



DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

Center for Medicaid and State Operations
7500 Security Boulevard
Baltimore, MD 21244-1850

April 7, 2000

Medicaid / TANF FILE

Dear State Medicaid Director:

Over the past few years, States have made enormous progress increasing access to health care coverage for low-income, working families. As a result of eligibility expansions, simplified enrollment procedures, and creative outreach campaigns, millions more low-income children and parents are eligible for health care coverage through Medicaid or through separate State Children's Health Insurance Programs (SCHIP). And yet, at the same time that States have made expansions of coverage a priority, instances in which eligible children and parents have lost out on coverage have come to light.

The delinkage of Medicaid from cash assistance has made it possible for States to offer low-income families health care coverage regardless of whether the family is receiving welfare, but it has created challenges as well as opportunities for States. Last August, President Clinton spoke to the National Governors' Association (NGA) about the importance of ensuring that everyone who is eligible for Medicaid is enrolled, and directed the Department of Health and Human Services (HHS) to take several actions to improve the health care available to low-income families.

Today, I am writing to provide guidance and information that will build on our joint efforts to improve eligible, low-income families' ability to enroll and stay enrolled in Medicaid. We are concerned that some families who left the Temporary Assistance for Needy Families (TANF) program and who remain eligible for Medicaid or Transitional Medical Assistance (TMA) benefits may have lost coverage. In addition, it appears that some children who became ineligible for Supplemental Security Income (SSI) benefits due to a change in the SSI disability rules may not have been continued on Medicaid despite Congressionally mandated requirements.

This letter covers three related topics. First, it outlines a series of actions that all States must take to identify individuals and families who have been terminated improperly and to reinstate them to Medicaid. Second, it clarifies guidance on Federal requirements relating to the process for redetermining Medicaid eligibility. Third, it reviews the obligations imposed by Federal law with regard to the operation of computerized eligibility systems. We have also enclosed a set of questions and answers to help States implement the guidance. We will continue to issue written answers to questions that arise and make those questions and answers available to States on an ongoing basis.

Reinstatement for Improper Medicaid Terminations

Over the past several years, cash assistance rules have changed at both the Federal and State levels. As a result of these changes to promote work and responsibility, and a strengthened economy, many fewer families are receiving cash assistance. When eligibility for cash assistance and Medicaid were delinked, Congress and the Administration took specific actions to assure that Federal law continued to guarantee Medicaid eligibility for children and families who formerly qualified for Medicaid through their receipt of cash assistance.

These changes required a significant retooling of Medicaid eligibility rules and procedures at the State and local level. In some cases, it appears that necessary adjustments to State and/or local policies, systems and procedures have not been made.

Several States have taken action to reinstate coverage for families and children who have been terminated improperly from Medicaid. Reinstatement is compelled by Federal regulations and prior court decisions. Under Federal regulation 42 CFR 435.930, States have a continuing obligation to provide Medicaid to all persons who have not been properly determined ineligible for Medicaid. This includes individuals whose Medicaid has been terminated through computer error or without a proper redetermination of eligibility. Therefore, all States must take steps to identify individuals who have been terminated improperly from Medicaid and reinstate them, as described below.

Identifying Improper Actions

A. Requirements for TANF-related terminations

States must determine whether individuals and families lost Medicaid coverage when their TANF case was closed, or when their TMA coverage period ended without a proper notice or without a proper Medicaid redetermination, including an ex parte review consistent with previous guidance. For example, States should review whether their computer system improperly terminated Medicaid coverage when TANF benefits were terminated, and they should consider whether families whose TANF termination was due to earnings were evaluated with respect to ongoing Medicaid eligibility, including TMA. In addition, if a State did not implement its Section 1931 category until some time after its TANF program went into effect, the State must review Medicaid/TANF terminations that occurred before the State had an operative Section 1931 category.

B. Requirements for terminations of disabled children eligible for Medicaid under Section 4913 of the Balanced Budget Act of 1997

Children who became ineligible for SSI due to the 1996 change in the SSI disability rules and then were terminated from Medicaid either without adequate consideration of their eligibility

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under Section 4913 of the BBA, or without a proper redetermination, including an ex parte review consistent with previous guidance, must be identified and reinstated. States must compare the Social Security Administration (SSA) list of children whose Medicaid eligibility was protected by Section 4913 and determine which, if any, of those children are not currently receiving Medicaid or are receiving Medicaid but are not identified as a Section 4913 child. The Health Care Financing Administration (HCFA) and SSA will work with States to ensure that States have the information that they need to identify Section 4913 children. The results of these cross-matches should be promptly reported to the HCFA Regional Office.

C. Improper Denials of Eligibility

In some States, eligible individuals applying for both Medicaid and TANF may have been denied Medicaid improperly because eligibility determinations continued to be linked. While HCFA is not requiring States to identify and enroll these applicants, we encourage you to do so.

Reinstatement

If, after a State-wide examination of enrollment policies and practices, it appears that there have been improper terminations since their TANF plan went into effect, States must develop a timetable for reinstating coverage and conducting follow-up eligibility reviews as appropriate. Action to reinstate coverage should be taken as quickly as possible, and States should keep their HCFA regional office informed as they review their policies and practices and develop their plans. This guidance should not delay State actions to reinstate individuals that are already under way.

Because it may not always be clear or easy for the State to determine whether a particular individual was terminated properly, States that determine that problems in policy or practice did cause individuals to lose Medicaid improperly may reinstate coverage without making a specific finding that an individual termination was in fact improper. Such action is consistent with Federal regulations that require that eligibility be determined in a manner consistent with simplicity of administration and the best interests of the applicant or recipient (42 CFR 435.902).

Federal Financial Participation (FFP) will be available for up to 120 days of coverage after reinstatement, pending a redetermination of ongoing eligibility, regardless of the outcome of the redetermination process. States that have developed reinstatement procedures have typically reinstated individuals and families for a period of 60 or 90 days. Coverage provided during this time period will not be considered for any Medicaid Eligibility Quality Control (MEQC) purpose.

If a State determines that there have been no instances of improper terminations, it should inform the Regional Office of the review undertaken and the basis for its conclusions. HCFA will provide assistance to States throughout this process.

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Contacting Individuals and Families

States may have to reinstate individuals and families who have not been in contact with the Medicaid agency for some time, and should take all reasonable steps to identify the individual or family's current address. For example, States could check Food Stamp program records for a more up-to-date address and alert caseworkers to the list of affected individuals so that these individuals are identified if they contact the agency for other reasons. Other outreach efforts might include notices to families receiving child care services and television and radio spots.

Redetermining Eligibility Once Reinstatement is Accomplished

In most situations, States will need to redetermine eligibility after reinstatement to assess whether the family or individual is currently eligible for Medicaid. To ensure that families understand the process and have adequate time to respond to requests for further information, States should allow a reasonable time for the review process. As noted above, FFP will be available for up to 120 days after reinstatement to allow States adequate time to review ongoing eligibility.

Individuals and families whose most recent Medicaid eligibility determination or redetermination occurred less than 12 months before reinstatement may be continued on Medicaid until 12 months from the date of that last eligibility review, without any new redetermination of eligibility. In these situations FFP will not be limited to 120 days. Individuals and families who have earnings may be covered under TMA and therefore would be subject to the State's TMA reporting and review procedures.

When States redetermine the eligibility of children identified by SSA as a Section 4913 child, the child does not lose protection under Section 4913 because of a prior break in eligibility. Continuous eligibility is not a requirement of Section 4913.

Covering Services Provided Prior to Reinstatement

Many of the individuals and families who were terminated improperly will have incurred medical expenses that would have been covered under Medicaid. States have the option to provide payment to providers and individuals for the cost of services covered under the State's Medicaid plan provided between the time the individual was terminated from Medicaid and reinstatement. FFP will be available to States that provide such retroactive payments, including direct payments by the State to individuals who had out-of-pocket costs for services that would have been covered by Medicaid had the individual not been terminated from the program. FFP in direct payments will be based on the full payment amount. FFP in payments to participating Medicaid providers will be at the Medicaid rate.

