

medicaid
and the uninsured

THE MEDICAID ELIGIBILITY
MAZE: COVERAGE EXPANDS, BUT
ENROLLMENT PROBLEMS PERSIST
Findings from a Five State Study

Prepared by
Marilyn Ellwood
Mathematica Policy Research, Inc.,
Cambridge, MA
with support from
The Kaiser Commission on
Medicaid and the Uninsured
and the Urban Institute's
Assessing the New Federalism Project

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kaiser commission on medicaid and the uninsured

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Chairman

Diane Rowland, Sc.D.
Executive Director

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CONTENTS

EXECUTIVE SUMMARY.....	iii
INTRODUCTION AND OVERVIEW.....	1
BACKGROUND.....	5
FINDINGS.....	8
CHALLENGES IN SEVERING MEDICAID AND WELFARE	
Continued Medicaid Responsibilities of Welfare Staff, Even in a Severed System.....	8
Conflicting Objectives for Welfare Reform and Medicaid.....	10
COMPLEX RULES AND PROCEDURES	
Significant Expansions in Eligibility Policy.....	10
Greater Complexity in Eligibility Rules.....	13
Continuity of Coverage Under Medicaid: The Drop Off Problem.....	16
Challenges in Moving from Medicaid to Private Insurance.....	19
Immigrant Participation in Medicaid: A Worsening Problem.....	20
SYSTEMS AND COMMUNICATION INADEQUACY	
Room for Improvement: Written Materials and Notices for Medicaid Eligibility.....	21
Medicaid's Low Priority in Automated Eligibility Determination Systems.....	24
CONCLUSIONS.....	27
REFERENCES.....	33
ENDNOTES.....	35
APPENDIX.....	A-1

EXECUTIVE SUMMARY

For the first time in almost a decade, Medicaid enrollment for children and their parents began to decline in 1996, dropping by 2 percent from 1995. These declines in Medicaid enrollment are closely associated with welfare reform policies and dramatic reductions in the number of people receiving welfare. Policymakers have made provisions through Section 1931 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 to assure that poor families who leave welfare remain enrolled in Medicaid. In addition, opportunities for low-income children in working families to enroll in Medicaid have grown through poverty-related expansions and the new State Children's Health Insurance Program. Despite these measures, however, it appears that many children and their parents who are eligible for Medicaid coverage have not enrolled.

This report examines Medicaid eligibility policies and operations in five states —California, Colorado, Florida, Minnesota, and Wisconsin — following initial changes introduced by the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 and the new Children's Health Insurance Program (CHIP), which was part of the Balanced Budget Act of 1997. The study was motivated by concerns about national Medicaid enrollment declines that began in 1996 and could be related to welfare reform. Findings are based on interviews with state-level Medicaid and welfare staff, as well as supervisors and eligibility technicians in two large counties in each state.

All five study states have expanded health care coverage in response to options in the PRWORA and CHIP legislation. In four of the states, all children with family income from 185 to 200 percent of the federal poverty level (FPL) are now eligible for either Medicaid or CHIP, while child coverage in Minnesota extends to 275 percent of FPL for children (slightly higher for those under age two). Minnesota and Wisconsin have also made equivalent expansions for parents, using state monies, 1115 waivers, and enrollee premiums. The other three states have increased Medicaid coverage for parents to a lesser degree, using some (but not all) of the flexibility allowed in PRWORA.

It is too early to tell whether these expansions will be sufficient to reverse recent declines in Medicaid enrollment. From 1995 to 1998, for example, monthly Medicaid enrollment declined 12 percent in California, 18 percent in Florida, and 29 percent in Wisconsin (comparable data were not available on the decline for Colorado). Even Minnesota, with one of the most expansive Medicaid programs among states, reported only a modest increase (1 percent) over this period. These declines are troublesome because the number of uninsured persons rose during this period.

Study findings suggest that eligibility policy expansions alone may not prevent Medicaid enrollment declines. The report discusses several problem areas affecting Medicaid eligibility and enrollment operations.

CHALLENGES IN SEVERING MEDICAID AND WELFARE

Congress tried to minimize any adverse effects of federal welfare reform on Medicaid enrollment by severing the mandatory linkage of welfare and Medicaid eligibility rules. However, welfare staff continue to play a critical role in educating families about Medicaid

policies. They are pivotal to making sure families who are formally or informally diverted from welfare apply for Medicaid, and they are also responsible for helping families who no longer receive welfare benefits continue on Medicaid. Yet they struggle with these responsibilities, because Medicaid priorities for maintaining or expanding enrollment can seem to conflict with the objective of reducing welfare dependency. Since welfare and Medicaid are usually administered by different state agencies, local welfare staff are not adequately trained in Medicaid policies or objectives. Many welfare staff mentioned that Medicaid was too complicated now for them to understand much less try to explain to clients who are primarily focused on getting cash assistance benefits. As a result, low-income families may have trouble understanding that welfare and Medicaid are now severed, or independent of one another, and some families are reported to believe that the new welfare rules extend to Medicaid.

COMPLEX RULES AND PROCEDURES

The incremental policy changes resulting from federal legislation, state decisions, and litigation (in some instances) have created very complicated Medicaid eligibility rules in most of the states. Though well-intentioned, these rules create barriers to program participation by making the eligibility process difficult for Medicaid applicants and beneficiaries, as well as staff, to understand. Ironically, the Section 1931 rules (which implement PRWORA and cover the poorest families) are often the most confusing, while the rules are simpler for children in higher income families (whose income is above state welfare thresholds). Three areas of confusion are: the steps for determining transitional Medicaid coverage for working families, the impact on Medicaid eligibility when families fail to meet welfare reporting requirements, and differences in income disregards across eligibility groups.

States are especially concerned about sharp declines in the immigrant participation rates for Medicaid. PRWORA made changes in the eligibility of immigrants for Medicaid and other entitlement programs that have caused many immigrant families to believe erroneously that they no longer qualify for any Medicaid benefits, or made them afraid to apply for coverage. The legislation also added to complexity of the eligibility determination process for immigrants by increasing the number of steps involved in verifying immigration and citizenship status.

In all five states, the CHIP legislation has helped expand child health care coverage. However, the three study states that established separate CHIP programs have also added complexity by leaving Medicaid income thresholds for children variable by the age of the child. As a result, there will be some low-income families with children in both Medicaid and the separate CHIP program. Staff are concerned about the difficulty of explaining to these families that they will have to go through two different organizations for redeterminations, that CHIP and Medicaid may use different providers and delivery systems, and that CHIP may impose different cost sharing requirements than Medicaid.

All the study states now allow mail-in applications for children applying only for Medicaid or CHIP benefits. However, more lengthy application forms and face-to-face meetings with staff continue to be required in most states if parents or entire families are seeking coverage. In addition, few states have simplified the annual redetermination process, so that families have to complete lengthy forms that provide information they have submitted previously. Three of the five states still require face-to-face visits if eligibility is being redetermined for parents or entire families.

Perhaps because of these requirements, many enrollees drop off of the Medicaid program even though they may still qualify, including families leaving welfare for work. It is not clear whether these dropouts understand that they could continue to be eligible or whether they consider the value of Medicaid benefits not worth the effort involved with the eligibility process. Continuity in Medicaid enrollment has not been a Medicaid priority, and states are just beginning to

focus on why seemingly eligible children and families drop off of coverage and become uninsured. In addition, program rules do not smooth the transition from Medicaid to employer-sponsored insurance coverage.

SYSTEMS AND COMMUNICATION INADEQUACY

Due to the complexity of the eligibility rules, most states depend heavily on their automated eligibility determination systems (which handle applications for Medicaid, welfare, and food stamps) to establish Medicaid eligibility. Yet these systems, which manage much of the communication with applicants and beneficiaries, are inadequate, primarily because they are designed and operated to meet welfare, not Medicaid, needs. In every state, staff complained that these system inadequacies can contribute to confusion with Medicaid applicants and beneficiaries, and, occasionally, erroneous terminations in Medicaid coverage. Respondents were especially unhappy with the systems-generated notices and other correspondence sent to applicants and beneficiaries, which are often legalistic and difficult to understand. Medicaid staff reported that the management of the automated eligibility systems is beyond their control and that they are not able to have Medicaid needs addressed in a timely and comprehensive manner. However, it also seems that automated eligibility systems have not been a Medicaid priority, at either the state or the federal level.

CONCLUSIONS

States are hoping that CHIP outreach efforts will help them address Medicaid enrollment declines. However, study findings suggest that Medicaid enrollment problems go beyond the need for better outreach. States may want to reassess their Medicaid eligibility requirements and systems to make them more efficient, accessible, and understandable to consumers. Simpler rules, shorter application and redetermination forms (for everyone), easier-to-understand notices, and greater use of mail and telephone could help considerably. With the 1931 provisions, states have considerable latitude to modify their eligibility policies and procedures for covering entire families and working parents. States could also consider improvements to their automated eligibility systems, using the enhanced federal matching funds available through PRWORA for systems improvements.

At both the state and federal levels, more coordination between welfare and Medicaid is needed, since welfare continues to be the doorway through which many families first become enrolled in Medicaid. Planning for health insurance should become a greater part of welfare reform. It is critical that families diverted from welfare, or those going from welfare to work, understand the availability of Medicaid coverage.

Medicaid enrollment levels, as well as estimated participation rates, need to be reported on a more frequent and current basis. More timely numbers would help focus attention on the problems of inappropriate enrollment declines. Special attention may be warranted in counties or states that report particularly large welfare declines to ensure that Medicaid coverage is appropriately maintained.

Enrollment declines are compelling states to clarify what long-term objectives they are trying to reach with their Medicaid eligibility policies, similar to the rethinking which guided welfare reform efforts. The new focus in some states is to strive to enroll all qualified low-income families in Medicaid and to keep them enrolled, as long as they do not have access to any other source of affordable health insurance. Not all states are comfortable with the idea that Medicaid might become a long-term health insurance program for the poor, including the working poor.

The uneasiness states feel about the future direction of Medicaid eligibility is particularly apparent in states that are opting for separate CHIP programs. Whatever approaches states elect to follow with their health insurance coverage policies and procedures, careful monitoring and research will be required to ensure that state decisions are not unintentionally contributing to further increases in the uninsured population.

INTRODUCTION AND OVERVIEW

For the first time in almost a decade, Medicaid enrollment for children and their parents began to decline in 1996, dropping by 2 percent from 1995 (Ellwood and Ku, 1998). Preliminary national data suggest an additional 3 percent decline in 1997 (Ku, 1999). Individual states have reported declines from 1995 to 1998 of 12 percent (California), 18 percent (Florida), 19 percent (New York), and 29 percent (Wisconsin). Even Minnesota, with one of the most expansive Medicaid programs among states, reported only modest growth over this period (1 percent). These declines in Medicaid enrollment are closely associated with welfare reform policies and dramatic reductions in the number of people receiving welfare (Ku and Garrett, 1999). At the national level, welfare rolls have declined by 42 percent since 1994, with many states reporting decreases of over 50 percent. It appears that many children and their parents who leave welfare do not remain enrolled in Medicaid, even though most would probably continue to be eligible. Medicaid administrative data from California and Florida indicate that at least half of those leaving welfare (including children) lose their Medicaid coverage as well (Ellwood and Lewis, 1999).

