kaiser commission on medicaid and the uninsured

Can Medicaid Work for Low-Income Working Families?

Overview

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The Henry J. Kaiser Family Foundation

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The Kaiser Commission on Medicaid and the Uninsured serves as a policy institute and forum for analyzing health care coverage and access for the low-income population and assessing options for reform. The Commission, begun in 1991, strives to bring increased public awareness and expanded analytic effort to the policy debate over health coverage and access, with a special focus on Medicaid and the uninsured. The Commission is a major initiative of The Henry J. Kaiser Family Foundation and is based at the Foundation's Washington, D.C. office.

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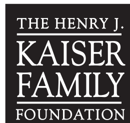

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Both the state officials we interviewed as well as senior staff at The Kaiser Family Foundation reviewed this report. Their comments were helpful and the report benefited greatly from their review. The opinions expressed in this report belong solely to the authors, however, and we are also responsible for any errors or omissions.

Finally, the challenges of collecting information accurately and consistently from the 50 states and the District of Columbia about a program as complex as Medicaid are substantial. We worked hard to ensure the accuracy and completeness of the information presented but have no doubt that a few errors persist nonetheless– we hope that these are minor. It is important to note, however, that the information presented here is accurate as of June 2001. The economic recession in summer and fall of 2001 and consequences of the September 11 events have had adverse effects on many state budgets, and these states are considering cuts in their Medicaid programs, among other strategies, to address their budget shortfalls. As this report is released in April 2002, it is likely that some states may have already changed elements of their Medicaid programs, therefore, this caveat should be considered when reading our report.

Overview

Introduction

In the wake of the 1996 federal welfare reform law and the delinking of cash assistance and Medicaid, states now have the flexibility to make Medicaid more available to low-income working families. The Personal Responsibility and Work Opportunities Reconciliation Act of 1996 (PRWORA) created a new Medicaid eligibility category for family-based coverage independent of eligibility for cash -- Section 1931 Medicaid. The flexibility inherent in the provisions of this new eligibility category allows states to think creatively about Medicaid as a stand-alone health insurance program for low-income working families.

Two-thirds of the 42 million uninsured Americans are in low-income working households with incomes less than 200 percent of the federal poverty level; over one-third of the uninsured come from families living below 100 percent of the federal poverty level. For a family of three in 2001, 200 percent of poverty represents an annual income of less than $30,000 while 100 percent of poverty represents as annual income of less than $15,000. Low-income working families are at the greatest risk of being uninsured because their incomes are generally too high to qualify for Medicaid, but they also often lack access to affordable coverage through their workplaces.

The primary goal of this project is to present a more complete picture of states' efforts to address the health insurance needs of low-income working families by improving access to their Medicaid programs. Although states now have broad authority to expand eligibility for low-income working families and redesign the application process for these families, many contextual factors influence state decisions about their efforts in this arena. The study was designed to describe the states' Section 1931 Medicaid eligibility criteria as of June 2001, highlight variations among states, and understand why certain states were able to accomplish expansions and why other states did not. Presentation of the findings is designed to inform all state efforts to provide improved health insurance coverage to low-income working families.

Policy Context

Expanding Medicaid coverage for low-income working families is an important post-welfare reform strategy

The critical importance of health insurance for accessing health care services and for maintaining employment is widely agreed upon. Simply put, health insurance matters for the millions of parents in low-income working families: insurance status influences when and whether families get necessary medical care, the financial burdens they face in obtaining care, and their health status. Moreover, emerging evidence suggests that insuring parents is the best way to ensure that children are insured.[1] Expanding coverage to millions of families without health insurance is an important policy and health objective.

One of the most immediate and potentially effective means of broadening coverage for low-income families is to build on current public programs, particularly because the private insurance market often has not worked as a mechanism for insuring a significant portion of the

[1] Leighton Ku and Matthew Broaddus, "The Importance of Family-Based Insurance Expansions: New Research Findings about State Health Reforms," Center on Budget and Policy Priorities, September 2000.

low-income population. Medicaid, which by design provides health insurance coverage for low-income families, represents a viable option for expanding coverage for this population. However, recent expansions in Medicaid and SCHIP coverage have largely focused on covering children to the exclusion of covering their parents.