Review of Federal Requirements for Eligibility Redeterminations

Over the past few years, HCFA has issued guidance on the redetermination process (see letters issued February 6, 1997, April 22, 1997, November 13, 1997, June 5, 1998 and March 22, 1999). This guidance instructs States that individuals must not be terminated from Medicaid unless the State has affirmatively explored and exhausted all possible avenues to eligibility. It also outlines requirements for ex parte reviews. However, recent reports indicate that inadequate redetermination procedures have caused some eligible individuals and families to lose coverage, and some States have asked for more guidance in this area. As such, this letter restates and clarifies the previous guidance on (1) information that can be required at redeterminations; (2) ex parte reviews; and (3) exhausting all possible avenues of eligibility.

Information Required at Redeterminations

Pursuant to Federal regulations (42 CFR 435.902 and 435.916), States must limit the scope of redeterminations to information that is necessary to determine ongoing eligibility and that relates to circumstances that are subject to change, such as income and residency. States cannot require individuals to provide information that is not relevant to their ongoing eligibility, or that has already been provided with respect to an eligibility factor that is not subject to change, such as date of birth or United States citizenship.

Questions about the proper scope of a redetermination also arise when an individual reports a change in circumstances before the next regularly scheduled redetermination. Federal regulations require a prompt redetermination in such cases, but States may limit their review to eligibility factors affected by the changed circumstances and wait until the next redetermination to consider other factors. For example, if a State generally conducts a redetermination every 12 months and a parent reports new earnings three months after the family's most recent redetermination, the State must assess whether the individuals in the family continue to be eligible for Medicaid in light of the new earnings. However, it may wait until the next regularly scheduled redetermination to consider other eligibility factors.

Ex Parte Reviews

States are required to conduct ex parte reviews of ongoing eligibility to the extent possible, as stated in HCFA's previous guidance. By relying on information available to the State Medicaid agency, States can avoid unnecessary and repetitive requests for information from families that can add to administrative burdens, make it difficult for individuals and families to retain coverage, and cause eligible individuals and families to lose coverage. States should use the following guidelines and enclosed questions and answers in conducting redeterminations.

Program records. States must make all reasonable efforts to obtain relevant information from Medicaid files and other sources (subject to confidentiality requirements) in order to conduct ex

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parte reviews. States generally have ready access to Food Stamp and TANF records, wage and payment information, information from SSA through the SDX or BENDEX systems, or State child care or child support files.

Family records. States must consider records in the individual's name as well as records of immediate family members who live with that individual if their names are known to the State. Again, this should be done in compliance with privacy laws and regulations.

Accuracy of information. States must rely on information that is available and that the State considers to be accurate. Information that the State or Federal government currently relies on to provide benefits under other programs, such as TANF, Food Stamps or SSI, should be considered accurate to the extent that those programs require regular redeterminations of eligibility and prompt reporting of changes in circumstances. Even if benefits are no longer being provided under another program, information from that program should be relied on for purposes of Medicaid ex parte reviews as long as the information was obtained within the State's time period for conducting Medicaid redeterminations unless the State has reason to believe the information is no longer accurate.

Timing of redetermination. States have the option to schedule the next Medicaid redetermination based on either the date of the ex parte review or the date of the last eligibility review by the program whose information the State relied on for the ex parte review. Since the date of the ex parte review will be the later of the two dates, States could reduce their administrative burden by scheduling the next redetermination based on the ex parte review date.

Use of eligibility determinations in other programs. The responsibility for making Medicaid eligibility determinations is generally limited to the State Medicaid agency or the State agency administering the TANF program. However, the State may accept the determination of other programs about particular eligibility requirements and decide eligibility in light of all relevant eligibility requirements.

Obtaining information from individuals. If ongoing eligibility cannot be established through ex parte review, or the ex parte review suggests that the individual may no longer be eligible for Medicaid, the State must provide the individual a reasonable opportunity to present additional or new information before issuing a notice of termination.

Exhausting All Possible Avenues of Eligibility

The Medicaid program has numerous and sometimes overlapping eligibility categories. For eligibility redeterminations, States must have systems and processes in place that explore and exhaust all possible avenues of eligibility. These systems and processes must first consider whether the individual continues to be eligible under the current category of eligibility and, in the case of a negative finding, explore eligibility under other possible eligibility categories.

The extent to which and the manner in which other possible categories must be explored will depend on the circumstances of the case and the information available to the State. If the ex parte review does not suggest eligibility under another category, the State must provide the individual a reasonable opportunity to provide information to establish continued eligibility. As part of this process, the State will need to explain the potential bases for Medicaid eligibility (such as disability or pregnancy).

In addition, in States with separate SCHIP programs, children who become ineligible for Medicaid are likely to be eligible for coverage in SCHIP. States should develop systems for ensuring that these children are evaluated and enrolled in SCHIP, as appropriate. As is consistent with the statutory requirements, States must coordinate Medicaid and SCHIP coverage.

Computerized Eligibility Systems

Changes in eligibility rules affecting cash assistance and Medicaid have required States with computerized eligibility systems to modify their computer-based systems. If a State has not modified its system properly, some applicants may be erroneously denied enrollment in Medicaid. In addition, some beneficiaries may lose coverage even though they still may be eligible.

States have an obligation under Federal law to ensure that their computer systems are not improperly denying enrollment in, or terminating persons from, Medicaid. The attached questions and answers explain this obligation and present some practical suggestions on how States might meet their responsibilities under the law.

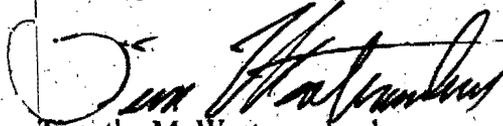
Conclusion

Most States are addressing the challenges associated with changing eligibility rules and systems, and many have developed promising new strategies for ensuring that children and families who are not receiving cash assistance are properly evaluated for Medicaid. HCFA will work with States as they assess the need for reinstatement, provide technical assistance to States implementing reinstatements, and facilitate exchanges among States to promote best practices to improve and streamline redetermination procedures. We anticipate that there will be many questions about the reinstatement process and the redetermination guidelines. We will make every effort to address your questions promptly, and to post and maintain a set of questions and answers on HCFA's website so that all States will be aware of how particular situations should be handled.

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As important as it is to correct problems that have led eligible children and families to lose coverage, it is equally important that we improve eligibility redetermination processes and computer systems to prevent problems in the future. We are committed to working with you to implement this guidance to help achieve our mutual goal of an efficient, effective Medicaid program that helps all eligible families. If you have any questions concerning this letter, please contact your regional office.

Sincerely,



Timothy M. Westmoreland
Director

Attachment

cc:

All HCFA Regional Administrators

All HCFA Associate Regional Administrators
For Medicaid and State Operations

Lee Partridge
Director, Health Policy Unit
American Public Human Services Association

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Director of Health Legislation
National Governors' Association Director

QUESTIONS AND ANSWERS

Redeterminations

- Q. When should a State rely on information available through other program records?**
- A.** States must rely on all information that is reasonably available and that the State considers to be accurate. Information that the State or Federal government is relying on to provide benefits under other programs, such as TANF, Food Stamps or SSI, should be considered accurate to the extent that those programs require regular redeterminations of eligibility and prompt reporting of changes in circumstances. For example, in the Food Stamp program, Federal law requires States to recertify eligibility on a regular basis, and individuals receiving food stamps are required to report promptly any change in their circumstances that would affect eligibility. Thus, information in Food Stamp files of individuals currently receiving food stamp benefits should be considered accurate for purposes of Medicaid ex parte reviews.
- Q. If benefits are no longer being paid under another program, can information from that program be relied on for purposes of Medicaid ex parte reviews?**
- A.** It can be relied on if the information was obtained within the time period established by the State for conducting Medicaid redeterminations unless the State has reason to believe the information is no longer accurate. For example, take the case of a State that normally schedules Medicaid redeterminations every 12 months. If a child was determined financially eligible for SSI in January, 2000 and then loses SSI on disability-related grounds in March, 2000, the SSA financial information should still be considered accurate when the State redetermines Medicaid eligibility in March, 2000.
- Q. When can the State schedule the next Medicaid redetermination if it relies on information from another program for its ex parte review?**
- A.** The State may schedule the next Medicaid redetermination based on the date of the ex parte review or the date when the last review of eligibility was conducted in the other program. For example, consider a State that normally schedules Medicaid redeterminations every six months and that determines, based on a Medicaid ex parte review in March, that the family continues to be eligible for Medicaid. If the ex parte review relies on Food Stamp program information, and the last Food Stamp review took

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place in January, the State may wait until September (six months from March) to schedule its next Medicaid redetermination review, or it may schedule the next redetermination in June (six months after the last Food Stamp recertification).