Unfortunately, Medicaid enrollment declines cannot be taken as evidence of welfare reform's seeming success or a booming economy. Even though there have been major reductions in the unemployment rate and welfare rolls have plummeted, people are not always finding jobs with health insurance. Indeed, the number of people without health insurance has increased every year since 1987. About one in six persons in the nonelderly population lacks health insurance. Many of these uninsured are children who live in low-income families in which one or both parents work. These families often lack access to affordable employer-sponsored coverage. A recent survey found that only 23 percent of mothers who left welfare from 1995 to 1997 had private insurance coverage, and 27 percent of children (Garrett and Holahan, 1999).

Policymakers did not expect Medicaid enrollment to decline with welfare reform. Numerous routes to continued Medicaid eligibility are available to children and parents leaving welfare, including up to 12 months of transitional Medicaid coverage for families leaving welfare for work. The opportunities for low-income children in working families to enroll in Medicaid have grown steadily since the mid 1980s through the poverty-related expansions and have accelerated recently with the availability of enhanced federal funding through the State Children's Health Insurance Program (CHIP), enacted as part of the Balanced Budget Act of 1997 (BBA97).

Many states have also expanded eligibility for both children and parents under provisions in the new section 1931 of the Social Security Act. Section 1931 was enacted as part of the federal welfare reform legislation, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA). PRWORA severed the longstanding relationship between welfare and Medicaid, so that Medicaid eligibility requirements are now completely separate from welfare rules. Under PRWORA, states are instructed to use their old Aid to Families with Dependent Children (AFDC) rules to establish Medicaid eligibility for the poorest families, so that no families lose their eligibility for Medicaid as part of welfare reform changes. In addition, states have been given the flexibility to make these rules less restrictive and to increase their coverage of two-parent working families.

This report examines the responses of five states to the eligibility-related changes introduced by welfare reform and CHIP, at least in the early stages. The findings suggest that states are using the new options to expand their Medicaid coverage policies, but a variety of other factors may keep enrollment from growing:

- **Challenges in Severing Medicaid and Welfare.** The difficulty of severing Medicaid from welfare may be a factor in declining enrollment. Welfare staff continue to play a critical role in educating families about Medicaid policies. They are pivotal to making sure families who are diverted from welfare apply for Medicaid, and they are also responsible for helping families who no longer receive welfare benefits continue on Medicaid. Yet they struggle with these responsibilities, because Medicaid priorities for maintaining and even expanding enrollment can seem to conflict with the objective of reducing welfare dependency. Since welfare and Medicaid are usually administered by different state agencies, local welfare staff are often not adequately trained in Medicaid policies or objectives. Many welfare staff mentioned that Medicaid was too complicated now for them to understand much less try to explain to clients who are primarily focused on cash assistance benefits. Low-income families may have trouble understanding that welfare and Medicaid are now severed, or independent of one another, and many families are reported to believe that the new welfare rules, such as work requirements and time limits, extend to Medicaid.
- **Complex Rules and Procedures.** The incremental policy changes resulting from federal legislation, state decisions, and litigation have created very complicated Medicaid eligibility rules in many states. Though well-intentioned, these rules create barriers to program participation by making the eligibility process difficult for Medicaid applicants and beneficiaries, as well as staff, to understand. Ironically, Medicaid rules are often the most complicated for the poorest families, while children in higher income families (whose income is above state welfare thresholds) have simpler program requirements. Also troublesome, many enrollees seem to drop off of the Medicaid program even though they may still qualify, including families leaving welfare for work. It is not clear whether these dropouts understand that they could continue to be eligible or whether they consider the value of Medicaid benefits not worth the effort involved with the eligibility process. Additionally, program rules do not smooth the transition from Medicaid to employer-sponsored insurance coverage.
- **Systems and Communication Inadequacy.** Due to the complexity of the eligibility rules, most states depend heavily on their automated eligibility determination systems (which handle applications for Medicaid, welfare, and food stamps) to establish Medicaid eligibility. Yet these systems, which manage much of the communication with applicants and beneficiaries, are not fully responsive to the needs of the Medicaid program, and they may be contributing to enrollment declines. Notices and other correspondence with applicants and beneficiaries are often legalistic and difficult to understand. Medicaid staff often feel the management of these systems is beyond their control and that a higher priority is given to welfare needs. It also seems that automated eligibility systems have not been a Medicaid priority at either the federal or state levels.

State Medicaid programs are aware of many of these problems and are beginning to take steps to address enrollment declines, particularly through their CHIP outreach efforts. However, Medicaid enrollment problems go beyond the need for better outreach, and states may want to consider seriously reengineering their Medicaid eligibility systems to make them

more efficient, accessible, and understandable to consumers. States may also want to give greater attention to simplifying their eligibility policies under the 1931 provisions, since these are the rules that affect the poorest families applying for Medicaid.

The report is organized as follows. After a brief background section, the extent to which states have used the new policy options introduced by PRWORA and CHIP to expand Medicaid coverage is reviewed. The next section focuses on how these policy changes have increased the complexity of Medicaid eligibility rules, which could work against improving participation rates.

Next, the conflicting objectives of welfare reform and Medicaid are discussed, followed by an analysis of the critical role that welfare staff continue to assume in informing families about Medicaid eligibility policies, in spite of the supposed de-linking of the relationship between welfare and Medicaid. Then the discussion turns to administrative issues, including shortcomings in the written materials used by Medicaid programs and inadequacies in the automated eligibility determination systems that all states use. Two other broad concerns are also addressed — the extent to which Medicaid is implemented to promote continuous health insurance coverage for the poor, and whether it also facilitates a seamless transition to private insurance coverage. The report concludes with suggestions for how federal and state agencies could simplify their Medicaid eligibility policies and improve their operations so that Medicaid participation rates increase.

Study Design

Findings are based on visits to five states—California, Colorado, Florida, Minnesota, and Wisconsin. The visits took place from August 1998 to January 1999. Each visit lasted for two to three days and included interviews with state-level Medicaid administrative staff, as well as supervisors and eligibility technicians in two large counties in each state. Interviews were also conducted with state and local welfare staff. Because of time constraints, the site visits did not include interviews with officials for separate state CHIP programs. Table 1 lists the counties visited in each state.

The topics covered during the course of the interviews included

- current eligibility policies for Medicaid;
- general procedures for determining initial and ongoing eligibility;
- coordination issues between the Medicaid and welfare programs, and how states insure that families in the welfare system learn about Medicaid and assist them with remaining insured in their transition from welfare to work;
- responsiveness of the state's automated system for eligibility determination to both the recent changes associated with welfare reform and ongoing needs; and
- the relationship between Medicaid and new CHIP programs.

The study emphasized Medicaid policies and process; the topics discussed did not include CHIP outreach efforts. During each visit, application and enrollee reporting forms, routine notices, and information brochures and handouts related to Medicaid eligibility were collected.

Table 1.
States and Counties/Districts Included in the Site Visits

States	Counties/Districts
California	Alameda County Orange County
Colorado	Denver County Jefferson County
Florida	Gainesville District Tampa District
Minnesota	Anoka County Hennepin County
Wisconsin	Kenosha County Milwaukee County

BACKGROUND

The incremental expansions to Medicaid eligibility that began in the mid 1980s contributed to a surge in Medicaid enrollment in the early 1990s, particularly for children. Of importance, these expansions gave states the opportunity to simplify eligibility rules for some groups of children and pregnant women qualifying for Medicaid. For example, states were permitted to drop asset testing and set income thresholds for Medicaid that were no longer tied to their welfare standards. Nevertheless, many problems with eligibility policy remained, including different income thresholds for children of different ages in the same family, different rules for determining the eligibility of parents, and lack of coverage for two-parent low-income working families. The 1931 provisions in PRWORA and the CHIP legislation gave states additional flexibility to address many of these problems related to eligibility policy.

Section 1931 Provisions. States can elect in their section 1931 plans to increase income thresholds (within limits), earned income disregards, and allowable resource levels, as well as to expand coverage to low-income working families with both parents in the home.¹ They can even elect to eliminate asset testing for parents as well as children (by completely disregarding resources). States were not given the same flexibility to make Medicaid rules stricter. PRWORA generally prohibited states from making their section 1931 eligibility rules any more restrictive than their old AFDC rules were in 1996.

As part of their section 1931 plans, states can make their Medicaid eligibility policies consistent with their new welfare programs, called Temporary Assistance to Needy Families (TANF). Most state TANF programs have increased the asset limits, vehicle exemptions, and earned income disregards employed in assessing eligibility for welfare beyond those allowed under the old AFDC program. And a majority of states have opened up TANF coverage to two-parent families (Gallagher et al, 1998). At the same time, though, PRWORA required state TANF programs to impose time limits and work requirements as new conditions of welfare receipt. However, PRWORA generally prohibited state Medicaid programs from imposing these time limits and work requirements.

States can also use their 1931 plans to expand Medicaid eligibility policy even more than they have expanded eligibility for their TANF programs. In the past, the only way a state could open up coverage for all low-income working families under Medicaid was through a section 1115 waiver demonstration. But now, section 1931 gives states the same latitude without the budget constraints associated with a demonstration waiver. How many states will take advantage of this new latitude remains to be seen. Recently, Rhode Island and the District of Columbia announced that they are extending Medicaid coverage to all low-income working families to 185 percent and 200 percent of the federal poverty level, respectively, under their 1931 plans. Both states are also dropping any asset testing under the 1931 provisions.

CHIP Provisions. CHIP provides still more opportunity to expand public health insurance coverage. The enhanced federal match in CHIP gives states incentives to expand child coverage to 200 percent of the FPL (and higher, for some states) and the potential to make the poverty-related income thresholds uniform for children of all ages. Further, CHIP gives states the flexibility to implement these expansions through either Medicaid or separate state programs or both. In addition, other provisions in the BBA97 give states the option to guarantee child enrollment in Medicaid and CHIP for up to 12 months. This guarantee is another approach states can use to help address enrollment declines for children.

Several recent publications explain in detail how states can use the section 1931, CHIP, and BBA97 provisions to expand and simplify Medicaid eligibility for both parents and children (Ross and Jacobson, 1998; Guyer and Mann, 1999; Schott and Mann, 1998; Administration for Children and Families, 1999; Shuptrine and Hartvigsen 1998).

