do not necessarily qualify for some additional federal benefit.

But I would say this. As you well know, there is a -- I think we're in the -- where'd that gentleman go. There he is, okay.

I think in the last -- I'm gonna say five years, it might be four, it might be six. But there has been increasing concern among policy makers for fathers in general. And recognition of the importance of the role of fathers in two parent families, and the recognition of the potential importance of fathers in single parents families. And not just to pay child support, but their contribution to children's development.

And we've had several pieces of legislation that have actually passed the House that would've established programs to encourage fathers in these roles that I just mentioned.

So I do think there's the beginning of a reconsideration and, as that grows, the kind of policy that Paul mentions, of course, that would be one of the things on the table. But I still think we're a long ways from it.

**MR. HOWARD:** We've got a question, maybe Laurie is an appropriate person to direct it to, but anyone who feels the need and the feeling can jump in.

Does anyone on the panel -- the Alliance doesn't take positions. I'm not sure if the Kaiser Family Foundation or the Commission takes these kinds of positions -- support any specific proposals that might help low wage firms?

And I know, Laurie, you were talking about -- that is to say, help them offer healthcare coverage. And you were talking about the survey in your presentation that you're involved in. Do you have some suggestions from that or from your other experience?

**MS. RUBINER:** Well, one of the things that we spent a lot of time on in our survey work with the Kaiser Foundation was what kinds of things could we do to reach -- because we have such a problem with people being eligible for Medicaid but not enrolled -- are there ways to get to these individuals through their employers. And, in fact, that was the original purpose of this research was to talk to the employers about whether or not they would be interested in helping reach their low wage employees.

It makes perfect sense because, when you start a job, you -- most people have their -- this is a country that has an employer sponsored healthcare system and so you -- when you start your first day on your job, you get all your healthcare forms and whatever your retirement benefits are and so forth.

And so it makes sense that, at the same time, if it's an employer who has a disproportionate number of low wage workers, that maybe that would be a time at which you would also provide your individuals with applications for Medicaid and CHIP for their children.

And it was something that we tested out in this survey and got a very good response from employers who were very interested in trying to find ways to help their employees get this coverage.

And so we fully plan to continue to pursue this once we get the research finalized, and figure out ways that we can work closely with these employers. Clearly, you have to have different strategies, depending on the size of the firm and the kinds of resources that they have available in terms of their accounting departments and so forth.

But there are many, many things that we can do, not only handing out the forms, but there are ways in which employers can help their employees fill out the forms or provide the kinds of information that, you know, if it is a 37-page application, some of the financial information that those employees would need. Help them with the reporting that they're required to do every month about their income, to make sure that they remain eligible for the program. So, that's something that we think has tremendous promise.

**MR. HOWARD:** And I should point out, in your materials, one of the pieces Laurie has made available is this "Helping Your New Workers Access Healthcare" piece that covers what she has been saying in somewhat more detail.

I've got a question for Ron Haskins. It has to do with the question of whether legal immigrants will be eligible for Medicaid. It asks about the Bush Administration's position and whether there's some intellectual or analytical support for that position, whatever it is, and whether, in the absence of that, you might get him to change it.

**MR. HASKINS:** The policy of the United States government since colonial times, even before we had a United States government, the policy in Massachusetts and many colonies. And the first time Congress passed legislation in the 1870s, reinforced on several such occasions, is that non-citizens who come to the United States not only are not eligible for welfare, but if they become dependent on welfare, they're subject to deportation.

Somehow, in the 1960s, in our -- as we became enamored with welfare in this country, we extended welfare to every, you know, all kinds of new groups of people. And non-citizens began to qualify for benefits. And by the time the 1995 Welfare Reform debate opened, Census Bureau data showed that household that had non-citizens were more likely to receive a welfare benefit than households composed exclusively of citizens.

So House Republicans, with some support from Senate Republicans, adopted the policy that we should go back to our traditional policy, which is people do not get welfare until they become citizens. Once they become a citizen, they're eligible for welfare just like everybody else.

Now, President Bush made a modest exception to this policy in his budget, and that was the basic policy the Republicans enacted in '96 was a five-year ban on welfare benefits, except in emergency conditions. And the Bush Administration amended that policy somewhat in that food stamps and SSI, which are 100 percent federal, the ban continued forever.

And President Bush proposed that we end the ban after five years for food stamps so that, once non-citizens had been in the United States for five years, they would become eligible for food stamps.