Q. When can Medicaid accept another program's eligibility requirement determination?

- A. When an eligibility requirement under another program applies equally to the Medicaid program, the State may accept the other program's determination with respect to this particular eligibility requirement. For example, if the resource standard and method for determining countable assets under the State's TANF program were the same or more restrictive than the asset rules in the Medicaid program, the Medicaid agency may accept TANF agency's determination that a family's assets fall below the Medicaid asset standard without any further assessment on its own part regarding this requirement. The Medicaid agency would then proceed to make a final determination of eligibility in light of all relevant eligibility requirements.

Q. When an individual reports a change in circumstances before the next regularly scheduled redetermination, must the State conduct a full redetermination at that time?

- A. No. The State may limit this redetermination to those eligibility factors that are affected by the changed circumstances and wait until the next regularly scheduled redetermination to consider other eligibility factors. For example, if a State generally conducts a redetermination every 12 months and a parent reports new earnings three months after the family's most recent redetermination, the State must assess whether the individuals in the family continue to be eligible for Medicaid in light of the new earnings. However, it may wait until the next regularly scheduled redetermination to consider other eligibility factors.

Whether the State conducts a full or limited redetermination when an individual reports a change in circumstance, Federal regulations require that the redetermination must be done promptly.

Q. How must the State proceed to consider all possible avenues of eligibility before terminating (or denying) eligibility?

- A. The systems and processes used by the State must first consider whether the individual continues to be eligible under the current category of eligibility and, if not, explore

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eligibility under other possible categories. The extent to which and manner in which other possible categories must be explored will depend on the circumstances of the case and the information available to the State.

For example, if the State has information in its Medicaid files (or other available program files) suggesting an individual is no longer eligible under the poverty-level category but potentially may be eligible on some other basis (e.g., under the disability or pregnancy category), the State should consider eligibility under that category on an ex parte basis. If the ex parte review does not suggest eligibility under another category, the State must provide the individual a reasonable opportunity to provide information to establish continued eligibility. As part of this process, the State will need to explain the potential bases for Medicaid eligibility (such as disability or pregnancy).

Q. If a State has determined that an individual is no longer eligible under the original category of coverage, does the State have the option to terminate coverage and advise the individual that he or she may be eligible under other categories and could reapply for Medicaid?

A. No. States must affirmatively explore all categories of eligibility *before* it acts to terminate Medicaid coverage.

Q. Does this requirement to explore all categories of coverage apply to Transitional Medical Assistance? When the TMA period is over, can the State terminate coverage and advise the family to reapply for Medicaid?

A. No. TMA is like any other Medicaid eligibility category. Eligibility under other categories of coverage must be explored before coverage is terminated. In light of expansions in coverage, particularly for children, many children in families receiving TMA will continue to be eligible under other eligibility categories.

Computer Systems

Q. My State's computer system may be erroneously terminating Medicaid coverage when families leave cash assistance. Because of Y2K, programming on a number of priorities has been backed up. The delinking reprogramming is scheduled to take place this fall. Is this an acceptable corrective action?

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- A. No. HCFA recognizes that Y2K delayed other priorities, and we know that it takes time to make computer changes. However, States have an obligation to move expeditiously to correct computer programming problems that are leading to erroneous Medicaid denials and terminations. HCFA will be working with States to correct computer problems and will provide whatever assistance we can to help resolve the problem.

In the meantime, no person should be denied Medicaid inappropriately due to computer error, and no person should have his/her Medicaid coverage terminated erroneously due to computer error. Once a problem with a State's computerized eligibility system has been identified, the State must take immediate action to correct the problem. If programming changes cannot be made immediately, an interim system to override computer errors must be put in place to ensure that eligible individuals are not denied or losing Medicaid. HCFA will review State procedures and State plans to adopt new procedures as follow-up to the Medicaid/TANF State reviews.

Q. Have other States experienced these problems? How have they corrected the problems?

- A. Each State's issues and processes are unique. The measures that will be effective to remedy computer-based problems will vary from State to State. There are a number of ways States can address these issues:

Correct the Computer Error - The most direct way to remedy the problem is by making the necessary changes to the computer system. This should occur expeditiously.

Implement an Effective Back-Up System to Prevent Erroneous Actions - While corrections to the computer system are being made, States must ensure that erroneous actions do not occur. States that have identified computer-based problems in their systems have adopted different approaches; four different approaches are described below. In each case, the State adopted a formal and systematic approach to correcting computer-based errors. A simple instruction to workers to override or work around computer errors is insufficient to ensure that erroneous denials and terminations will not occur.

Supervisory review. To stop erroneous terminations from occurring due to Medicaid/TANF delinking problems, Pennsylvania required supervisors to review all TANF case closures before any Medicaid termination could proceed. Having trained supervisors review terminations (and denials) can prevent wrongful terminations (and denials) from occurring.

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Centralized review. Maryland instituted a system in which local supervisors and a State-level task force review all Medicaid denials and terminations that coincide with a TANF denial or termination. This system has been instrumental in ensuring that thousands of eligible families were not denied or terminated from Medicaid while computer fixes were finalized.

"Peremptory" reinstatement. The State of Washington devised a system in which cases to be terminated were given a next-day audit by caseworkers and managers. Cases that continue to be eligible for Medicaid are 'reinstated' before the case is scheduled to be closed.

Interim hold on case actions. A short-term moratorium on Medicaid case closings based on certain computer codes pending implementation of other solutions might be an option for some States. Medicaid case closings could be held as long as Federal requirements on the frequency of redeterminations are met.

Q. Are there any actions that States must take before they alter their computer systems?

A. Yes. In general, prior authorization from HCFA must be obtained in order for a State to receive federal matching funds for changes it makes to its computer systems. HCFA will work with States and provide technical assistance as early in the planning process as possible in an effort to help States accomplish their objective.

Q. Is there additional funding available to help with the changes in the computer system?

A. Yes. Per our letter of January 6, 2000 concerning the \$500 million federal fund established in 1996, there is federal funding available for computer modifications related to delinking. We encourage you to review that letter and the amount your State has available from the enhanced matching funds to make changes needed as a result of the enactment of Section 1931 (the delinking provision). MMIS enhanced funding may also be available for some MMIS changes; please consult with your regional office.

Chris =
Here's a
summary
of the 1.
letters
in case
you wanted
it for 2.
Team
Leaders.
I have
some
specific
questions
on privacy
& how
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reinstatement
process
works
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I will
ask
HCFA
tomorrow.
D.

SUMMARY OF PROPOSED HHS LETTERS ON TANF-MEDICAID

1. Overview Letter

This letter states our concern that families leaving TANF and disabled children on SSI may have been inadvertently dropped from the Medicaid rolls and provides an overview of the three letters HHS is releasing on the legal requirements that states have towards these families. It credits the President.

2. Requirements for Redetermination of Eligibility

The letter details the following requirements for the redetermination process:

Limiting requests for information.

When redetermining eligibility, states must limit the scope of their inquiry to information that is necessary to determine ongoing eligibility and that relates to circumstances that are subject to change, such as income or residency.

They cannot ask for date of birth or US citizenship.

Requiring ex parte reviews.

In order to eliminate the need for individuals to provide information that is already available to states through other means, states must conduct an ex parte review, making all reasonable efforts to obtain relevant information from Medicaid files and other sources (food stamp records, TANF files, and SSA information) in order to make a determination of eligibility.

States do not have to independently verify the information in these files, and should consider them accurate for the purposes of eligibility determination.

Even if benefits are no longer being provided under another program, information from that program's files should be relied on to determine eligibility if the information was obtained in the time frame established by the state for conducting Medicaid redeterminations.

States must consider records in the individual's names as well as records of immediate family members if their names are known to the state.

States will not be liable for eligibility determination errors made because they relied on this information.

Requiring a comprehensive review.