Other Barriers to Participation. Over the last decade, it has become apparent that some Medicaid enrollment problems are related to factors beyond eligibility policy concerns. Several studies have documented that seemingly eligible individuals often do not enroll in Medicaid (Dubay and Kenney, 1996; Selden et al, 1998). Low participation rates in Medicaid are especially an issue for uninsured children in families not poor enough to qualify for welfare benefits. There are many theories about why participation is low. Recent focus groups and surveys have identified the following barriers to participation (Smith et al, 1998; Perry et al, 1998; and Shuptrine et al, 1998):

- The stigma associated with welfare receipt extends to Medicaid as well and keeps many families from applying for coverage.
- Many low-income people think Medicaid is for families on welfare, not working families.
- Some people confuse the new rules associated with welfare reform with Medicaid rules, leading them to believe mistakenly that Medicaid is now time-limited like welfare, or that Medicaid coverage (without welfare) counts as part of the new welfare lifetime limit, or that the welfare work requirements extend to Medicaid.
- Immigrants, in particular, are worried that participation by any family member in Medicaid (even children who are citizens) may cause parents to be considered public charges and thus disqualify them from eventual citizenship.
- Families who have been on welfare and Medicaid in the past say they dropped out because the eligibility process is burdensome and demeaning, or they were frustrated with the complexity of the rules.
- Families say they are healthy, and they believe they can get Medicaid if they need it.

Thus, even when states make their Medicaid eligibility policies more generous, other barriers to participation may prevent the expansions from increasing enrollment. Some of the obstacles to Medicaid enrollment relate to a negative image of the program and poor information about the rules, while others relate to how Medicaid operates. Perhaps the hardest problem to address is that some families elect not to participate unless someone in the family gets sick or needs health care.

FINDINGS

CHALLENGES IN SEVERING MEDICAID AND WELFARE

Continued Medicaid Responsibilities of Welfare Staff, Even in a Severed System

The PRWORA legislation severed Medicaid from welfare: a family's welfare or TANF status is now immaterial to Medicaid eligibility. However, most states have designed their section 1931 plans to ensure that families receiving TANF benefits also qualify for Medicaid. As a result, persons seeking cash assistance typically complete a joint application for welfare and Medicaid (and food stamps) benefits. It is usually invisible to welfare applicants that welfare and Medicaid are technically determined separately in the newly “severed” system. This makes it easy to see how clients may not understand that welfare and Medicaid rules are different.

Potential welfare applicants learn about Medicaid rules primarily from welfare staff, just as they always have. They do not meet separately with specialized Medicaid staff regarding Medicaid requirements. In all the larger counties among the study states, separate Medicaid eligibility staff meet with persons who are applying for Medicaid benefits only. Welfare staff continue to be primarily responsible for educating welfare applicants and beneficiaries about Medicaid and explaining to them the increasingly complicated nuances of Medicaid eligibility

- Welfare staff are responsible for making clear to families that they can apply separately for Medicaid benefits if they decide they do not want to continue with their welfare applications.
- Welfare staff are responsible for informing applicants who go to work immediately or those who elect a TANF diversion payment that these actions may adversely affect their eligibility for up to 12 months of transitional Medicaid benefits. This is an area in which there can be conflicts between welfare and Medicaid objectives.
- Welfare staff are responsible for explaining to welfare applicants and recipients that TANF's work requirements and time limits do not apply to Medicaid. This is particularly important because many families reportedly drop out of the TANF application process when they learn about the work requirements. Others decide that the TANF benefits are not substantial enough to make it worthwhile, given the new time limits on coverage. In both instances, welfare staff are the ones who have to make clear to welfare applicants or recipients that Medicaid rules are different and that what happens with TANF is separate from Medicaid. In addition, decisions about TANF benefits are delayed in some states while applicants participate in a mandatory “job search.” In these situations, welfare staff are responsible for informing applicants that their Medicaid applications are not dependent on any job search activities and they will be processed independently (Schott and Mann, 1998).
- Finally, welfare staff in most states carry the main responsibility for gathering the information needed to continue Medicaid for welfare recipients who have gone to work and may qualify for 12 months of extended Medicaid coverage.² Study respondents repeatedly said that welfare staff are often unsuccessful in getting the information needed to

ensure that families going to work can qualify for the transitional Medicaid coverage. Many TANF recipients just drop off of the welfare system when they begin work, failing to submit the necessary documentation to continue their welfare (and Medicaid) benefits. In addition, respondents said that sometimes TANF recipients call in and report that they have gone to work, but refuse to provide detailed information to the welfare staff on their circumstances. According to one welfare worker, more than one TANF recipient has said to her, “Close my whole case so I don’t have to have anything more to do with the welfare department.” Yet another respondent said that he thinks sometimes TANF recipients drop off of the system (failing to submit necessary paperwork) because they are worried that they may have received some TANF benefits they were not really eligible for. For example, if a mother failed to report earnings from a new job right away, she worries that she may have committed fraud. In all of these situations, welfare staff play a major role in whether families continue their Medicaid enrollment through the transitional coverage provisions.

Welfare staff are struggling with their responsibilities to inform clients about their eligibility for Medicaid. Because welfare and Medicaid are usually administered by separate state agencies, local welfare staff typically have had little training in Medicaid eligibility policies and objectives. Many respondents said that Medicaid was too complicated now for them to understand, much less to try to explain to clients who are focused mainly on getting cash assistance benefits. Others mentioned that the initial welfare application process can take six to eight hours, and that Medicaid is just one of many topics to be covered by a multi-person welfare team. A respondent in one state described the welfare intake process as a full-court press that is deliberately intimidating, in order to discourage people from applying for welfare unless they really need it. It seems plausible that a discussion of Medicaid might get relatively little attention in this situation.

County Medicaid staff in several states indicated that they are trying to be more available to welfare staff to help them with Medicaid issues. One county was making Medicaid “buddies” available for welfare staff who had questions. Another county established Medicaid mentors to help both welfare staff and more junior Medicaid staff with difficult Medicaid questions or with complicated family situations related to Medicaid eligibility. One of these counties also held special training sessions for welfare staff, going over new Medicaid rules with them.

Conflicting Objectives for Welfare Reform and Medicaid

The issues surrounding the continued responsibilities for Medicaid of welfare staff are exacerbated as state welfare and Medicaid programs often work at cross-purposes, with one program trying to move people out and the other trying to bring people in. The objectives of state welfare programs are primarily to get people to work and to reduce welfare enrollment; health insurance coverage does not figure prominently in the welfare reform agenda. In contrast, Medicaid programs are concerned with retaining and even expanding enrollment, given the high rates of uninsurance in most states.

All respondents agreed that, ideally, the objectives of welfare reform and Medicaid should overlap, since the provision of Medicaid or private health insurance benefits after welfare can be critical to a family's success at remaining employed. However, keeping families enrolled in Medicaid is not an explicit welfare reform objective. State respondents repeatedly mentioned that staff on the welfare side get "credit" the sooner they get families to work and off welfare (or prevent them from ever getting on welfare at all). Most important, their job performance is not at all tied to whether qualifying families sign up for Medicaid once they no longer qualify for welfare benefits or whether the jobs that welfare recipients go to have affordable health insurance benefits. Indeed, all the welfare staff who participated in the study acknowledged that jobs available to low-income persons on welfare rarely included affordable health insurance for the entire family.

There is one eligibility policy area—transitional Medicaid—in which the conflicting objectives of welfare and Medicaid can directly collide, even though the policies of both programs are intended to be supportive of families going to work. To qualify for up to 12 months of transitional Medicaid coverage, families have to meet two conditions. First, they must have been eligible for Medicaid under the 1931 rules for at least three of the past six months. Second, they must have lost their eligibility for Medicaid under the 1931 rules on account of earnings. This means that parents who go to work quickly (so that their families do not qualify under the 1931 rules or qualify only for one or two months) may not qualify for Medicaid under the transitional coverage provisions, and families that receive lump-sum diversion payments from state welfare programs may not meet the requirements of transitional coverage. In these situations, welfare staff may not counsel families about how their TANF benefit and job decisions may affect their Medicaid eligibility. A recent report on state diversion programs offers suggestions to states on how to design their welfare programs to avoid adverse consequences for Medicaid (Maloy et al, 1998).

COMPLEX RULES AND PROCEDURES

Significant Expansions in Eligibility Policy

All five of the study states have used the section 1931 and CHIP provisions to expand public health insurance coverage for low-income families, although it is too soon to tell whether these changes will help stem their declines in Medicaid enrollment. Three of the states—California, Colorado and Florida—have expanded their Medicaid eligibility provisions largely to parallel TANF changes, but they also plan further expansion through separate CHIP programs.

Wisconsin's initial section 1931 plan did not change Medicaid policies to parallel the state's TANF program or expand Medicaid. However, the state has since finalized plans with the Health Care Financing Administration (HCFA) for a new BadgerCare program. BadgerCare will significantly expand the state's health insurance coverage of low-income working families with children. Minnesota reported the least expansion among the five study states. But that is because

Minnesota had expanded coverage for its low income population several years earlier, through both its Medicaid program and MinnesotaCare, its health insurance program for the uninsured.

The generosity of child coverage provisions varies somewhat by state, as shown in Table 2. Colorado and Wisconsin have established a uniform 185 percent FPL income threshold for children of all ages, while California and Florida use a 200 percent threshold. Minnesota has a 280 percent threshold for children under age two and a 275 percent threshold for older children. In California, Florida, and Colorado, these higher uniform levels are accomplished through a separate CHIP program, while the Medicaid child income thresholds are lower and remain variable by age. For example, in these states, the Medicaid poverty-related income thresholds for children ages one through six remain at 133 percent FPL, while 100 percent FPL is used for older children. In all the states but Minnesota, neither Medicaid nor CHIP requires asset testing for children.

Minnesota and Wisconsin extend their health expansions to parents as well as children, so that all members of low-income families will have access to expanded coverage. Both states are using a combination of Medicaid funding, CHIP funding, HCFA section 1115 demonstration waivers, state subsidies, and premiums (for higher income families) to cover parents and children to the same income levels. Minnesota already covered low-income families with children to 275 percent FPL through its MinnesotaCare program (which operates separate from Medicaid), while Wisconsin implemented its BadgerCare coverage for all low-income families with children (with income to 185 percent FPL) effective July 1, 1999. Wisconsin has eliminated asset testing in BadgerCare.

California, Colorado, and Florida adopted some expansions in Medicaid coverage for parents as part of their section 1931 plans, but their coverage provisions for parents are still not as generous as those for children. For example, California and Florida are using more generous earned income disregards, thus effectively increasing the income thresholds for eligibility beyond what is shown in Table 2.³ These three states have also loosened their restrictions on the coverage of two-parent families and on countable assets. However, none of these three states is using the section 1931 provisions to make Medicaid rules for parents equivalent to those for children. Parents will continue to have much lower income thresholds for eligibility than children, and assets will continue to be a factor in determining their Medicaid eligibility.