The compelling Medicaid policy challenge then for state officials post-welfare reform is whether and how Medicaid can provide low-income working families with access to the health insurance essential to their success and well being. To accommodate Medicaid applicants with earned income and to avoid disqualifying families participating in work shortly after their enrollment in Medicaid, states need to expand eligibility for working families. States must also consider whether their Medicaid programs are designed to be accessible for low-income families that increasingly have earned income and spend little or no time receiving cash assistance.

New Medicaid eligibility category offers states broad flexibility to cover low-income working families

When it eliminated the automatic eligibility link between cash welfare and Medicaid for families, Congress replaced it with the new Section 1931 Medicaid eligibility category. States must establish a Section 1931 eligibility category that complies with the following four parameters: (1) at a minimum, states must provide Medicaid to families who meet a state's July 16, 1996 AFDC income, resource, and family composition rules; (2) states can reduce the income standards they use under Section 1931 as long as they do not reduce them below May 1988 AFDC levels; (3) states can increase the income and resource standards they use under Section 1931 to keep pace with inflation, as measured by the CPI; and (4) states can use less restrictive income and resource methodologies when evaluating financial eligibility under Section 1931. The Section 1931 option to use less restrictive (i.e., more liberal) methodologies gives states substantial flexibility to expand Medicaid eligibility for working families who otherwise might be rendered ineligible due to the low income standards used by states under their old AFDC programs. States can use this flexibility to adopt broad-based expansions that extend Medicaid to a significant number of low-income working families, or to adopt more targeted strategies aimed at improving or extending the coverage available to families when the first secure a job or otherwise increasing their earnings.

For example, the availability of the less restrictive methodologies under Section 1931 means that states can choose to disregard (i.e., deduct or not count) some or all of a family's income and assets (or certain kinds of income or assets) when determining financial eligibility for Medicaid. Strategies to expand Medicaid eligibility for low-income working families using less restrictive methodologies include: (1) adopting more generous income disregards that have the effect of raising the income standard for family Medicaid coverage (2) eliminating the gross income test; (3) disregarding entirely the first three months of earned income; (4) disregarding a higher percentage of earnings for longer periods; (5) extending transitional Medicaid assistance by extending the availability and duration of earned income disregards; (6) treating lump sum payments as income or an asset that is disregarded; and (7) eliminating the asset test.

The foregoing options are not listed in a particular order of importance because the most effective approaches to improving Medicaid access for low-income working families will be accomplished by implementing a combination of options tailored to achieve certain results responsive to each state context. The provisions of Section 1931 give states the authority to engage in the deliberate recalibration of their Medicaid eligibility rules necessary to promote access to Medicaid for low-income working families.

Improved enrollment and retention procedures can Medicaid eligibility expansions for families more meaningful

The impact of policies to expand Medicaid eligibility for families will be strengthened and maximized by aggressive outreach strategies and simplified enrollment and retention/redetermination procedures. Concerted campaigns to simplify enrollment procedures for children applying for SCHIP and Medicaid for children have highlighted the range of strategies available to states to establish enrollment and retention procedures that complement expanded eligibility for families including: (1) eliminating the face-to-face interview requirement, (2) accepting mail-in applications; (3) reducing the complexity of the application form; and (4) simplifying verification requirements. To the extent that states expand eligibility for low-income families, enhanced access to Medicaid won't necessarily result unless families are given meaningful opportunities to apply. On the other hand, states that have not been able to adopt more generous eligibility criteria for Medicaid can still improve participation in their Medicaid programs by already-eligible low-income families by simplifying enrollment and retention procedures. States can use outreach efforts to promote the availability of Medicaid independent of cash assistance, monitor the quality of their Medicaid enrollment procedures, and establish opportunities for families to apply for coverage outside of welfare offices.