States must have systems in place that explore all possible avenues of eligibility before terminating or denying eligibility. They must first consider whether the individual continues to be eligible under the current category of eligibility, and if not, explore eligibility under other possible eligibility categories, including S-CHIP.

3. **Obligations to Individuals Improperly Terminated from Medicaid**

This letter details the requirements for reinstatement of coverage to individuals who were improperly terminated from Medicaid:

Federal regulations require that states provide Medicaid to all eligible individuals until they are found to be ineligible:

States have a continuing obligation to provide Medicaid to everyone who has not been properly determined ineligible for Medicaid, including individuals who have been terminated through computer error or without a proper redetermination of eligibility.

States can reinstate coverage without determining that an individual or group was terminated improperly.

Because it may be difficult to determine whether a termination was appropriate, FFP will be available for all individuals reinstated in accordance with this guidance even without a specific determination that the termination was improper.

Requiring a state action plan.

By 6/1, states must develop a plan to address any improper terminations of Medicaid eligibles to be submitted to their regional office. These plans must include a timetable for reinstatements and follow-up eligibility reviews.

At a minimum, states must identify whether individuals lost Medicaid coverage when: their TANF case was closed; their TMA coverage period ended without a proper notice or without proper redetermination; or their SSI case was closed. States must also explore whether individuals applying for TANF may have been denied Medicaid improperly because the Medicaid and TANF eligibility were still linked.

Contacting families.

States must take reasonable steps to contact and reinstate families, including reviewing other state records to find current addresses and other pertinent information.

Redetermining eligibility once individuals are reinstated.

After a family is identified and re-enrolled in Medicaid, FFP will be available for up to 120 days of coverage while redetermination takes place, regardless of the outcome of the redetermination process.

Individuals and families whose most recent Medicaid eligibility determination occurred less than 12 months before reinstatement are eligible for Medicaid until 12 months from that last review. FFP will not be limited to 120 days in these instances.

Coverage for medical care provided before re-enrollment in Medicaid.

FFP will be available to states who provide payment to providers and individuals for medical care provided to families between the time the individual was improperly terminated from Medicaid and his reinstatement.

4. Operation of Computerized Eligibility Systems

This letter asserts that states have an obligation under Federal law to ensure that their computer systems are not improperly denying enrollment in or terminating eligibility for Medicaid. There are q&a that present practical suggestions on how to meet this requirement attached to the letter. These q&a also detail the steps necessary to claim funds from the \$500 million fund to pay for computer systems changes.

STATUS UPDATE ON FEDERAL REVIEWS OF STATE MEDICAID ELIGIBILITY AND ENROLLMENT PRACTICES

SUMMARY OF ACTIVITY

The national HCFA review of state Medicaid eligibility and enrollment began in September of 1999. Currently, all 50 states have been visited by HCFA regional office staff, who have completed their initial evaluation of state practices. The reports have been sent to HCFA's central office, which will review them and send them to the states, who will have two weeks to respond before the reports released to the public.

In late May, HCFA will release the first four reports (AK, UT, NV, and HI) to be completed. By mid-July, the next group of reports (CA, FL, KY, MI, SD, WI, and WY) will be ready for release. All of the reports will be released by the fall of 2000.

RESULTS FROM THE FIRST REPORTS

State reviews focused on two main issues:

- Whether states had, as required by PRWOA, established a new Medicaid eligibility category (1931) to ensure that individuals who are no longer eligible for cash assistance retained Medicaid eligibility.
- Whether states had taken action, as required in the BBA (section 4913), to ensure that children with disabilities transitioning off SSI retained their Medicaid eligibility.

UTAH. The regional office review found that Utah did not implement the 1931 eligibility category until November of 1999, causing families to be inappropriately denied Medicaid benefits, transitional Medicaid, or be required to spenddown to retain their Medicaid eligibility. In addition, the state failed to provide Medicaid benefits to the vast majority of the disabled children transitioning off SSI.

HAWAII. The regional office review found that Hawaii failed to implement the 1931 eligibility category, resulting in families being inappropriately denied Medicaid benefits and transitional Medicaid.

ALASKA. The state is in compliance with Federal statute and regulation.

NEVADA. The regional office review found that the state did not implement the 1931 eligibility group until March 19, 1999, resulting in families being inappropriately denied Medicaid benefits and transitional Medicaid. In addition, the state has not appropriately implemented section 4913, resulting in disabled children losing access to Medicaid.

WYOMING. The regional office review found that even though the state had implemented the 1931 eligibility category, families were inappropriately denied Medicaid benefits and transitional Medicaid.

PUBLIC REPORTS OF INAPPROPRIATE DENIALS OF ELIGIBILITY

Three states have independently reported that errors in their computer systems have caused the systematic denial of benefits to hundreds of thousands of people.

PENNSYLVANIA. Approximately 40,000 beneficiaries were inappropriately terminated from Medicaid. The state has begun to identify these individuals and asked them to reapply for benefits.

WASHINGTON. Approximately 100,000 beneficiaries were inappropriately terminated from Medicaid. The state has launched an aggressive outreach campaign to re-enroll these individuals.

MARYLAND. Approximately 60,000 beneficiaries were inappropriately terminated from benefits. The state is reviewing case files to reinstate individuals where appropriate.



THE KAISER COMMISSION ON **Medicaid and the Uninsured**

MEDIA ADVISORY
April 5, 2000

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Declines in Medicaid Enrollment: Has the Tide Turned?

New Data from 21 States Indicate Recent Trends, Help Assess Impact of Welfare Reform, Medicaid Expansions, CHIP

As the number of uninsured continues to climb, Medicaid – the principal source of health coverage for the low-income population – experienced declines in enrollment beginning in 1995 and continuing through 1997. Recent federal and state policy efforts have been aimed at improving coverage through Medicaid and the Children's Health Insurance Program, but policymakers have been hampered by lack of timely data to assess the impact on enrollment resulting from recent changes in welfare, job growth, implementation of the CHIP, and state efforts to streamline the Medicaid enrollment process.

The Kaiser Commission on Medicaid and the Uninsured has conducted two studies to obtain recent Medicaid enrollment data. The first, conducted in collaboration with Health Management Associates, is a pilot study that obtained Medicaid enrollment data for June 1997 to June 1999 directly from 21 states. This study provides state-by-state data on trends in overall Medicaid enrollment, as well as specific eligibility categories. The second study, conducted with the Center on Budget and Policy Priorities, provides profiles of state efforts to expand Medicaid eligibility, streamline the enrollment process, and keep eligible families enrolled.

The Commission will release new data from these studies with discussion from experts on what these findings portend for the future. These states – including the 12 with the largest Medicaid enrollments plus nine others selected to include broader representation – represented 73% of Medicaid enrollment in 1997:

Arkansas	Kansas	Ohio
California	Massachusetts	Oklahoma
Florida	Michigan	Pennsylvania
Georgia	New Jersey	Tennessee
Illinois	New Mexico	Texas
Indiana	New York	Utah
Iowa	North Carolina	Wisconsin

What: A Breakfast Briefing for Policymakers and the Media

When: Wednesday, April 12, 2000
9:00 a.m. -10:30 a.m. (8:30 Registration and Continental Breakfast)

Where: The Holeman Lounge, National Press Club

Who:

- Moderator:** Diane Rowland, Sc.D., Executive Director, Kaiser Commission on Medicaid and the Uninsured
- Presenters:** Vern Smith, Principal, Health Management Associates
Donna Cohen Ross, Director of Outreach, Center on Budget and Policy Priorities
- Discussants:** Cindy Mann, Director, Family and Children's Health Programs, HCFA
William Waldman, Executive Director, American Public Human Services Association