States have made other changes to eligibility requirements, not specifically related to section 1931 or CHIP. The three states with separate CHIP programs (California, Colorado, and Florida) are using the BBA97 provisions to guarantee continuous child enrollment for up to 12 months for CHIP children, while only one state (Florida) is guaranteeing enrollment for Medicaid children.

Table 2.
Income Eligibility Thresholds for Study States, October, 1998
(as a percent of the federal poverty level)

State	Children				Parents/Caretaker Relatives (Adults)	
	Infants	Ages 1-5	Ages 6-14	Ages 15-19	Pregnant Women	All Other
California Medicaid/Medicaid CHIP Separate CHIP	200 200	133 200	100 200	100 200	200 NA	86 ^a NA
Colorado Medicaid Separate CHIP	133 185	133 185	100 185	39 ^b 185	185 NA	39 ^b NA
Florida Medicaid/Medicaid CHIP Separate CHIP	185 200	133 200	100 200	100 200	185 NA	28 ^a NA
Minnesota Medicaid/Medicaid CHIP/MinnesotaCare	280 ^c	275	275	275	275	275
Wisconsin Medicaid/Medicaid CHIP/BadgerCare	185	185 ^d	185 ^d	185 ^d	185	185 ^d

Source: Site visits to states.

^a State medically needy income level.

^b State Section 1931 income level.

^c The 280 percent threshold in Minnesota applies to children under age 2.

^d Wisconsin's Badger Care program for families with children was implemented July 1, 1999. Prior to this implementation, Wisconsin's income thresholds for children generally followed the federally mandated poverty-related thresholds, except for infants. The income limit for a child 15-19 years of age was 64 percent FPL. Other than pregnant women, the income limit for parents was 51 percent FPL.

Application forms and the verification requirements for children have also been simplified to encourage greater participation. All of the states but Wisconsin now have separate, shorter application forms for children (and pregnant women) who are applying only for Medicaid or CHIP coverage. These forms are five or fewer pages in length in several of the states and can be submitted by mail. However, these simplified forms cannot be used for parents or entire families applying for Medicaid coverage, because the rules for section 1931 and other types of Medicaid coverage require much more extensive information. In all the study states, the regular joint application forms (which cover Medicaid, welfare, and food stamps) range in length from 15 to 30 pages. However, these joint forms allow families to apply simultaneously for welfare and food stamps in addition to Medicaid. Applicants for any type of welfare or Medicaid coverage in Wisconsin are required to have a face-to-face interview in a local office, where basic information is entered directly on-line into the state's eligibility determination system. Minnesota is the only study state that currently allows mail-in applications for all applicants (not just children). Wisconsin plans to implement in the future a new one-page Medicaid/BadgerCare application form that can be submitted by mail.

A summary of how each study state has changed its eligibility provisions under Medicaid and CHIP is included in the Appendix.

Greater Complexity in Eligibility Rules

Although every state had expanded eligibility, study respondents reported that their new section 1931 and CHIP plans and rules have made eligibility even more complicated than it already was. They said that even the most experienced staff will be challenged to master how all the new rules work. In short, the rules and procedures for determining eligibility have become more convoluted, leaving both Medicaid and welfare staff uncertain about their grasp of the new Medicaid and CHIP requirements.

How is coverage more complicated? To start, the three states with separate CHIP programs (California, Colorado, and Florida) continue to use variable poverty-related income thresholds under Medicaid for children of different ages, even after the section 1931 and CHIP changes. In these three states, then, there will be families in which some children will qualify for Medicaid while other children in these families will only qualify for the separate CHIP program. This could be confusing because separate CHIP programs may use different providers and impose different cost-sharing requirements. Although program differences may not be a problem if all the children in a family are enrolled in the separate CHIP program, it becomes very complicated when a single family has children in both Medicaid and CHIP. In addition, due to family income fluctuations, children may have to switch back and forth between the Medicaid and CHIP programs, unless a state has opted for a guaranteed period of enrollment in both programs. Respondents were concerned over the difficulty of implementing separate CHIP programs and especially concerned about how to explain the new rules to families with children in both programs.⁴

Respondents in all the states were confused about how certain aspects of the new section 1931 rules will work, now that Medicaid eligibility is supposed to be independent of welfare or TANF eligibility. In particular, several were puzzled over whether a family's failure to meet TANF reporting requirements should also trigger a redetermination of Medicaid coverage. For example, if a family with earnings fails to report detailed monthly income information as required by TANF, TANF benefits are usually terminated. In this situation, does Medicaid coverage have to be officially redetermined in order to continue eligibility? That is, is Medicaid eligibility dependent upon a family's meeting TANF reporting requirements? Some respondents said they have concluded that a failure to meet TANF's monthly reporting requirements (or other TANF rules) does not necessarily mean all family members have to be redetermined for

Medicaid benefits. In many instances, they have found that there is sufficient information in the case record to continue benefits until a Medicaid redetermination would routinely occur. However, not all states or counties within a state follow this interpretation.

The rules for transitional Medicaid coverage are another example of Medicaid's greater complexity as a result of section 1931. Before PRWORA, transitional coverage provided up to 12 months of continued Medicaid eligibility to families leaving welfare due to earnings. To qualify for transitional coverage, families *must have been eligible to receive* welfare benefits in three of the previous six months. After PRWORA, whether a family meets this requirement is not determined by whether they received (or were eligible to receive) TANF benefits. Instead, the determination is made according to *whether they qualified for Medicaid under the 1931 rules* over a three month period. Thus, to determine eligibility for transitional coverage, Medicaid programs are supposed to look at whether families would have qualified for Medicaid under the old, but usually amended, AFDC rules incorporated in their 1931 plans. Although many states have amended their old AFDC rules (under their 1931 plans) to make them mirror their new TANF rules as much as possible, in most states some differences remain. Thus, in these states, testing for Medicaid eligibility under the transitional benefit rules can involve a somewhat confusing determination.

Unfortunately, state 1931 and CHIP rules are being added on to an already complicated set of eligibility requirements under Medicaid. The rules for determining medically needy eligibility and implementing the "spend-down" requirements, for example, are the bane of Medicaid staff and Medicaid applicants alike.⁵ But the medically needy rules are only part of the complexity. All the states have dozens of Medicaid eligibility groups, some mandatory and some optional, each with its own specific set of eligibility rules. In addition to the non financial rules, eligibility for each group is calculated to some extent by looking at income, but income can be calculated differently across these groups:

- Some eligibility groups use gross income to determine eligibility, while other groups use net income, after certain deductions and disregards are applied. Whether gross or net income is compared to the income thresholds can make a big difference in eligibility.
- Even among Medicaid eligibility groups using net income, there are differences in the deductions (educational expenses, work expenses, and child care costs, for example) and earned income disregards used. For example, how a family's income is calculated can vary, dependent on whether eligibility is being tested under the section 1931 provisions, the medically needy provisions, or the CHIP program.

These existing complexities leave states feeling frustrated with having to implement yet another new set of requirements, much less explain these provisions to low-income families.

Challenges in Implementing Section 1931 Provisions in California. California respondents expressed the greatest concern over their new 1931 provisions. California's section 1931 plan is by far the most complicated among the study states, in part due to existing complexities in California's Medicaid (and welfare) eligibility rules. Compared with most other states, California's Medicaid program is both more generous and more complicated. It covers almost 100 different groups, each with distinct eligibility rules. Class action lawsuits over the years have also contributed to the rather daunting set of rules used in California for eligibility determination. The state's 1931 plan, which includes 120 pages of instructions to counties, adds to this complexity.

California's section 1931 instructions are hard to follow, even for experienced Medicaid staff. Here is just one (slightly edited) example from the instructions, which explains how the new 1931 rules may be used to cover a family no longer eligible for medically needy coverage. Basically, this situation occurs because California's section 1931 plan drops many of the restrictions on the Medicaid coverage of two-parent families. Yet these 1931 changes do not extend to the medically needy program, so that the medically needy program still restricts the coverage of two-parent families

A two parent family was receiving Medi-Cal benefits under the medically needy provisions before the 1931 rules were implemented. The parent who is the principal wage earner in the family was working, the employer increased this parent's job duties to over 100 hours and earnings increased. As a result, the family is no longer eligible for the medically needy program under the AFDC-related medically needy rules because the parent is now working more than 100 hours. In reviewing the case, the county determines that the family would have been eligible under the new 1931 program in the 3 months before the 100 hour rule was exceeded under the medically needy program, and before current earnings increased and exceeded the 1931 income limits. The family, therefore, is now eligible for transitional medical coverage beginning in the month their AFDC-related medically needy eligibility stopped.

In this example, the new section 1931 rules allow a family that would otherwise have become ineligible to continue to qualify for Medicaid. However, complicated rules such as this can be difficult to implement, particularly for less experienced eligibility staff.

In response to the complexity of the new section 1931 provisions, some counties in California insisted upon delaying the 1931 implementation for almost a year. They felt that the burden of implementing these new eligibility rules was enormous, especially given that the state already had almost 100 other Medicaid eligibility groups, each with its own set of rules. One local California official described the section 1931 provisions as "the straw that broke the camel's back."

Challenges in Implementing Separate Programs Like CHIP. Respondents in several states also expressed concern about the confusion and delays that result when Medicaid has to coordinate with separate state programs such as CHIP. For example, California experienced a major public setback with getting its new CHIP program started. Initially, the state implemented a 28-page combined CHIP/Medicaid application booklet that included forms and instructions. This combined booklet instructed families on how to figure out whether they should apply for Medicaid or the separate CHIP program, depending on family income. Although this approach had some good features (it allowed families to mail in applications, and it tried to facilitate coordination between Medicaid and CHIP), the form proved to be too long and confusing. After six months of operation, only 20,000 children had enrolled in CHIP, out of a first-year goal of 200,000. The state has since announced that it will start using a new four-page single application form in early 1999. The new form will be mailed to one location for determination of both CHIP and Medicaid eligibility (Mann, Ross and Guyer, 1998). It remains to be seen whether this new strategy will result in greater CHIP enrollment.

The problems the Minnesota Medicaid program experienced in coordinating with the separate MinnesotaCare program may be instructional for states planning separate CHIP programs. Until recently, eligibility determination for MinnesotaCare was centrally administered using a mail-in application, while counties continued to determine eligibility for the Medicaid program. However, some families experienced up to two to three month delays in the processing of their applications when both programs were involved. Counties also found it

difficult to ensure that MinnesotaCare coverage began as soon as a family was no longer eligible for Medicaid. Families were frustrated when MinnesotaCare applications were not processed quickly, as MinnesotaCare coverage commences only when an application is approved and there is no retroactive coverage. Counties also reported problems in expediting the consideration of MinnesotaCare applications for families they believed had high priority. At times, this meant county expenditures which could have been avoided for uncompensated or charity care. In response to these problems the state recently decided to give counties the option to administer the MinnesotaCare program for their residents. Many of the large urban counties plan to begin implementing eligibility determination locally for MinnesotaCare shortly.

