

Transitional Medical Assistance (TMA): Medicaid Issue Update

What is TMA?

TMA helps low-income families with children transition to jobs by allowing them to keep their Medicaid coverage for a limited period of time after they find a job even though their earnings make them ineligible for regular Medicaid. TMA is also available on a temporary basis for families that would otherwise lose Medicaid due to child support payments.

Who are the families that receive TMA?

In order to qualify for TMA, a family must have received regular Medicaid for at least three of the prior six months. TMA was designed as a "welfare-to-work" initiative, and while Medicaid and welfare eligibility are no longer linked under federal law, TMA still primarily serves families who have been receiving welfare and who then get a job or begin to receive child support payments.¹ Most of the families are headed by single mothers, but there are no national data showing how many families receive TMA or the composition of those families as states are not required to separately report TMA enrollment.

Must all states cover families through TMA?

TMA is a mandatory Medicaid eligibility category. States must provide TMA to eligible families as a condition of receiving federal Medicaid matching funds.

How long can a family receive TMA?

Families eligible due to earnings receive TMA for six months. If their earnings stay below 185 percent of the poverty line (\$27,787 a year for a family of three in 2002) taking child care expenses into account, they can receive an additional six months of coverage (12 months total). Families that qualify for TMA due to child support are eligible for four months of TMA coverage. Six states have waivers that allow them to provide TMA for a longer period of time.² In order to maintain eligibility, families must comply with TMA reporting requirements.

What are the Federal TMA reporting requirements?

The federal Medicaid law generally offers states broad flexibility to decide how they will ensure that families remain eligible for Medicaid after initial enrollment. Federal TMA rules, however, are quite prescriptive. The law requires all states to send families income reporting forms three times during their 12-month period of eligibility (families must report their income in the 4th, 7th and 10th

months), and it prescribes what information must be on the state reporting forms. Families that do not receive, complete or return the forms on time lose their coverage. The GAO has recommended that Congress consider allowing states flexibility³ to change or eliminate these reporting requirements.

What happens if a family eligible for TMA is offered employer-based coverage?

Under federal Medicaid rules, individuals are not disqualified from Medicaid if they have other insurance; Medicaid becomes the payer of last resort. It will pay for services not covered by the private plan and help the family pay the premiums, deductibles, and co-payments imposed by the plan. These rules apply to TMA as well as to regular Medicaid. In addition, if a state believes it is cost effective to purchase available insurance on behalf of an individual or family eligible for TMA, it may do so and provide "wrap around" benefits and cost-sharing protections through Medicaid.

How is TMA authorized?

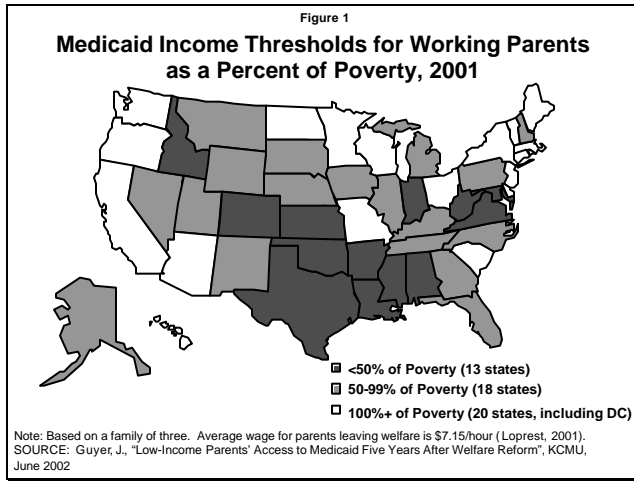
The basic design of TMA that is currently in place was adopted as part of the Family Support Act of 1988, although a version of TMA was established 30 years ago as part of the Social Security Amendments of 1972. The provisions adopted in 1988 were originally scheduled to expire in 1998, but they were extended until 2001 by the 1996 welfare law. In December 2000, TMA was extended for another year. It is currently set to expire on September 30, 2002.

How is TMA financed?