Space is limited, please RSVP to Tiffany Ford at (202) 347-5270



THE KAISER COMMISSION ON Medicaid and the Uninsured

DRAFT

Total Medicaid Enrollment in 21 States June 1997 to June 1999

State	Monthly Enrollment in Thousands					Percent Change			
	Jun-97	Dec-97	Jun-98	Dec-98	Jun-99	June 97 to June 99	June 97 to June 98	June 98 to June 99	June 97 to June 99
Arkansas	297.9	321.2	353.1	370.5	383.9	86.0	18.5%	8.7%	28.9%
California	5,179.0	4,969.3	4,980.9	4,988.5	5,064.9	-114.1	-3.8%	1.7%	-2.2%
Florida	1,454.9	1,460.0	1,417.9	1,485.0	1,521.2	66.3	-2.5%	7.3%	4.6%
Georgia	946.6	941.4	926.0	942.5	927.4	-19.2	-2.2%	0.2%	-2.0%
Illinois	1,305.0	1,290.3	1,243.7	1,233.9	1,246.3	-58.7	-4.7%	0.2%	-4.5%
Indiana	490.8	495.1	448.2	500.4	549.8	59.0	-8.7%	22.7%	12.0%
Iowa	213.7	210.7	206.0	201.1	200.3	-13.4	-3.6%	-2.6%	-6.3%
Kansas	183.1	175.7	168.6	167.6	178.5	-4.6	-7.9%	5.9%	-2.5%
Massachusetts	672.4	746.2	823.4	859.0	890.3	217.9	22.5%	8.1%	32.4%
Michigan	1,115.9	1,107.5	1,106.5	1,066.4	1,073.0	-42.9	-0.8%	-3.0%	-3.8%
New Jersey	693.6	669.5	671.5	675.7	659.8	-33.8	-3.2%	-1.7%	-4.9%
New Mexico	255.3	246.8	252.8	267.7	284.7	29.4	-1.0%	12.6%	11.5%
New York	2,918.7	2,858.7	2,806.3	2,746.5	2,727.5	-191.2	-3.9%	-2.8%	-6.6%
North Carolina	828.5	822.0	815.4	814.7	828.5	0.0	-1.6%	1.6%	0.0%
Ohio	1,107.8	1,060.8	1,066.9	1,062.8	1,045.6	-62.2	-3.7%	-2.0%	-5.6%
Oklahoma	282.5	291.3	310.5	318.8	355.3	72.7	9.9%	14.4%	25.7%
Pennsylvania	1,475.2	1,449.4	1,430.2	1,406.1	1,409.0	-66.1	-3.0%	-1.5%	-4.5%
Tennessee	1,324.1	1,231.1	1,282.5	1,288.8	1,306.7	-17.4	-4.7%	3.5%	-1.3%
Texas	1,944.1	1,892.7	1,803.5	1,825.0	1,776.9	-167.2	-7.2%	-1.5%	-8.6%
Utah	122.0	118.9	120.3	117.6	119.2	-2.8	-1.4%	-0.9%	-2.3%
Wisconsin	435.5	412.8	413.8	408.7	395.3	-40.1	-5.0%	-4.5%	-9.2%
21 States	23,246.5	22,771.3	22,627.8	22,727.2	22,944.1	-302.5	-2.7%	1.4%	-1.3%

Source: Compiled by Health Management Associates from State Medicaid enrollment reports.

The Administrator
Washington, D.C. 20201

MAR 22 1999

Dear TANF Administrators, State Medicaid Directors, and CHIP Directors:

Through an ongoing strategy to reform welfare, the Administration has fought to continue efforts to support low-income families, especially those trying to make the transition from welfare to self-sufficiency. As part of these efforts, it is critical that progress is made towards increasing the number of Americans with health insurance. The delinkage of Medicaid from cash assistance and declining welfare caseloads have created both challenges and opportunities for providing this support for working families. It important that we use effective strategies and find new ways to reach children and families outside, as well as through, the welfare system.

In order to help policy makers overcome these challenges, and to realize the potential of these opportunities, we have developed the enclosed guide, "Supporting Families in Transition: A Guide to Expanding Health Coverage in the Post-Welfare Reform World." This guide contains information regarding processes and procedures that will help ensure as many children and families as possible obtain health insurance.

In a letter we sent you on June 5, 1998 (<http://www.hcfa.gov/medicaid/wrdl605.htm>), we encouraged you to coordinate both the administration of and eligibility for your TANF and Medicaid programs. In that letter, we highlighted states' responsibilities to establish and maintain Medicaid eligibility for families and children affected by welfare reform, and we also outlined the broad flexibility the statute affords you to expand eligibility. Through the enclosed guide, we are providing additional information to help you accomplish these important goals.

In addition to explaining state options and suggesting appropriate strategies, the guide summarizes the application and enrollment requirements for the Medicaid program. Two of the most critical requirements are that States must:

- **Provide Medicaid applications upon request.** Based on Medicaid regulations (42 CFR 435.906), the Department of Health and Human Services (DHHS) has determined that states using joint TANF-Medicaid applications must furnish a Medicaid application immediately upon request and may not impose a waiting period before providing the application for Medicaid.
- **Process Medicaid applications without delay.** States must assure that an application for Medicaid is processed quickly and not delayed by any TANF requirement. In states where TANF application or eligibility is delayed (i.e., families receive diversionary assistance or face any other initial administrative steps), the state must process the joint application immediately to determine Medicaid eligibility.

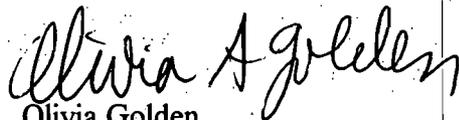
Page 2 – Dear Administrators and Directors

In addition to issuing the guide, we will be expanding our technical assistance efforts to states to ensure that TANF programs are designed and implemented so that children and their families are informed about Medicaid and CHIP and enrolled when eligible. To focus our efforts more effectively, we will work with states to review their welfare and Medicaid eligibility and enrollment procedures. This process will help us assist state agencies in improving their practices, it will further help us by identifying successful models of coordination that can be shared with other states.

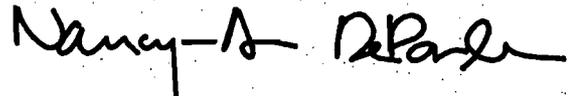
We recognize the new needs for outreach, accessibility, and coordination that have arisen from the delinkage of Medicaid from the welfare system, and the growing number of working families unlikely to enter the welfare office but likely to be eligible for Medicaid. In light of these new challenges, we are committed to working with you to establish the most effective Medicaid application and enrollment procedures for low-income families with children.

We look forward to continuing this very important work with you and to charting the gains we make together in improving the health coverage of all low-income children and families, and in supporting the transitions of families from welfare to self-sufficiency. In the meantime, please contact your HCFA or ACF Regional Administrator or your Regional Director with any questions or for additional information.

Sincerely,



Olivia Golden
Assistant Secretary
Administration for Children and
Families



Nancy Ann Min DeParle
Administrator
Health Care Financing
Administration

**PRESIDENT CLINTON:
MOVING PEOPLE FROM WELFARE TO WORK**

August 4, 1998

"Perhaps no aspect of the welfare system did more to defy common sense and insult our values than the so-called 100-hour rule. Just think of the message it sent: Instead of rewarding work, it took away health care from people who secured a full-time job. Instead of rewarding stable families, it punished couples that work hard and stay together. Instead of demanding responsibility, it basically said a father would do more for his children by sitting at home or walking away than earning a living. The 100-hour rule was wrong, and now it is history."

President Bill Clinton
August 4, 1998

Today, President Clinton will take new action to promote work and responsibility as he announces the elimination of one of the last vestiges of the old welfare system that has prevented some states from providing health coverage to working two-parent families. The President will also: send Congress a report showing that millions of families have made a successful transition from welfare to work in the two years since he signed welfare reform legislation, announce the release of new welfare-to-work grants to six states and Guam, and release new numbers showing that over 5,700 former welfare recipients have been hired by the federal government.

ELIMINATING ANTI-WORK AND ANTI-FAMILY RULES THAT DENIED FAMILIES HEALTH COVERAGE. Today, the President will announce that the Department of Health and Human Services will revise its regulations to allow all states to provide Medicaid coverage to working, two-parent families who meet state income guidelines. Under the old welfare regulations, adults in two-parent families who worked more than 100 hours per month could not receive Medicaid regardless of income level, while there were no such restrictions on single-parent families. These regulations provided disincentives to marriage and full-time work, and the Administration had already allowed a number of states to waive this rule. The new regulation eliminates this rule in every state, providing health coverage for more than 130,000 working families to help them stay employed and off welfare.