Implications of Greater Complexity for Staffing and Training. The increased complexity resulting from section 1931, CHIP, and separate state programs adds to staffing problems already facing states. Several states said they are having trouble recruiting and retaining staff because of the large Medicaid caseloads and the low salaries offered to entry-level eligibility technicians under Medicaid. Several mentioned that they have lost experienced Medicaid staff to higher paying jobs in the welfare program. Even before the latest eligibility changes, it took substantial time and effort to train new workers for Medicaid, and it may take several months before new staff are ready to assume full responsibilities. A supervisor in a California county said that it takes a year before a new staff person can handle routine Medicaid cases independently (and longer for the more complicated cases).

Continuity of Coverage Under Medicaid: The Drop Off Problem

State officials, policymakers, and researchers have not given adequate attention to what may be one of the most important problems contributing to Medicaid enrollment declines: the Medicaid “drop off” rate among children and families who continue to be eligible. Evidence is mounting that more attention needs to be focused on keeping eligible children and families enrolled in Medicaid, not just on enrolling them at the start. In every state, respondents pointed to problems they face with persuading families to submit the information necessary to redetermine their eligibility for continued coverage. These drop off problems have probably existed all along, but they received little notice when Medicaid enrollment was continuing to grow.

Due to the enormous welfare declines, attention is now focusing on the Medicaid drop off problem among families leaving welfare. Colorado staff reported the results of a seven-county investigation of why Medicaid enrollment was declining. They found that many welfare recipients were unwilling to provide the detailed income reporting required when they went to work to allow them to maintain their Medicaid enrollment. They also confirmed that some families stay away from Medicaid because they are nervous about the TANF recovery process. They fear that if the state gets details about their income, there may an attempt to collect back TANF benefits for which they may have been ineligible.

Wisconsin and one of the California counties have attempted to contact families who were recently terminated from both welfare and Medicaid to see if they would be interested in reapplying to Medicaid. The California county even offered \$20 gift certificates to families who reapplied for Medicaid. However, neither of these programs was regarded as successful. In part, they failed because it was difficult to locate families whose eligibility had ended several months earlier. In other instances, families were just not interested in applying for Medicaid. As was reported for Colorado, California staff said that several families were “afraid” to reapply for Medicaid and report their income, for fear that they might have to pay back “overissued” welfare benefits they received in the past. Welfare rules regarding fraud are stringent, so it is understandable that families would be concerned. It is difficult to ascertain what advice welfare and Medicaid staff should give in this type of situation. Although they want to encourage families to remain on Medicaid, they do not want to be perceived as encouraging fraud.

Even if families that leave welfare sign up for the six months of initial transitional coverage under Medicaid, many fail to meet the reporting requirements necessary to continue eligibility for the second six months of coverage, although they may continue to qualify (Alpha Center, 1999). Federal requirements stipulate that families must report their earnings to qualify for the second six months of coverage, and income cannot exceed 185 percent of the FPL. Four of the study states require families with transitional coverage to report their earnings quarterly; Colorado requires monthly reporting. Respondents in all the states reported that many families neglect to send in the documentation necessary to continue coverage for the second 6 months. A California respondent expressed the concern that "We've just made it too hard."

The drop off problem extends beyond families leaving welfare and also includes children qualifying for Medicaid under eligibility groups not tied to welfare, such as the poverty-related child expansion groups. States reported that many families fail to submit the paperwork necessary to complete redetermination requirements, causing their children to drop off of Medicaid even though they may continue to qualify.

Although states have simplified aspects of the initial application process for Medicaid (for example, by shortening application forms, allowing forms to be mailed in, dropping the assets test, and improving outreach), few have simplified the redetermination process. Most of the study states use the same forms for redetermination as for initial application. This means that families often have to provide information (and sometimes verification documents) they have submitted previously. A recent federal publication (Administration for Children and Families, 1999) suggests, "Redetermination forms can be shortened, most of the necessary information can be filled in by the state based on the information on hand, and the family can be asked to send in the signed form with any noted changes." None of the study states had made this type of change in its redetermination system.

Medicaid staff in Hennepin County, Minnesota started a new "Continuity of Care" initiative in 1998, designed to reduce Medicaid drop offs and support the state's welfare reform program. This initiative rests on two premises: (1) families need affordable health care to become self-sufficient and stay employed and (2) eligible families should stay continuously enrolled in Medicaid until private insurance commences. Hennepin County officials recognize that this focus on continuity of care will require a shift in the mindset of most staff. They want staff to start thinking of Medicaid families who drop off and become uninsured as a Medicaid program failure for which they have some responsibility. And they believe this type of failure should receive just as much attention as other program shortcomings, such as those measured in the state's Medicaid quality control system.

A large proportion of children and adults exited Medicaid enrollment each month in California and Florida during 1995 (Ellwood and Lewis, 1999). For example, in both states, 6 to 10 percent of the child poverty-related group were exiting Medicaid each month, which was slightly more than the rate of new children coming in. Indeed the child poverty-related groups in both states would not have grown at all in 1995 except for children transferring into poverty-related coverage from welfare and other Medicaid eligibility groups. Although some level of turnover has to be expected for poverty-related children (given the higher income levels of their families), most respondents believed that many children were dropping out of coverage who probably continued to qualify. And they had little confidence that many of these children were covered by private insurance. A senior Florida official suggested that once some families understand how Medicaid works and the hassle that is involved, they slip into pursuing coverage episodically, only bothering with all the paperwork if a child is sick or otherwise needs care.

States report that many of the children who drop off of Medicaid (and some who are currently on Medicaid) are applying to their CHIP programs. One HCFA official recently estimated that 40 percent of children applying to state CHIP programs are determined to be eligible for Medicaid (Thompson and Nathan, 1999). Before CHIP, Florida had a CHIP-like Healthy Kids program (separate from Medicaid) that did not require children to be screened for Medicaid eligibility. Florida now has evidence that many of the pre-CHIP Healthy Kids enrollees were previously on Medicaid, and many would probably have qualified for Medicaid coverage if they had applied (Shenkman et al, 1998). Researchers from the University of Florida conducted a telephone survey of 325 families who had to switch from Healthy Kids to Medicaid coverage, when the new CHIP rules on Medicaid screening were implemented. They found that 72 percent of the families said their children had been enrolled in Medicaid before they enrolled in the (pre-CHIP) Healthy Kids program. Further, 14 percent of the families

thought their children were probably eligible for Medicaid when they applied to Healthy Kids. However, only 24 percent of the survey respondents said they would have applied for Medicaid if they had realized they were eligible. Many reported negative perceptions about the Medicaid program, citing the stigma associated with Medicaid and the belief that Medicaid did not attract high quality providers who were readily accessible. Others indicated that they preferred to pay for their children's coverage.

The high rate of Medicaid drop offs underscores why many states have chosen to set up separate CHIP programs, which do not have to contend with the stigma and burdensome application process associated with Medicaid. However, over time, separate CHIP programs may face a drop off problem as well, particularly for families that are required to submit monthly premiums.

Challenges in Moving from Medicaid to Private Insurance

Everyone agrees that Medicaid should be designed to help working families make the transition from Medicaid to affordable employer-based private insurance coverage. However, there are a surprising number of roadblocks to this transition. To start, although Medicaid funds can supposedly be used to cover employer premiums, study respondents indicated that this option is only rarely used when Medicaid families have access to employer coverage. Generally, they said it is too difficult to meet the federal requirement that employer coverage has to be more cost-effective than Medicaid.⁶ For families that want Medicaid to help them get employer coverage, it also takes considerable effort for Medicaid staff to collect all the needed information on premiums, coverage restrictions, cost-sharing and other out-of-pocket costs.

Second, there is the issue of timing. With most employers, there is a limited period during which new employees can sign up for coverage. After that time, an employee has to wait until the annual open enrollment period, when evidence of insurability may also be required. Unless it is found to be cost-effective, Medicaid will not enroll a family qualifying for transitional Medicaid in an employer insurance plan. However, if a family waits until transitional coverage expires, they will probably not be able to sign up immediately for coverage under the employer plan. In a few instances, Medicaid staff have written letters to employers asking them to allow persons leaving Medicaid to sign up for private coverage outside the open enrollment period. However, it is still probably the exception when Medicaid (or welfare) staff have this level of involvement in helping working families make the transition to private coverage. In addition, employers may resist making exceptions to their rules.

A third issue is that families have to go from paying nothing for Medicaid (since cost-sharing is generally prohibited) to paying the employee share of premiums (and other cost sharing requirements) for employer-sponsored insurance when Medicaid eligibility expires.

Thus, low-income families who have access to employer coverage often turn it down, because they cannot afford it (Thorpe and Florence, 1999). In effect, they make too much money to qualify for Medicaid, but they do not make enough money to be able to afford the high cost of private insurance. Indeed, one of the attractions of separate state CHIP programs is that they have more flexibility to impose income-adjusted premiums and other forms of cost-sharing than

Medicaid allows. In separate CHIP programs (and a few state 1115 Medicaid waiver programs), family cost-sharing requirements are income adjusted, so that families assume a greater proportion of their health insurance costs as their income rises.

Among the study states, both Minnesota and Wisconsin are planning ways to help more low-income families sign up for employer coverage. With its BadgerCare program, Wisconsin is planning to help families pay for employer-sponsored coverage when appropriate. Similarly, a proposal is being considered to allow MinnesotaCare families to buy into employer coverage, using a sliding-scale premium. As part of the "Continuity of Care" initiative, Hennepin County staff have developed a mandatory training program for both welfare and Medicaid staff that is focused on learning how to talk about health insurance issues, including issues of affordability, with clients entering the workforce. They have pulled together considerable background information and resource materials to educate staff and clients better about how employer-sponsored coverage works and what publicly sponsored insurance alternatives are available. They are determined to make health care planning a routine part of helping clients make the transition from welfare to work.