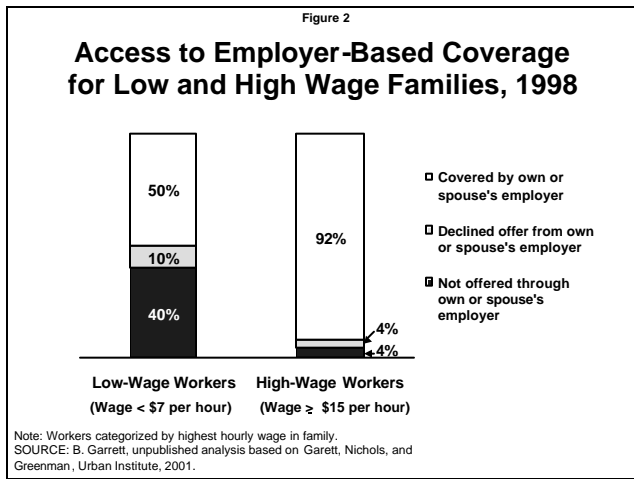
TMA is financed under Medicaid jointly by the federal and state governments. States receive federal matching funds that range from 50% to nearly 80% of the cost of providing this coverage. The Congressional Budget Office estimates that the one-year federal cost to extend TMA to September 30, 2003 would be \$310 million.

What coverage alternatives will be available to parents without TMA?

Without TMA, many parents would lose their Medicaid coverage immediately or soon after they began to receive a paycheck. This is because the regular (non-TMA) Medicaid eligibility standards for parents are quite low in all but a handful of states (Figure 1). Without TMA, many more low-income parents would be at risk of being



uninsured. Parents leaving welfare for jobs are typically earning low wages, on average, \$7.15 per hour.⁴ While most workers get their insurance through their employers, low-wage workers are considerably less likely to have job-based coverage because their employers either do not offer benefits or they cannot afford the health insurance plan that is offered (Figure 2).



According to the most recent census data, in 2000, only 40 percent of low-income parents, including 19 percent of poor parents, had employer-sponsored coverage in 2000. Eight in ten poor parents who are uninsured were working outside the home or living with a spouse who was working.

Will children lose coverage if TMA expires?

Because children have alternative routes to publicly-funded coverage through Medicaid and SCHIP, ending the TMA provision would affect children less than their parents. In all but 11 states, children with family incomes up to at least 200 percent of the federal poverty line can either qualify for Medicaid or the State Children's Health Insurance Program. However, the Congressional Budget Office projects that some children will lose coverage if TMA is not extended because it believes that states will not always correctly transfer children whose families are

leaving welfare to the appropriate alternate eligibility category.

What changes to TMA is Congress considering?

As Congress considers the reauthorization of the Temporary Assistance to Needy Families (TANF) block grant and whether to extend TMA, several bills have been introduced to try to make TMA a more effective route to coverage for families with earnings. These proposals:

- Allow states to drop the prescriptive TMA reporting requirements and rely on regular state-designed Medicaid procedures for keeping track of changes in family circumstances.
- Allow states to drop the requirement that families must have received regular Medicaid for at least 3 months in order to qualify for TMA. This rule prevents parents who find work more rapidly from continuing their coverage.
- Allow states to keep families enrolled in TMA for the full 12-month period, regardless of changes in family circumstances, similar to the "continuous eligibility" option already permitted for children in Medicaid.
- Allow states to extend TMA to families with earnings for a total of 24 or 36 months.⁵
- Allow states to drop TMA if the state has expanded coverage under its family coverage category (section 1931) up to at least 185% of the federal poverty line.
- Require states to regularly report TMA enrollment data to Centers for Medicare and Medicaid Services (CMS).

¹ The 1996 federal welfare law delinked Medicaid and welfare eligibility and created a new family coverage eligibility category for Medicaid known as "section 1931." Eligibility is based on a family's income and resources, not its status as welfare recipients, but in most states, the income standards are so low that virtually all of the families who qualify under this category are eligible for TANF.

² According to CMS, NE, DE, AZ, TX, SC, and TN have waivers extending TMA beyond 12 months (3 of these expire in 2002).

³ GAO, *Medicaid Enrollment: Amid Declines, State Efforts to Ensure Coverage After Welfare Reform Vary*, GAO HEHS-99-163, 9/99; GAO, *Medicaid: Transitional Coverage Can Help Families Move from Welfare to Work*. GAO-02-679T, 4/02.

⁴ P. Loprest, *How are Families that Left Welfare Doing? A Comparison of Early and Recent Welfare Leavers*, New Federalism Policy Brief, Urban Institute, April 2001.

⁵ Waivers extending TMA are generally no longer available due to federal budget neutrality rules. In the past, states could extend TMA through waivers by offsetting increased federal Medicaid costs with decreased federal AFDC costs, based on the expectation that extended TMA would reduce welfare expenditures. With the TANF block grant, a reduction in the number of people receiving cash assistance does not necessarily result in federal savings.