That now is law. It was passed as part of the Farm Bill. It cost about \$1 billion over five years.

At the moment, the Bush Administration does not support further expansions of coverages for non-citizens. So the answer to the question is, no, the Administration does not support it, primarily for historical reasons.

**MR. HOWARD:** And including the idea of giving the states the option.

**MR. HASKINS:** Yes, including not giving states the option.

**MR. HOWARD:** Okay. Laurie?

**MS. RUBINER:** I feel like I'm having a walk down memory lane with Ron, because I remember debating this issue back in 1996, when we were reforming the welfare system.

And I understand where the Administration is coming from, but I think you need to understand that many, many of these immigrants who are in the country, though they may not be citizens, they're working and paying taxes. And I believe that they are -- if they get sick or their children get sick, or they lose their jobs, these are people who could have lived here for many, many years and are paying taxes. They may not be citizens, but for all intents and purposes, they are contributing to the United States in the same way that we are. They can be drafted, there's all kinds of things that we can do.

So, the idea that, number one, to consider -- the idea that we talk about Medicaid and healthcare assistance as "welfare," I think is really a misnomer. I think it's a very fundamental need that people have and we should stop putting it in the same context as cash assistance. I think we need to separate out the two.

And so I think it's unfortunate that the Administration has not changed its position on the legal immigrant provision.

**MR. HOWARD:** Diane, you want to --.

**MS. ROWLAND:** This is for Mr. Offner. Could you please elaborate on what you mean propose for simplifying, eliminating the bureaucracy of Medicaid?

**MR. OFFNER:** Well, I mean I think that the -- right now, for the CHIP program, the CHIP program really ought to be the model, you know. It's -- the point I was trying to make is it's as if we've created two ways for people to get onto Medicaid in this country. One is if you're in the CHIP program where -- I mean, the model -- it really, it's so simple.

I mean, you never have to go and sit down with a welfare worker. You can do it all in the mail. It's a two-page form that requires that you simply identify who you are, where you live and how much you made last month versus what we do for everybody else, which is, you know, the metaphor of the Ohio's 37-page form, where you have to divulge everything you own in the world and all of that.

And so it seems to me that the better model is the CHIP model, that states ought to have the flexibility to not ask all these questions about whether you own a sofa or three suits, and how much the three suits are worth. That way, we would make the eligibility process a lot simpler and that would contribute to the message.

The message it seems to me that we want right now on the streets is that, if you're on welfare and you get a job, we're gonna let you keep -- we're gonna make sure that your health insurance is still there. That's the message that we ought to send. Not, if you're on welfare and you get a job, we're gonna put you through some horrendous -- well, in many states, of course, you will lose your health insurance, as has been pointed out, and you will go through this process, which you wouldn't want your worst enemy to have to go through, to determine their eligibility.

**MS. RUBINER:** I just wanted to add to that, which is, when we were doing our research with Kaiser, we did a 1,200 person survey, but we also did some focus groups with employers. And one of the key memories I have is we showed the -- they were all very interested in helping their employees fill out the forms and provide them with the financial information.

And then we showed them the form. And when they looked at the form, they said, "Whoa! Wait a minute! I don't want to have to ask my employees how much jewelry they have." Or, as Paul said, whether their sofa is two years old or three years old.

But when we showed them the simplified form, they were perfectly happy and interested in helping their employees access that health benefit. So I think that underscores how important it is to simplify these forms to make it easier for people to fill them out.

**MS. ROWLAND:** I think, however, that the key point here is that they have the flexibility now to simplify these forms if they want to. But, when Paul talked earlier about mixed incentives in the program, when you have a fiscal crisis and you want to restrain who becomes eligible, then re-instituting these very informal but formidable barriers, such as requiring extensive documentation and paperwork,

and turning someone down when they apply if they're missing one piece of paper becomes a way of limiting your rolls.

And we have a question here asking, "What do you think states will do in this fiscal crisis?" And I think one of the things we need to watch for is -- are the progressive steps that have been taken to both simply eligibility first for children, and then if that could be extended to their parents, being rolled back so that the rolls will stay smaller. And that's the real challenge that I think we're gonna face over the next year.

We're talking here about the importance of extending health coverage and how going to work may be getting harder in the softening of the economy. And going to work with insurance is probably getting even harder. And, at the same time, keeping Medicaid enrollments up is gonna be harder as well, because of the state fiscal situation.