Immigrant Participation in Medicaid: A Worsening Problem

A recent federal General Accounting Office (GAO) study concluded that in 1996 one out of three uninsured children who were eligible for Medicaid, but not participating, lived in immigrant families (GAO, 1998). Making matters worse, there is now evidence that participation rates among immigrant families may have deteriorated even more (Fix and Passel, 1999). The PRWORA legislation made some changes in the eligibility of immigrants for Medicaid and other entitlement programs that have caused many immigrant families to believe erroneously that they no longer qualify for any Medicaid benefits or made them afraid to apply for coverage. PRWORA also added major responsibilities to state welfare and Medicaid for verifying the immigration and citizenship status of all applicants, making the eligibility determination process for immigrants much more complicated. These added requirements are particularly troubling because many of the uninsured children in immigrant families are citizen children, that is, they were born in the United States and thus are citizens and are fully eligible for Medicaid coverage, if they otherwise qualify. Foreign born parents and children may qualify only for emergency services under Medicaid, depending on when they arrived in the United States and the legality of their immigration status.

Many immigrant families believe that they will jeopardize their immigration status if anyone in the family, including a citizen child, enrolls in Medicaid. Respondents in all the study states agreed that there was reason for families to be concerned, because the Immigration and Naturalization Service (INS) has not made clear whether the receipt of Medicaid benefits causes immigrants to be considered a "public charge," a status that might disqualify them from becoming citizens. Study respondents were adamant that Medicaid programs regard enrollee information as confidential and that they will not release any information to the INS or to any other government agency. In May 1999 the INS, working in conjunction with HCFA and other federal agencies, issued policy guidance and a proposed regulation clarifying the public charge issue. The new guidance says that receipt of Medicaid or CHIP benefits (with the exception of long-term care services) will not count against immigrants who apply for citizenship.

Nevertheless, the confusion over the rules has caused many immigrant families to stay away from Medicaid and other entitlement programs, and this misunderstanding will probably take considerable time and effort to correct.

California officials have repeatedly identified ambiguous federal immigration policy as the number one barrier to child Medicaid and CHIP enrollment. Medicaid staff in California reported that Spanish radio stations were counseling families not to apply for anything. A similar situation exists in Florida. A survey of 87 immigrant households in Dade County, Florida, found 85 in which a child was eligible for Medicaid but not participating (Schlosberg, 1998). A Florida respondent reported that many immigrants there are in a state of “disinformation,” with the word out in many communities that both welfare and Medicaid benefits for immigrants have ended.

Language barriers may also impede immigrant Medicaid participation, given the complexity of Medicaid rules and the added confusion of special requirements for different members of immigrant families. Medicaid programs report that they try to hire bilingual eligibility staff and to make application forms and other written materials available in the languages of potential applicants. However, they acknowledge that not all the forms, brochures, and notices get translated into every language needed, and bilingual staff or interpreters are not always readily available.

SYSTEMS AND COMMUNICATION INADEQUACY

Room for Improvement: Written Materials and Notices for Medicaid Eligibility

To supplement the Medicaid information provided by welfare staff, the Medicaid programs in every state have developed special handouts and brochures that explain Medicaid eligibility rules in a simplified form. These materials are usually included in the packet of information given to new applicants, whether they apply for both welfare and Medicaid or for Medicaid benefits only. They are also distributed to providers and community organizations that have contact with low-income families in need of health insurance coverage. Some states have begun to enclose periodic information bulletins about Medicaid eligibility with monthly TANF checks. These informational materials usually emphasize that welfare and Medicaid no longer operate under the same rules, and that Medicaid can continue when families leave welfare and go to work. Many materials have also been developed that emphasize the more generous Medicaid and CHIP eligibility provisions for children.

The visual attractiveness and readability of these materials vary, but all the states have tried to develop materials that are simple and easy to understand. The Medicaid brochures developed by several southern states, in conjunction with the Southern Institute on Families and Poverty, are particularly well done (Shuptrine, Grant and McKenzie, 1998). These brochures are colorful and appealing and they have been tested with focus groups of welfare recipients to ensure their effectiveness.

Regardless of how good they are, Medicaid information handouts or brochures distributed by states may get lost in the plethora of information new welfare and Medicaid applicants receive. These materials include information related to job search and work requirements for welfare, food stamps, child support requirements, the EPSDT program, transportation programs, child care, and even voter registration. Several respondents believe that information overload may be a problem.

In addition to program brochures and handouts, state Medicaid programs rely heavily on official notices to convey eligibility information and requirements. State Medicaid programs are legally required to send notices, and any notice of denial or termination must explain consumer rights to appeal Medicaid decisions. Notices are mailed for a variety of reasons:

- to notify families who have been enrolled that they need to submit new application forms or additional information to continue Medicaid eligibility;
- to notify families who have newly applied to Medicaid that their applications are being approved or denied; and,
- to notify families who have been enrolled that they are now being terminated from Medicaid.

A notice of denial or termination is caused by either failure to meet specific eligibility requirements or failure to provide all the information and supporting documentation necessary to redetermine Medicaid status (including incomplete application forms).

Problems with notices predate welfare reform, but the de-linking of welfare and Medicaid has made the problems even greater. Respondents in several states were not satisfied with the quality of the Medicaid notices they used. In fact, one state official asked, “Is there any state Medicaid program with good notices that we could take a look at?” The complaints about notices included the following

- Notices are usually written in a legalistic style to make sure the Medicaid program has met various legal requirements about applicant rights to appeal the decision and request a fair hearing. While it is important that this legal information be conveyed clearly, at times it seems this part of the notices has received more attention than the part that explains to an applicant why eligibility is being denied or terminated.
- Notices usually are computer generated and allow only limited customization and detail describing exactly why Medicaid is being denied or terminated.
- Notices often use terms, program names or acronyms that may be unintelligible to applicants or beneficiaries.
- The automated computer systems in several states are programmed to send notices to every individual in every family (since Medicaid is determined, in a technical sense, on an individual basis). Many respondents believed it was confusing and wasteful to send an individual notice to every family member.
- The notices in one state were designed to list the results of every Medicaid eligibility group for which applicants were tested. So the notice would in effect say, “You did not qualify for group a, you did not qualify for group b, you did not qualify for group c,” et cetera. Further, for each group, the applicants’ rights to appeal the decision were described. In this example, it could be the fifth group (and many pages into the notice) before an individual applicant might learn that she was eligible for Medicaid. Workers in this state said they often get calls from applicants who believe they have been denied Medicaid, when in fact the very last page of the notice says that they qualify for coverage.

- Some states even send notices to ongoing beneficiaries whose Medicaid eligibility under one group (or set of rules) is being terminated, while their eligibility under another group (and another set of rules) allows them to continue to qualify for coverage. This practice causes confusion for managed care organizations as well as Medicaid beneficiaries.

Eligibility technicians often have the option of suppressing computer-generated notices, if, in their judgment, the notices will be more confusing than helpful. Nevertheless, this suppression requires a deliberate action, and less experienced workers are not as likely to know about this feature or remember to use it when appropriate. Several experienced workers said they routinely supplement the computer-generated notices with their own handwritten notes, which provide more detailed information to applicants. As an example, a handwritten note might say, “If you will just bring in a recent pay stub, we can approve your Medicaid application for another six months,” whereas the computer-generated notice would say the application is being denied because of “a failure to file” or “pend for income.” Eligibility supervisors in one Minnesota county estimated that their workers add personal comments to the routine notices 60 percent of the time.

A front-line worker in one county said, “We hate the notices and just tell clients to quit reading them and call us when they have questions.” Although this view was extreme and by no means unanimous, most respondents felt that much improvement could be made in how the Medicaid program communicates with applicants and beneficiaries about eligibility actions, and that improved communication could help reduce anxiety and unnecessary confusion.

Medicaid's Low Priority in Automated Eligibility Determination Systems

In every state, respondents complained about the inadequacies of their automated eligibility determination systems for Medicaid. These inadequacies may contribute to confusion among Medicaid applicants and beneficiaries and, occasionally, lead to erroneous terminations in Medicaid coverage. Of concern as well, inadequate automated systems make Medicaid eligibility determination more time-consuming and complicated for staff than it has to be.

All the study states use computer systems to support simultaneous eligibility testing for welfare, food stamps, and Medicaid. (Because of California's county-administered approach, there is not one state system but multiple county-based systems.) A major problem is that these eligibility determination systems are managed by the welfare agency, not the Medicaid program. In effect, Medicaid programs piggyback their eligibility determination needs onto systems which are primarily designed for the monthly issuance of welfare and food stamps benefits. These eligibility determination systems are not part of a state's Medicaid Management Information System (MMIS). However, they are the source of most Medicaid eligibility and enrollment information transmitted into the MMIS.

Typically, a family applying for welfare and Medicaid benefits completes a joint application form, and then basic information from that application is entered into the online eligibility determination system.⁷ In recent years, a few states (such as Wisconsin) and some counties in California have dispensed with application forms and enter information directly online while the applicant is in the office (although a paper application continues to be available when needed). With either application mode, the system uses the information to determine eligibility under each program, applying each program's slightly different set of rules (involving countable income, disregards, the family unit, assets, etc.).

However, unlike welfare and food stamps, Medicaid eligibility encompasses many sets of groups and rules. And multiple tests may have to be conducted before the final Medicaid eligibility status for each member of a family is determined. The automated systems in most states use a hierarchical approach to Medicaid eligibility testing: (1) eligibility under the 1931 provisions, (2) eligibility under the transitional coverage for families leaving AFDC due to earnings, (3) eligibility for medically needy coverage, and (4) (for children) coverage under the poverty-related groups. (This, of course, is just a partial list.) Further, Medicaid eligibility is determined for each individual in the application, not for the entire family unit (as welfare uses) or the household (as the Food Stamp program uses).

Given this complexity, each state Medicaid program is highly dependent on its automated system. Yet respondents in every state felt that these systems were not meeting their needs. At least part of the problem is that welfare needs for system change have been enormous in the past few years, and these needs have received primary attention, while Medicaid needs have been secondary. Numerous system changes were required to implement the new TANF programs, which in many states used different benefit levels, disregards, asset levels, and family configuration rules, as well as the new work and time limit requirements. To some extent, it is understandable that greater priority has been given to these welfare requirements, since welfare reform has been a highly visible national and state priority. In addition, the state welfare programs are responsible for the day-to-day management of the systems, so it is not surprising that their needs would be addressed first. However, the current shared-systems approach is causing problems for Medicaid, given the many changes resulting from severing welfare and Medicaid, establishing separate section 1931 rules, and adding new CHIP requirements. A respondent in one state summarized the situation by saying that the Medicaid program feels like an unwelcome guest when it makes requests for changes to the state's automated system.

For example, in the past few years, Florida's Medicaid program has issued 95 different Medicaid "workarounds." Workarounds are instructions to county staff for situations in which a worker has to intervene manually in the eligibility determination process because the state's automated system has not yet been reprogrammed to reflect new Medicaid eligibility rules. A recent instruction, for example, explained to workers how to prevent the automated system from terminating Medicaid coverage for children who continue to be eligible under the new policy, which guarantees six months of continuous eligibility for children. The problem with manual interventions, particularly a large number of them, is that workers can forget them and families can be denied coverage erroneously. The risk of these types of errors is increased when many staff are new or inexperienced, as is the case with many state Medicaid programs.