In practice, the options available to a working family to apply for Medicaid are a function of a state's formal application policies and procedures, as well as of the status of the state's efforts to implement these policies and procedures. For example, a state's decision to allow families to apply for coverage via mail without a face-to-face interview should certainly ease the process of applying. However, other dynamics also can contribute to what families actually experience when they apply (e.g., how easy it is to get an application for mail in, how easy it is to complete the mail in application without assistance, and/or how widely is it known that families need not go to a welfare office to apply for Medicaid coverage). Consequently, the information that we collected concerning simplified applications provides just a partial picture of how easy it might be for families to apply for 1931 Medicaid.

Methods

During summer and fall 2000, we contacted senior Medicaid officials in all 50 states and the District of Columbia to participate in a 60-minute telephone interview using a structured interview guide. All states participated in the interview. The interview guide covered the following topics: activities to coordinate Medicaid with TANF and promote enrollment in Medicaid; climate in state to use Medicaid to support the transition to work; best practices with respect to eligibility expansions and simplified enrollment and retention policies and procedures; and lessons learned/next steps. We also collected and reviewed state materials and secondary data sources, conducted follow-up interviews with state officials during winter and spring 2001, and consulted with other researchers in the field. The information presented is generally accurate as of June 2001. Where state information is more current, this is noted on the state fact sheet.

Principal Findings

We found that many states have taken steps to improve their Medicaid coverage of low-income families using the flexibility accorded to them in designing their Section 1931 eligibility

categories. While these findings are reported in greater detail in the Guide to State Fact Sheets, it is notable that with respect to their Section 1931 eligibility categories:

- 39 states have increased their earned income disregards, expanding eligibility for working families;
- 21 states have eliminated their gross income test;
- 18 states have used their earned income disregards or other policies to promote access to transitional Medicaid assistance by eliminating the effect of the '3 out of 6 month' rule and/or extending transitional coverage;
- 42 states have opted to extend Medicaid to two-parent families on the same terms as single-parent families by eliminating the '100 hour' rule;
- 16 states have eliminated their asset test; and
- 18 of the 35 states retaining their asset test disregard the value of one automobile/vehicle entirely.

Although a substantial number of states have increased their earnings disregards and thereby expanded Medicaid eligibility for families, it is also notable that Medicaid eligibility levels still remain relatively low in most states, including for working families. [2]

- In 14 states, a working family of three must have earnings below 50% FPL to be found eligible for coverage, in 16 states such a family must have earnings between 50% and 74% FPL, and in nine states it must have earnings between 75% and less than 100% FPL. Families can have income equal to or greater 100% FPL and be eligible for Medicaid in just 12 states.

Once enrolled in Medicaid, families often face a somewhat different set of eligibility rules because several states offer more generous earnings disregards for a limited period (i.e., usually four months) to families already enrolled in Medicaid. Nevertheless, the longer-term outcome is the same:

- In 14 states a working family of three enrolled in Medicaid must have earnings below 50% FPL to remain eligible for regular Medicaid coverage, in 17 states such a family must earn between 50% and 74% FPL, and in seven states it must earn between 75% and less than 100% FPL. Families can have income equal to or greater 100% FPL and remain eligible for Medicaid in just 13 states.

Structured interviews with officials also yielded qualitative information about states' willingness, ability, and capacity to expand and restructure their Medicaid programs to cover more families under Section 1931. Notable highlights from these findings include:

- *Lack of understanding led to initial difficulties in implementing Section 1931.* Understanding the provisions of Section 1931 Medicaid, and the potential for using these provisions to expand coverage for low-income working families or to account for the effects of welfare to work strategies was initially difficult for a majority of states. Many states did not comply immediately with the requirement to establish a separate eligibility category for 1931 Medicaid, and so maintained a two-tiered eligibility for TANF/Medicaid recipients and Medicaid-only recipients.