TWO YEARS LATER, MILLIONS OF WELFARE RECIPIENTS ARE WORKING. Almost two years after President Clinton signed sweeping welfare reform legislation, reports indicate that welfare reform is on the right track. The President will release a report to Congress showing a dramatic increase in the number of welfare recipients who have gone to work since welfare legislation was signed in August, 1996. The report shows that:

- The rate of employment of individuals on welfare in one year who were working in the following year increased by nearly 30 percent between 1996 and 1997. As a result, 1.7 million adults on welfare in 1996 were working in 1997;
- Families moving from welfare to work enjoy increases in income;
- Welfare rolls have dropped 27 percent since the welfare reform law was signed and the percentage of the population on welfare is at its lowest point since 1969.

GIVING STATES THE RESOURCES TO HELP MOVE PEOPLE FROM WELFARE TO WORK. Today, President Clinton will release \$60 million in funds to six states and Guam to help them move long-term welfare recipients who have significant barriers to employment obtain and retain jobs. With the funding released today, the Department of Labor has now approved resources for 38 states and Guam under the Welfare-to-Work program.

THE FEDERAL GOVERNMENT IS DOING ITS SHARE TO MOVE PEOPLE FROM WELFARE TO WORK. If we are to move people from welfare to work, the federal government must lead by example. Under the leadership of the Vice President, federal agencies have hired 5,714 people off the welfare rolls and are well on their way to meeting their goal of hiring 10,000 former recipients by 2000. Nearly 80 percent of these new employees are working outside the Washington Metropolitan area. The White House had pledged to hire six former welfare recipients and has already hired seven former recipients.

THE PRESIDENT CALLS ON CONGRESS TO FULLY FUND WELFARE-TO-WORK HOUSING VOUCHERS. The President is calling on Congress to fully fund his proposal for 50,000 Welfare-To-Work housing vouchers to help welfare recipients get or keep jobs by moving closer to job opportunities, reducing long commutes, or securing more stable housing. Although the House and Senate have approved some funds for this purpose, that funding is less than half the President's request.

BACKGROUND ON THE MEDICAID "100-HOUR RULE"

OVERVIEW. The new "100-hour rule" regulation gives states increased flexibility to offer Medicaid to low-income, working parents. Under previous welfare and Medicaid rules, a two-parent family could only be eligible for assistance if the primary wage earner was unemployed, defined in regulation as working less than 100 hours per month. Because this tended to discourage parents from working and was not applied to single-parent families, a number of states received a waiver of this "100-hour rule" prior to welfare reform. However, states that did not receive such a waiver cannot do so now because welfare reform locked in place the states' eligibility rules as of 1996.

The revision of the regulation allows all states, including those without waivers, to change the 100-hour rule, thus allowing them to cover two-parent, working families. As such, it eliminates a vestige of the old welfare system that provided disincentives against marriage and full time work. Combined with flexibility in setting income eligibility, this provision also enables all states to cover many low-income, two-parent families under Medicaid.

PROBLEM. Historically, Medicaid was an add-on to welfare, so that, in general, only people receiving welfare were eligible for Medicaid. Welfare (prior to reform in 1996) was limited to certain types of families — in particular, single-parent families or two-parent families where the primary wage earner is unemployed. These "deprivation rules" date back to the creation of the Aid to Families with Dependent Children (AFDC) program, which was targeted toward "broken" rather than poor families.

Since President Clinton took office, the inequities of limiting cash assistance and Medicaid to only a narrow group of two-parent families led to changes designed to encourage work and marriage. Rather than using the regulatory definition of "unemployed" under the old welfare law -- working less than 100 hours per month -- many states received waivers to encourage work by considering parents working more than 100 hours a week as "unemployed." As of 1996, ~~30~~ 32 states had received such waivers.

Welfare reform in 1996 limited other states from changing the 100-hour rule to allow them to cover two-parent, working families under Medicaid. It replaced it with a rule that states must, at a minimum, offer Medicaid to people who would have been eligible for welfare prior to the law. States could cover additional groups of people, but only if their income or resources were higher -- not if they worked more hours. While states that received waivers of the 100-hour rule prior to 1996 could continue those waivers, the remaining ~~20~~ states plus the District of Columbia were locked into their pre-1996 rules.

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REVISED REGULATION. To allow all states the flexibility previously offered under welfare waivers, the Secretary of Health and Human Services is revising the regulations at 45 CFR 233.101(a)(1) to permit states to extend Medicaid eligibility to families whose parents would not have met the 100-hour rule contained in the existing definition. This is a final regulation with a 60-day comment period.

EFFECTS OF THE CHANGE

The following 20 states (plus District of Columbia) did not, at the time of welfare reform, have statewide waivers of the 100-hour rule:

Alabama

Alaska

Arkansas

Colorado

Florida

Kentucky

Louisiana

Maine

~~Nebraska~~

Nevada

New Hampshire

New Jersey

New York

North Dakota

Oklahoma

Pennsylvania

South Dakota

Virginia

Wyoming

States with waivers for only subsets of families (e.g., certain counties; only parents under the age of 21) also can broaden eligibility through this revised regulation.

There are two main benefits of this change. First, it eliminates an anti-work and anti-family vestige of the old welfare system. Instead of rewarding work, the 100-hour rule took away health care from two-parent families who increased their hours at work. And instead of rewarding marriage, it punished single mothers who married and gave preference to single over two-parent families.

Second, the revision allows all states the important option of covering low-income parents. While Medicaid coverage of children has expanded, most states have not been able to extend coverage to their parents because of this rule. This change gives all states the flexibility to give the whole family, and not a fraction of it, health coverage. With this flexibility, approximately 135,000 people could gain Medicaid coverage.



July 2, 1998

Taking the Next Step: States Can Now Expand Health Coverage to Low-Income Working Parents Through Medicaid

by Jocelyn Guyer and Cindy Mann

The federal welfare law enacted in August of 1996 gives states a little-recognized opportunity to use Medicaid to provide health care coverage to low-income working parents, a population at high risk of being uninsured. This opportunity could provide an important tool for states seeking to support families that are struggling to get by at low-wage jobs with no health insurance coverage. Because this new opportunity is a Medicaid option, the federal government will finance anywhere from 50 percent to 80 percent of the cost of the coverage for low-income parents, with the exact portion determined by each state's regular Medicaid matching rate.

This issue brief describes the new opportunity and explores some of the reasons why many states are looking for ways to expand coverage to low-income working parents.⁽¹⁾

Low-Income Working Parents Are at High Risk of Being Uninsured

Nearly half (49.3 percent) of all parents who earn at least \$5,150 a year (equivalent to half-time, full-year work at the minimum wage) but whose income is still below the federal poverty line are uninsured.⁽²⁾ There is thus good reason for states to consider ways to extend coverage to poor and near-poor working parents.

Why Are So Many Low-Income Working Parents Uninsured?

Low-income working parents are at high risk of being uninsured because often their jobs do not offer health insurance, and in most states they are ineligible for publicly funded health insurance coverage.

Limited Access to Employer-Sponsored Coverage

While the vast majority of non-elderly adults can look to their employers for health insurance coverage, the majority of workers in low-wage jobs cannot. In 1996, only 43 percent of workers making \$7 or less per hour were offered health insurance coverage by their employers.⁽³⁾ Moreover, a growing share of low-wage workers who are offered coverage cannot afford to take up the offer — they cannot afford the premiums, deductibles, or co-payments they must pay to take advantage of the coverage offered by their employers.

Limited Access to Publicly Funded Coverage

Low-income working parents also have little or no access to publicly funded coverage in most states. While states have expanded Medicaid coverage for the *children* in low-income working families in recent years, the parents in these families generally remain ineligible for Medicaid.⁽⁴⁾

Most parents who are covered by Medicaid qualify under an eligibility group established in the 1996 welfare law which replaced the automatic eligibility link between Aid to Families with Dependent Children and Medicaid. Under the new eligibility group parents can qualify for Medicaid if they meet the income and resource standards and conform to certain of the family composition rules that a state used to determine eligibility under its AFDC program on July 16, 1996.⁽⁵⁾ These standards generally limit eligibility to parents with incomes well below the poverty line — parents in families with earnings become ineligible for Medicaid when their incomes are still *55 percent below* the federal poverty level (\$6,143 for a family of three) in the median state. Moreover, under these standards a parent typically must have countable resources of less than \$1,000.