Minnesota respondents also reported systems problems. Minnesota's eligibility workers have to enter the same basic information twice for a family applying to both welfare and Medicaid because the programs use different software applications that do not allow information to be shared. In addition, the automated system in Minnesota cannot directly transfer Medicaid eligibility information to the state's MMIS. Thus, once eligibility has been determined in the automated system, workers have to reenter this information manually into the MMIS. Since Medicaid eligibility is individually determined, this means information for a four-person family would have been entered four times into the automated system for Medicaid purposes and then four times again into the MMIS. Finally, Medicaid staff in Minnesota have to do a monthly reconciliation of Medicaid enrollment, to see if enrollment according to the MMIS matches the list of active enrollees in the automated eligibility system. Minnesota's system problems are extreme and do not represent all states. Nevertheless, they show for one state how the automated eligibility determination system serving the Medicaid program could be improved. The Minnesota Medicaid program deserves credit for maintaining Medicaid enrollment levels in spite of these systems problems.

Another problem mentioned by several states is that the automated eligibility systems are case- or family-based in concept, which fits with welfare's approach to eligibility determination. In contrast, Medicaid eligibility determination is individually determined, with different family members sometimes qualifying for Medicaid under different eligibility groups. Medicaid's individualized approach maximizes the likelihood of eligibility for family members, particularly children. However, some automated systems seem to have trouble accommodating Medicaid's individual-based needs simultaneously with the family-based approach for welfare and the household-based approach for food stamps.

In a few states, computer system problems have led to dire consequences, with thousands of Medicaid enrollees erroneously terminated from coverage. In Wisconsin, for example, 15,000 enrollees were cut off Medicaid by mistake during 1997, when a new three month redetermination requirement was instituted for the Food Stamp program. Wisconsin moved to fix its problems as quickly as possible so that eligibility was restored. To do so, the state had to construct a special computer program and run it weekly for several months, until the issues associated with the food stamp change were resolved.

As part of PRWORA, \$500 million in federal funds were made available to states for both outreach and redesign of their Medicaid enrollment systems, with an enhanced matching rate ranging from 75 to 90 percent. However, states have been slow to request these monies for systems efforts (only \$17 million through October 1998), perhaps in part because there are other more pressing priorities for their automated systems, including the welfare changes and the Y2K requirements. Also, as mentioned earlier, the management of these systems is largely outside the control of state Medicaid staff. Several of the states have realized, however, that their automated systems need work and are planning to make major improvements for eligibility

determination processing in the future. Wisconsin and Colorado, for example, are planning major systems improvements.

The lack of attention to automated eligibility systems for Medicaid probably reflects the reality that this has not been a high-priority area for Medicaid at either the federal or state levels. Generally, Medicaid systems efforts have largely focused on the MMIS and issues related to claims processing.

CONCLUSIONS

States have responded to many of the options in recent federal legislation that allow them to expand health care coverage. In all five study states, children with family income from 185 to 200 percent FPL are now eligible for either Medicaid or CHIP coverage (and coverage in Minnesota extends to an even higher income level). There were also expansions in policies governing adult Medicaid coverage, particularly with regard to the coverage of two-parent working families. Minnesota and Wisconsin have now made their Medicaid eligibility coverage provisions equivalent for parents and children. In the other three states, the expansions for parents were less comprehensive. These changes suggest that most states intend to expand the availability of health care coverage. It is too early to tell, however, whether these expansions will be fully realized. There is concern that these policy changes will not be sufficient to reverse recent declines in Medicaid enrollment. This study has identified a range of problems plaguing Medicaid eligibility operations, all of which may be contributing to unintended enrollment declines:

- In spite of the supposed de-linking of Medicaid and welfare rules, Medicaid and welfare systems and operations remain closely linked. Welfare staff continue to have major responsibility for educating the poorest families about Medicaid rules and serving as gatekeepers for Medicaid enrollment. Their role is pivotal to Medicaid participation for families formally or informally diverted from welfare and families leaving welfare who might qualify for transitional Medicaid coverage.
- Medicaid priorities to maintain and even expand enrollment seem to be in direct conflict with welfare reform efforts to substantially reduce enrollment.
- State responses to section 1931 requirements and the new CHIP provisions have made Medicaid eligibility rules more complicated than ever.
- Continuity in enrollment for families has not been a Medicaid priority, and states are just beginning to focus on why seemingly eligible children and families drop off of coverage and become uninsured.
- As some low-income families move into jobs where employers offer health insurance, program rules make it difficult to transition from Medicaid to this employer-sponsored health insurance coverage smoothly.
- Misinformation and confusion about Medicaid rules have become major barriers to low-income immigrants, whose participation rates have sharply declined.
- The notices and other written materials used by state Medicaid programs to communicate program rules and eligibility decisions to low-income families are often difficult to understand and may be lost among all the other types of information families receive, making them only marginally effective.
- Due to the complexity of Medicaid eligibility requirements, states are highly dependent on automated eligibility determination systems that have

become increasingly inadequate, primarily because they are designed and operated to meet welfare, not Medicaid, needs.

In response to these problems, all the study states seemed to be rethinking how Medicaid eligibility is working and beginning to consider serious changes in their program operations that would improve participation rates. They are also hopeful that CHIP outreach efforts will provide a needed boost to Medicaid enrollment.

Greater Delinking of Medicaid and Welfare. State decisions about how to address Medicaid eligibility problems will be guided by how far they choose to go in severing Medicaid from the welfare system and establishing rules and procedures for Medicaid eligibility that are more appropriate to determining the need for health insurance. An obvious direction is to move Medicaid eligibility determination for families away from the welfare-based rules and to use instead a set of simplified rules and procedures. These rules and procedures would be similar to those being used for poverty-related and CHIP children, except that states could elect to make the family financial limits more restrictive. Now that the programs are supposed to be severed, the rationale for using welfare-based approaches to counting income and assets for families under Medicaid, while using a different approach for poverty-related children, has been weakened. Nevertheless, states would probably want to design their coverage provisions so that families qualifying for welfare would continue to qualify automatically for Medicaid as well.

Just as Medicaid and welfare rules need separating, so might the infrastructures and systems that support these two programs. Medicaid programs are heavily dependent on the staff, computer systems, and local offices of the welfare system for their eligibility determination functions. Over time, the creation of a separate infrastructure to deal solely with health insurance eligibility determination might go a long way to reduce confusion among applicants and beneficiaries, as well as reducing the stigma that is associated with Medicaid by virtue of its links to welfare.

A New Vision for Medicaid. Enrollment declines are also compelling states to clarify what long-term objectives they are trying to reach with their Medicaid eligibility policies and procedures, similar to the rethinking of objectives that guided welfare reform efforts. Before reform, welfare success was measured to a large extent by whether states were writing checks for the right amount of money to families that qualified. Welfare's new objectives are to move low-income families into work as quickly as possible and to reduce dependence. As a result, success is no longer measured by quality control error rates but by caseload reductions and job placement rates.

Perhaps Medicaid needs a new vision as well. Given the federal and state governments' new emphasis on reducing uninsurance and boosting enrollment in public insurance programs, perhaps Medicaid should think of new standards of performance and quality control. New measures of "success" could include high rates of enrollment of potentially eligible children and parents, and high rates of retention and continuity of coverage for these populations. A new focus could be to get all eligible low-income families enrolled in Medicaid and keep them enrolled, as long as they do not have access to any other source of affordable health insurance.

Not all Medicaid programs are comfortable with the idea that Medicaid might become a long-term health insurance program for the poor, including the working poor. The uneasiness states feel about the future direction of Medicaid eligibility is particularly apparent in states that are opting for separate CHIP programs, which address many of the complaints about Medicaid eligibility rules and procedures. In addition to more generous financial rules, these separate programs generally extend even further the simplified eligibility approaches pioneered with child-poverty-related coverage under Medicaid. The application forms are shorter, and the

rules are less complicated. Many rely almost exclusively on mail and telephone communication with program applicants. CHIP programs also include provisions to ensure that CHIP coverage is not being substituted for private insurance. Even though they are trying to reach children in families with higher incomes, CHIP programs seem less focused on fraud and abuse. The separate CHIP programs in this study were also more likely than Medicaid to guarantee continuous enrollment for children if family circumstances change. Ironically, the separate CHIP programs seem more focused on implementing rules and procedures that facilitate continuous enrollment than Medicaid, even though the CHIP programs are serving a higher income population. However, it remains to be seen whether these separate CHIP programs will be successful in enrolling the expected numbers of low-income children and maintaining enrollment (when premiums are involved), as well as coordinating with Medicaid.

Other Steps. States and the federal government should consider not only simplification of the rules and an expanded vision for Medicaid but also other steps that might improve Medicaid participation. Listed below are ideas for consideration, although this list is not intended to be comprehensive:

Federal

- HCFA could exercise more leadership in monitoring Medicaid participation rates and reporting state enrollment levels on a more frequent and current basis. Beginning in FY1999, all the state Medicaid programs were supposed to begin submitting automated quarterly enrollment reports to HCFA, so that it should become feasible in the near future for HCFA to release Medicaid enrollment data on a much more timely basis. More timely enrollment data would help focus attention on the problem of inappropriate enrollment declines. HCFA might also consider developing action plans with states that report particularly large welfare declines to insure that Medicaid coverage is appropriately maintained.
- Over the past year, HCFA staff have stepped up their efforts to provide policy clarification and technical assistance to states on eligibility simplification for Medicaid. By posting much of this information on the HCFA website, they have greatly increased its accessibility to advocates, local Medicaid staff, and state officials. However, more could be done. In particular, priority should be given to clarifying of the relationship between TANF and state section 1931 requirements and to the issues related to Medicaid eligibility redetermination for families leaving TANF.
- HCFA could consider a greater effort to help state Medicaid programs improve their automated eligibility systems. State Medicaid officials need guidance about how to make sure these systems respond to their needs. HCFA should also consider initiatives at the federal level to help states share technology and system improvements specifically focused on Medicaid enrollment issues. HCFA should also investigate why states are not taking more advantage of the available enhanced matching funds. Areas in which

the automated systems could be improved include greater responsiveness and flexibility to meet Medicaid needs in a timely manner, customized and simplified notices and redetermination forms for applicants and beneficiaries, and single entry of information used for multiple purposes.

- HCFA might work with the federal oversight agency for welfare reform, the Administration for Children and Families, to identify better practices for coordinating welfare and Medicaid. One option to consider is sponsoring demonstrations in this area.