**MR. HOWARD:** This question that just got handed to me actually is a pretty good one. I'm gonna make use of it immediately.

"Are there currently programs available to assist families eligible for CHIP to help with employer based insurance premium payments?" The child is eligible. Could a program help pay for it. Private insurance that are offered under an employer plan.

Anybody? Laurie?

**MS. RUBINER:** Do you know the answer to that, Diane? I'm not sure (inaudible).

**MS. ROWLAND:** Well, there are programs that are being set up now to allow for some buy-in of private insurance, but there's no program that I know of that directly supports employer based insurance, although that's being talked about directly.

**MR. OFFNER:** It's the state, an option, right? I mean, states could do that.

**MR. HOWARD:** It's pretty complicated because they have to show some sort of revenue neutrality, so it's tough.

Is there someone in the audience who would like to contest that?

**MR. OFFNER:** Better not be.

**MS. ROWLAND:** If states do face a financial crisis and must make cutbacks in their Medicaid program, which cuts would you find least destructive of the policy objectives shared by the panel?

**MS. RUBINER:** (Inaudible) think that through.

**MS. ROWLAND:** We can start with Paul.

**MR. HASKINS:** Well, obviously, the answer is that states should cut their defense spending.

**MS. RUBINER:** Their Homeland Security budget. Do you want to start?

**MR. OFFNER:** Well, I don't know the answer to this questions. I think it's gonna be harder for states to cut this than may first appear to be the case.

I -- my own sort of simple answer to this would be, you know, there are more essential benefits in Medicaid and less essential benefits. And, you know, in sort of an ideal world, you would probably say, well, if you have to cut 10 percent, I would -- you know, at least on a temporary basis, if they cut out sort of less critical benefits in the assortment of the benefits approach people are eligible, I would -- that would be the better way to go, rather than lopping people off the rolls completely by reducing eligibility.

But, I'm not sure -- I'm not sure either of those are gonna happen. And so I really don't know -- I don't know if we have an experience with this. Do we?

**MS. ROWLAND:** Well, the usual history is that the first place a state turns is to reducing provider payments and to reducing what's paid for services since those tend to be the easier to implement cuts.

I think we're going to see a great deal of attention to the pharmacy benefit under Medicaid. And so what's happening to pharmacy costs, into putting new restrictions on, which pharmaceutical agents will be paid for and how to access and get them.

Those tend to affect more the elderly and disabled on the Medicaid program than children and families. I think we're also begin to see some rollbacks in eligibility expansion, some reinstatement of reporting requirements, and other obstacles that keep people from staying on the program. And that all of those things are out there. I think the goal, though, is to maintain coverage whenever we can.

**MS. RUBINER:** I mean, there's no easy choices. I think one of the things that we forget about is that Medicaid covers an array of people. It covers the -- it not only covers women and children, but it also covers the elderly, the disabled, and many, many people in nursing homes. And while there are -- while single parents and children are -- there are more of them on the Medicaid program, they also represent much less a defending. It's obviously much more expensive to keep somebody in a nursing home than it is to provide coverage for a child's regular medical care cost.

And I think the unfortunate thing about the state budget crises, and the priorities that our current Administration has established, is it does pit some of us, each of the interest groups, against one another. And that's a really unfortunate occurrence, because the way that we keep the Medicaid program strong is to -- is for all of the populations to work together to keep the Medicaid program in place.

And every time we have some of these policies that want to cut back on the Medicaid program, it forces all of the different interest groups to sort of pit themselves against one another.

**MR. HOWARD:** I don't see anybody standing at any of the microphones. If any of the panelists would like to get in a final word, you can take the opportunity now. Otherwise, I think we're going to give you an early recess to start your weekend sooner and finish the rest of your lunch outside I guess.

I want to ask you to join me in thanking our panel for what I think has been a very useful discussion.

We reiterate our thanks to the Kaiser Commission for its support and co-sponsorship. Remember to watch it on [Kaisernetwork.org](http://Kaisernetwork.org), and listen to it on [AllHealth.org](http://AllHealth.org).

And those of you who follow these issues will be interested and you should mark down on your calendars July 12th, the Alliance will be holding a briefing in an as yet undetermined space to talk about early childhood development and healthcare availability that will build on some work done by Sara Rosenbaum at the George Washington University.

Please fill out your blue evaluation forms before you leave, and thank you very much for attending!

END

© Federal Network, Inc.

[www.FedNet.net](http://www.FedNet.net)

202-393-7300