Some low-income working parents may be eligible for coverage through Transitional Medicaid Assistance. TMA allows families that are on Medicaid and that would otherwise lose coverage because of an increase in earnings to continue to receive coverage for up to 12 months.⁽⁶⁾

The major shortcoming of TMA is that in order to qualify for it a family must first receive Medicaid under the July 16, 1996, AFDC income and resource standards described above. Thus, a parent whose income in recent months has not been low enough for her to meet these standards is ineligible for TMA even though her earnings may be very low and she may have no health insurance coverage. Moreover, TMA is time-limited and conditioned on a parent's ability to meet extensive reporting requirements that burden parents and states alike. Although few empirical data are available, it appears that only a small portion of families eligible for TMA coverage may be receiving it.⁽⁷⁾

Given the stringent income and resource standards that operate in most states for parents in need of Medicaid and the limited access of parents in low-wage jobs to employer-sponsored coverage, it is not surprising that large numbers of low-income working parents are uninsured.

What Is the New Opportunity?

The opportunity to expand Medicaid to low-income working parents arises primarily from the broad flexibility accorded states to define what *counts* as income and resources when they determine Medicaid eligibility for families.

The federal law requires states to disregard (i.e., not count) certain kinds and amounts of income and resources when calculating a family's *countable* income and resources. Eligibility is determined by comparing countable income and resources with the state's standards. For example, states are required to disregard \$90 in earnings each month to help parents cover some of the expenses associated with working, such as transportation costs. Thus, a parent who earns \$400 a month is treated as having *countable* income of \$310 (\$400 - \$90 = \$310).

The opportunity to expand coverage for working parents arises because the law offers states the option of setting their own income and resource disregards above the federal minimum standards when determining the Medicaid

Gross earnings (federal poverty level for family of 3)	\$1,138
Expanded disregard for earnings	- \$676
Countable income	\$462
Eligibility threshold	\$463

eligibility of families.⁽⁸⁾ For example, a state can double the \$90 earnings disregard and thus treat a parent who earns \$400 a month as having countable income of \$220 (\$400 - \$180). The following example illustrates how the flexibility granted to states to adopt alternative definitions of what counts as income or resources can be used to expand coverage to working parents more broadly.

An Example: Covering Working Parents with Income Below Poverty

Consider a state that covers a mother with two children if her countable income falls below the state's July 16, 1996 income standard of \$463 per month (or about 41 percent of the federal poverty line). If the state wants to expand Medicaid to working parents with income below the federal poverty line (\$1,138 a month for a family of three in 1998), it could establish a larger disregard for earned income.⁽⁹⁾ If it adopted an earned income disregard of \$676 per month, a family of three with earnings at the poverty line would be treated for purposes of Medicaid eligibility as having *countable* income of \$462 a month (\$1,138 - \$676 = \$462). The family, therefore, would be eligible for Medicaid under the state's July 16, 1996 income standard of \$463 a month.

There is no dispute about states' authority to adopt broader disregards to expand Medicaid eligibility. For example, the Health Care Financing Administration has approved Pennsylvania's decision to disregard 50 percent of earnings for parents who find work while they are receiving Medicaid. Moreover, states already have extensive experience using their flexibility to define what counts as income or resources to expand Medicaid for other populations. In the past, states have used a provision directly parallel to the new option to expand coverage for children and pregnant women.⁽¹⁰⁾

Reasons to Consider Covering Working Parents

The concern that low-income working parents are at high risk of being uninsured is not the only reason states have for considering expanding Medicaid coverage to working parents. Some further reasons are the following:

- **Federal Medicaid Matching Funds Are Now Available** — In the past,

states could provide health insurance coverage to working parents only if the states were willing to use their own funds entirely or to pursue a waiver of federal law that would allow them to expand Medicaid to this population. The new option allows states to receive federal Medicaid matching funds to expand coverage for this group

Additional Examples of How States Can Use the New Opportunity

- To expand coverage to working parents with income below 150 percent of poverty (by disregarding a larger portion of earnings)
- To provide extended transitional Medicaid assistance to parents entering the workforce (by providing a time-limited disregard for earnings)
- To eliminate the resource test for families (by disregarding assets)

without a waiver. The federal government will finance anywhere from 50 percent to 80 percent of the cost of expanding coverage for low-income parents, with the exact portion determined by each state's regular Medicaid matching rate.

- **The Number of Uninsured, Low-Income Working Parents Is Likely to Grow** — Over the next several years, the number of parents working in low-wage jobs is likely to increase as welfare caseloads continue to contract because of new welfare program requirements and the strong economy. Many of the parents who leave welfare will become uninsured. According to a recent review of the literature, studies "show unequivocally that fewer than half of women who leave welfare have health insurance three years later."⁽¹¹⁾
- **Coverage Promotes Work and May Reduce the Need for Welfare** — Providing ongoing health care coverage to low-income working parents will make leaving welfare and entering the low-wage job market a more viable option for many parents. Moreover, the opportunity to receive regular health care could promote job retention among low-income working parents by helping them to avoid illnesses that might cause them to miss work. For some parents in need of ongoing medical care, coverage will eliminate the need to choose between forgoing essential health care in order to keep a job and leaving a job to qualify for Medicaid.
- **It Gives Low-Income Working Parents the Same Access to Health Care as Parents Who Are Not Employed** — In the past, the policy of offering Medicaid only to families who were receiving welfare (with narrow exceptions) meant that low-income working parents were uninsured at much higher rates than their unemployed counterparts. One study found that in the early 1990s working single mothers with income below 200 percent of poverty were uninsured at twice the rate of their non-working counterparts.⁽¹²⁾ While a parent now can qualify for Medicaid without going on welfare, she still must have extremely low income in most states, making it hard for an employed parent to qualify for coverage. States that expand coverage under the new opportunity will be addressing this inequity by giving working parents more access to coverage.

Expanding Coverage for Parents in Two-Parent Families May Be a Problem in a Minority of States

The majority of states can use the opportunity extended to them under the welfare law to expand coverage for *both* single-parent and two-parent families. However, some 19 states and the District of Columbia are limited in the extent to which they can expand coverage for parents in *two-parent* families.

The issue arises because in these 19 states and the District of Columbia a parent in a two-parent family generally can qualify for Medicaid only if the principal wage earner in the family works fewer than 100 hours a month. This eligibility restriction — a remnant of standard AFDC family composition rules from July of 1996 that generally allowed states to cover only single-parent families and a limited number of two-parent families — precludes some states from expanding Medicaid to a two-parent family in which the principal wage earner works 100 or more hours a month. The majority of states are not affected by this restriction because they secured waivers of the "100-hour rule" from the Department of Health and Human Services prior to enactment of the welfare law, and under the welfare law they may apply these waivers in their Medicaid programs. It is only the District of Columbia and the 19 states that did not receive such waivers that must continue to apply the 100-hour rule when determining the Medicaid eligibility of two-parent families. ¹³

Conclusion

Low-income working parents are at high risk of being uninsured because their jobs often do not offer affordable employer-sponsored coverage, and in most states they have very limited access to Medicaid. If states do not take action, the number of uninsured low-income parents is likely to grow as changes in welfare programs and the strong economy increase the number of parents in low-wage jobs that do not offer health insurance. States now have the opportunity to receive federal matching funds to address the problem by expanding Medicaid coverage for low-income working parents. States that expand Medicaid will be offering vital support to low-income working parents, allowing many either to avoid having to apply for welfare or to shorten their stays on cash assistance. This will assure more equitable treatment for families that are trying to survive in the low-wage job market.