State

- Medicaid staff at both the state and county levels need to work more closely with their counterparts on the welfare side to make sure that the health insurance needs of low-income families in the welfare system are being addressed, particularly when parents are being diverted from welfare or are beginning to work. Planning for health insurance should become a greater part of the welfare reform effort. Strategies should also be developed to increase the number of eligible families continuing on Medicaid after they leave welfare.
- Medicaid officials might want to consider redesigning and streamlining the application and redetermination process for Medicaid groups beyond poverty-related children and CHIP children. Working/focus groups of local Medicaid staff and beneficiaries could help identify barriers to timely enrollment and redetermination. All the forms used by Medicaid could be reviewed, including the income-reporting forms required for transitional assistance and the redetermination forms in addition to the basic applications. Consideration could be given to developing simplified Medicaid application forms for families diverted from welfare or families only interested in Medicaid benefits. The expanded use of mail-in applications and redeterminations could also be considered.
- States need to provide greater authority over the automated eligibility systems for Medicaid officials, so that Medicaid needs are addressed in a more comprehensive and timely manner. Efforts to improve the notices and other forms of written communication with applicants and beneficiaries should be a high priority. Every effort should be made to use the full potential of the automated systems to reduce the burden on staff and families. The feasibility of using laptop personal computers for remote application entry (by out-stationed staff) could also be assessed.

- Like HCFA states need to improve their efforts to monitor Medicaid enrollment rates. Some counties are not even aware that the Medicaid caseload is declining. Priority needs to be placed on ways to help children and families remain continuously enrolled in Medicaid as long as they continue to qualify.
- States could consider expanding the involvement of public health staff, health care providers, and other community groups in Medicaid enrollment efforts. These organizations and individuals are often directly involved in delivering health care services to low-income families and thus have repeated opportunities to refer families to the Medicaid program and to reinforce the importance of maintaining continuous health insurance coverage. In many instances, these groups have a direct stake in making sure as many low-income families are insured as possible. They depend on Medicaid revenues, and their already precarious fiscal well-being would be seriously set back by further growth in the uninsured population.

The importance of addressing these Medicaid enrollment issues cannot be overstated. Even with the recent declines, state Medicaid programs have more enrollees than either welfare or food stamps. Medicaid should not be consigned to a lesser priority in the public assistance management system. The recent enrollment declines signal that more attention and resources are needed at both the federal and state levels to make sure eligible families take advantage of Medicaid benefits. The findings in this report draw attention to policies and administrative practices that may (unintentionally) be impeding rather than assisting Medicaid enrollment.

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ENDNOTES

1. Under the old AFDC rules, the eligibility of two-parent families was restricted. Generally, low-income families in which both parents were present in the home were not eligible for AFDC (or Medicaid) coverage unless: (1) one of the parents was disabled; or (2) the parent who was the principal wage earner (PWE) was unemployed (defined as working less than 100 hours a month). Further, the PWE had to have been unemployed for at least 30 days before applying for benefits, and the PWE had to demonstrate some past attachment to the labor force. With PRWORA, the majority of states have dropped these restrictions on two-parent families in their new welfare programs, so that single-parent and two-parent families are treated the same (Gallagher et al, 1998). Section 1931 lets state Medicaid programs do the same.
2. California is using state monies to extend transitional coverage from 12 to 24 months.
3. Under its 1931 plan, California will disregard the first \$240 of earned income, plus half of the remainder. Florida's disregards for earnings are similar — \$200 plus one-half the remainder. In both states, these earned income disregards are available only to beneficiaries, not applicants. These disregards have the effect of raising the income thresholds significantly. For example, in California, a family of three could earn up to \$1,789 per month (157 percent FPL) and still qualify for Medicaid benefits, since the state's 1931 income threshold for this size family is \$775.
4. Similar problems can occur in Minnesota with Medicaid and the separately administered MinnesotaCare program. The state's Medicaid program continues to use poverty-related income thresholds for children that vary by age. Thus, some families have older children who qualify only for coverage through Minnesota Care (which requires premiums), while younger children in the family will qualify for regular Medicaid (without premiums).
5. Under the so-called spend-down provisions of the medically needy coverage group, applicants are allowed to subtract incurred medical expenses from income in order to qualify for Medicaid benefits.
6. A recent ACF/DHHS publication, "A Guide to Expanding Health Coverage in the Post-Welfare Reform World," indicates that states have the option under section 1925 to require families qualifying for transitional Medicaid coverage to enroll in employer-sponsored insurance, whether or not it is cost-effective. However, none of the study states had elected this option.
7. The requirements associated with automated eligibility processing are considerably reduced when families request only poverty-related Medicaid coverage for their children, and they submit shorter and simpler single-purpose application forms.

APPENDIX

STATE BY STATE SUMMARY OF RECENT MEDICAID AND CHIP ELIGIBILITY CHANGES

California. California's 1931 plan changed its income thresholds, earned income disregards, asset levels, and family structure requirements to be consistent with changes in its TANF program. Although California's TANF program relaxed some of the old AFDC restrictions for two parent working families, some remain. All TANF recipients will qualify for Medicaid. The state's 1931 plan also added other features so that some families may qualify for Medicaid who would be ineligible for TANF. For example, the 1931 program treats child care costs less restrictively.

California's CHIP plan has two components. First, it extends poverty-related Medicaid eligibility to 100 percent FPL for all children under age 19 (for infants and children under age 6, the Medicaid thresholds remain at 200 percent and 133 percent FPL, respectively). Second, it establishes a separate CHIP program which covers all children under age 19 with family income to 200 percent FPL who do not qualify for Medicaid. Thus, for some families in California with income between 100 and 200 percent FPL, younger children under age 6 could qualify under Medicaid, while the older children would only be eligible for coverage under the separate CHIP program.

Other recent changes in eligibility policy in California include: asset testing for children and pregnant women qualifying for Medicaid under the poverty-related provisions was dropped in March, 1998; a new shortened 4 page mail-in application for both CHIP and Medicaid is under development, with implementation planned for early 1999; and a decision was made to guarantee 12 months continuous eligibility for children in California's separate CHIP programs, but this guarantee was not extended to Medicaid children. California also provides 24 months of transitional Medicaid coverage to adults as part of a welfare waiver.

Colorado. Colorado's 1931 plan generally paralleled the changes in the state's TANF plan, which included higher asset levels and vehicle exclusions, as well as elimination of all restrictions on two-parent families. However, neither the TANF program nor the 1931 plan changed from the old AFDC rules with regard to income thresholds or earned income disregards.

Colorado elected to establish a completely separate CHIP program. This separate program will cover any children not qualifying for Medicaid whose family income is less than 185 percent FPL. This means the separate CHIP program will cover children under age 6 with family income from 133 to 185 percent FPL, children ages born after September 30, 1983 with family income 100 percent to 185 percent FPL. It will also cover to 185 percent any other older children not yet covered by the phased-in poverty-related expansions under Medicaid.

Like California, Colorado extends a 12 continuous enrollment guarantee to children in the CHIP program, but not Medicaid children. Colorado also has a new 5 page joint mail-in application for Medicaid and CHIP.

Florida. Florida's 1931 plan generally followed the new policies of its TANF program, with more generous income thresholds and earned income disregards, a

higher asset level, an increase in the allowable equity value for a car and the elimination of restrictions for two parent families.

Florida's CHIP program has two parts. First, it expands Medicaid eligibility so that all children under age 19 with family income less than 100 percent of the federal poverty level (FPL) are covered (except for infants and children ages 1-5 years, whose eligibility had previously been expanded to 185 percent FPL and 133 percent FPL, respectively). Second, Florida established a separately administered CHIP program covering children not qualifying for Medicaid to 200 percent FPL. Thus, for some families in Florida with income between 100 and 200 percent FPL, younger children under age 6 could qualify under Medicaid, while the older children would only be eligible for coverage under the separate CHIP program.

Florida is the only study state to guarantee some period of enrollment for Medicaid children. Beginning in 1998, Florida guaranteed 6 months of continuous eligibility for all Medicaid children. In 1999, this was expanded to 12 months for Medicaid children under age 6. (Need to check on whether this extends to CHIP children as well.) A 2 page mail-in joint application form is being used for the state's separate CHIP program and Medicaid.

Minnesota. Minnesota's 1931 plan largely left in place the state's AFDC rules for July 1996, while its TANF program raised assets limits, increased the vehicle exemption level and removed all restrictions on two parent families. However, the state has obtained a waiver from HCFA to make all TANF recipients automatically eligible for Medicaid. As mentioned above, Minnesota has by far the most generous public insurance coverage of the five study states. In addition to Medicaid, all low-income families can apply to the separately administered MinnesotaCare program (which covers uninsured families with children to 275 percent FPL and uninsured adults to 175 percent FPL). Funding for MinnesotaCare generally comes from provider taxes and enrollee premiums. An 1115 waiver from HCFA allows children enrolled in MinnesotaCare to qualify for Medicaid funding, although all MinnesotaCare enrollees have to pay premiums. Unlike other states, Minnesota has a waiver from HCFA allowing families to elect to cover their children under MinnesotaCare (and pay monthly premiums), even though they could qualify for Medicaid without any cost-sharing. Minnesota also has a state-funded General Assistance Medical Care (GAMC) program for low-income adults not covered by Medicaid.

Minnesota's CHIP program is modest, given the already high levels of coverage. CHIP funding is being used in Minnesota to raise the Medicaid income threshold for infants from 275 percent FPL to 280 percent FPL.

With regard to other eligibility policies, Minnesota did not opt to guarantee child Medicaid enrollment for 12 months. The state began several years to allow mail-in applications for all its Medicaid coverage groups, as well as the MinnesotaCare program.

Wisconsin. Wisconsin's 1931 plan for Medicaid largely retained AFDC rules in place in July 1996. This means that some TANF enrollees will not qualify for Medicaid under the 1931 provisions. For example, the Wisconsin TANF program raised asset levels to \$2,000 per family, while the Medicaid 1931 level stayed at \$1,000. Wisconsin's TANF program also removed all restrictions on the eligibility of two-parent families for welfare benefits, while the state's 1931 plan left these restrictions unchanged. However,

as discussed below, these restrictions will probably be moot with the implementation of BadgerCare.

Although not in place at the time of the study visit, state-wide implementation of BadgerCare coverage for families with children occurred July 1, 1999. BadgerCare (which uses Medicaid, CHIP, and state monies, as well as premiums for higher income families) extends Medicaid coverage to children and their parents with family income up to 185 percent of the poverty level, without regard to assets. Family structure continues to be a consideration — a parent must live with a child, and only parents and step-parents can be covered.

Currently, Wisconsin does not allow mail-in applications for Medicaid or BadgerCare, or extend any guarantee of continuous coverage for children. Program simplification initiatives are supposed to be phased in as part of BadgerCare, including mail and phone options for applications and reviews, and a new one page Medicaid/Badger Care application form.

1450 G STREET NW, SUITE 250, WASHINGTON, DC 20005
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