[2] It should be noted that some states have opted to expand coverage for low-income working families under Medicaid and SCHIP waivers, rather than under their Section 1931 eligibility categories. Although the findings on states' eligibility rules presented here refer exclusively to states' Section 1931 categories, the state fact sheets that accompany this overview describe whenever a state has opted to expand coverage for families via a waiver.

- *Focus on the mechanics of delinking distracted states from making conceptual shift.* State officials were frequently more focused on the mechanics of delinking for TANF recipients (i.e., making sure that TANF recipients continue to be eligible for Medicaid) than on the implications for non-TANF recipients (i.e., making sure that families not applying for or receiving TANF are gaining access to Medicaid). States have been slow to make the policy shift to seeing Medicaid as a stand-alone health insurance program for families instead of a benefit for families receiving cash.

- *Preexisting AFDC demonstrations impacted structure of Section 1931.* More than 40 states had AFDC demonstration programs in place when TANF was established, and the provisions of these demonstration programs had a substantial effect on the structure of 1931 Medicaid eligibility rules. This dynamic usually meant that more generous/expansive AFDC demonstrations resulted in more generous 1931 Medicaid eligibility rules.

- *States faced significant challenges updating computer systems to account for Section 1931 changes.* Antiquated automated eligibility and management information systems have frequently delayed or confounded state efforts to establish new and expansive rules and procedures for determining eligibility for Medicaid.

- *Mixed messages about TANF and Medicaid made Medicaid expansions more difficult.* Eligibility workers often faced conflicting messages about Medicaid and TANF. States focused their efforts on reducing TANF cases while also promoting Medicaid enrollment. Changing the culture in public benefits offices has been a frequent challenge.

- *Although most states' efforts to expand coverage initially focused on children, attention is turning toward families.* In many states, Medicaid officials initially focused on expanding coverage and improving enrollment for children, and did not consider expanding or improving access for their parents. But, a growing awareness of the importance of covering the entire family (i.e., parents and children) is now evident in many states.

Conclusion

Medicaid can work for low-income working Families – state fact sheets show how

By separating the eligibility criteria for cash assistance and Medicaid, the 1996 federal welfare reform law gave states new flexibility to expand Medicaid coverage to more low-income working families. The potential for 'Medicaid to work for low-income working families' by addressing these families' need for accessible health insurance is evident in the foregoing findings. The state fact sheets that comprise the main portion of this book provide salient details about each state's efforts to make 'Medicaid work for low-income working families' in a standardized format. Reviewing these fact sheets facilitates a substantive assessment of what is possible for states to accomplish with respect to Medicaid eligibility and family-based coverage. We found that many states have taken advantage of their authority under Section 1931, as well as under other policy options, to expand health insurance coverage to more families, in recognition of the importance of insuring parents as well as children, and to help families retain Medicaid coverage for longer periods of time so that families in transition from welfare to work have the vital support of health

insurance. On the other hand, in a substantial number of states, eligibility for low-income working families remains relatively limited. As noted above, only 12 states cover working families at 100 percent FPL or higher.

In order to continue reducing the number of uninsured people in the United States, states must be kept informed of their opportunities under Section 1931 Medicaid to insure more families and encouraged to use to these options to expand Medicaid coverage for low-income families. Our findings suggest that states will benefit from ongoing guidance and technical assistance concerning their options under Section 1931. Informing states about Section 1931 will be especially important to ensure that coverage is continued for families in states where AFDC demonstration and Section 1115 Medicaid waivers used to extend and improve transitional Medicaid coverage will expire. Activities that promote information sharing among the states such as CMS notices, regional conferences, and dissemination of research findings such as these will better enable state officials to take full advantage of their options such as eliminating the asset test, increasing income disregards, and extending transitional coverage to insure more low-income working families.

The Kaiser Family Foundation is an independent, national health philanthropy dedicated to providing information and analysis on health issues to policymakers, the media, and the general public. The Foundation is not associated with Kaiser Permanente or Kaiser Industries.

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