End Notes:

1. For a more detailed discussion of these issues and an explanation of the new opportunity, see Jocelyn Guyer and Cindy Mann, *Taking the Next Step: States Can Now Take Advantage of Federal Medicaid Matching Funds to Expand Health Care Coverage to Low-income Working Parents* (Washington, D.C.: Center on Budget and Policy Priorities, July 1998).
2. Based on Center analysis of 1997 March Current Population Survey data. "Parents" include all adults living in a household with children.
3. Philip F. Cooper and Barbara Steinberg Schone, "More Offers, Fewer Takers for Employment-Based Health Insurance: 1987 and 1996," *Health Affairs*, 16(6) (1997). The percentage of workers with wages at or below \$7 per hour who have "access" to employer-based coverage is somewhat higher — 55 percent in 1996 — because some low-wage workers are offered coverage through the employer of a family member.
4. Federal law requires states to provide Medicaid to children under the age of six with family income below 133 percent of the poverty line, as well as to older children born after September 30, 1983, with family income below 100 percent of poverty. The requirement to phase in coverage of older children assures that by the year 2002 all children under the age of 19 will be eligible for Medicaid if they have family income below the poverty line. At present, the requirement means that states must cover children between the ages of six and about 14 with family income below the poverty level. These are federal minimum requirements; a majority of states have expanded coverage above these eligibility standards, and more can be expected to do so as a result of the child health block grant included in the Balanced Budget Act of 1997.
5. Parents who are pregnant or disabled or who are experiencing extremely high medical bills may also be able to secure coverage at higher income levels.
6. Federal law requires states to extend Medicaid to families that otherwise would lose coverage because of an increase in earnings, the lapse of an "earnings disregard," or an increase in child support. Medicaid coverage for families that otherwise would lose eligibility because of child support income continues for four months, while coverage for families that otherwise would lose eligibility because of earnings continues for six months and may be extended for an additional six months if the family's gross income (not including child care expenses) is below 185 percent of the federal poverty line. Twelve states have received waivers to extend TMA for longer than 12 months, typically increasing the period of coverage to 18 months or 24 months. See Jan Kaplan, *Transitional Medicaid Assistance* (Washington, D.C.: Welfare Information Network, December 1997).
7. A recent survey of former welfare recipients conducted by the state of South Carolina found that nearly two-thirds (63 percent) of the adults who left welfare in January, February, and March of 1997 were uninsured when surveyed in October, November, and December of 1997. The vast majority of these adults are likely to have met TMA eligibility criteria. They were generally receiving Medicaid when on welfare and 63 percent of them reported that they left welfare because they got a job or earned too much money.
8. See section 1931(b)(2)(c) of the Social Security Act which allows states to use income and resource methodologies that are less restrictive than the methodologies they used on July 16, 1996 when determining the eligibility of families under the category that replaced the automatic eligibility link between AFDC and Medicaid. Since children in low-income working families generally are already eligible for Medicaid under other categories, an expansion of coverage under section 1931 will primarily help the parents in such families. In some states, older children without alternative routes to coverage may also benefit from an expansion of coverage under section 1931.
9. Under this approach, the amount of the disregard would vary by family size to allow the effective eligibility standard to correspond to the poverty line for families of all sizes. To prevent eligibility from eroding over time, the size of the disregard and/or the state's income threshold would need to be adjusted to reflect changes in the federal poverty level. For example, New York recently adopted a Medicaid disregard policy that varies with family size and over time to assure continued Medicaid coverage of working poor parents.
10. Specifically, states have relied on section 1902(r)(2) of the Social Security Act, which allows them to adopt less restrictive income and resource counting rules when determining the Medicaid eligibility of pregnant women and so-called poverty-level children.
11. Robert A. Moffitt and Eric P. Slade, *Health Care Coverage for Children Who Are on and off Welfare*, The Future of Children, Welfare to Work, Volume 7, No. 1 (California: The David and Lucile Packard Foundation, 1997).

File 100

hour
wage



July 2, 1998

**Taking the Next Step:
States Can Now Expand Health Coverage to
Low-Income Working Parents Through Medicaid**

by Jocelyn Guyer and Cindy Mann

The federal welfare law enacted in August of 1996 gives states a little-recognized opportunity to use Medicaid to provide health care coverage to low-income working parents, a population at high risk of being uninsured. This opportunity could provide an important tool for states seeking to support families that are struggling to get by at low-wage jobs with no health insurance coverage. Because this new opportunity is a Medicaid option, the federal government will finance anywhere from 50 percent to 80 percent of the cost of the coverage for low-income parents, with the exact portion determined by each state's regular Medicaid matching rate.

→ federal
govt.
financing
high portion
of costs

This issue brief describes the new opportunity and explores some of the reasons why many states are looking for ways to expand coverage to low-income working parents.⁽¹⁾

Low-Income Working Parents Are at High Risk of Being Uninsured

Nearly half (49.3 percent) of all parents who earn at least \$5,150 a year (equivalent to half-time, full-year work at the minimum wage) but whose income is still below the federal poverty line are uninsured.⁽²⁾ There is thus good reason for states to consider ways to extend coverage to poor and near-poor working parents.

Why Are So Many Low-Income Working Parents Uninsured?

Low-income working parents are at high risk of being uninsured because often their jobs do not offer health insurance, and in most states they are ineligible for publicly funded health insurance coverage.

Limited Access to Employer-Sponsored Coverage

While the vast majority of non-elderly adults can look to their employers for health insurance coverage, the majority of workers in low-wage jobs cannot. In 1996, only 43 percent of workers making \$7 or less per hour were offered health insurance coverage by their employers.⁽³⁾ Moreover, a growing share of low-wage workers who are offered coverage cannot afford to take up the offer — they cannot afford the premiums, deductibles, or co-payments they must pay to take advantage of the coverage offered by their employers.

★ many
work in low wage
jobs.

Limited Access to Publicly Funded Coverage

Low-income working parents also have little or no access to publicly funded coverage in most states. While states have expanded Medicaid coverage for the *children* in low-income working families in recent years, the parents in these families generally remain ineligible for Medicaid.⁽⁴⁾

Most parents who are covered by Medicaid qualify under an eligibility group established in the 1996 welfare law which replaced the automatic eligibility link between Aid to Families with Dependent Children and Medicaid. Under the new eligibility group parents can qualify for Medicaid if they meet the income and resource standards and conform to certain of the family composition rules that a state used to determine eligibility under its AFDC program on July 16, 1996.⁽⁵⁾ These standards generally limit eligibility to parents with incomes well below the poverty line — parents in families with earnings become ineligible for Medicaid when their incomes are still 55 percent below the federal poverty level (\$6,143 for a family of three) in the median state. Moreover, under these standards a parent typically must have countable resources of less than \$1,000.

→ too stringent requirements

Some low-income working parents may be eligible for coverage through Transitional Medicaid Assistance. TMA allows families that are on Medicaid and that would otherwise lose coverage because of an increase in earnings to continue to receive coverage for up to 12 months.⁽⁶⁾

→ Transitional Medicaid

The major shortcoming of TMA is that in order to qualify for it a family must first receive Medicaid under the July 16, 1996, AFDC income and resource standards described above. Thus, a parent whose income in recent months has not been low enough for her to meet these standards is ineligible for TMA even though her earnings may be very low and she may have no health insurance coverage. Moreover, TMA is time-limited and conditioned on a parent's ability to meet extensive reporting requirements that burden parents and states alike. Although few empirical data are available, it appears that only a small portion of families eligible for TMA coverage may be receiving it.⁽⁷⁾

TMA - time limited
→ small % of families

Given the stringent income and resource standards that operate in most states for parents in need of Medicaid and the limited access of parents in low-wage jobs to employer-sponsored coverage, it is not surprising that large numbers of low-income working parents are uninsured.

What Is the New Opportunity?

The opportunity to expand Medicaid to low-income working parents arises primarily from the broad flexibility accorded states to define what *counts* as income and resources when they determine Medicaid eligibility for families.

→ what are you counting in come. disregard

The federal law requires states to disregard (i.e., not count) certain kinds and amounts of income and resources when calculating a family's *countable* income and resources. Eligibility is determined by comparing countable income and resources with the state's standards. For example, states are required to disregard \$90 in earnings each month to help parents cover some of the expenses associated with working, such as transportation costs. Thus, a parent who earns \$400 a month is treated as having *countable* income of \$310 (\$400 - \$90 = \$310).

The opportunity to expand coverage for working parents arises because the law offers states the option of setting their own income and resource disregards above the federal minimum standards when determining the Medicaid

Gross earnings (federal poverty level for family of 3)	\$1,138
Expanded disregard for earnings	- \$676
Countable income	\$462
Eligibility threshold	\$463

eligibility of families.⁽⁸⁾ For example, a state can double the \$90 earnings disregard and thus treat a parent who earns \$400 a month as having countable income of \$220 (\$400 - \$180). The following example illustrates how the flexibility granted to states to adopt alternative definitions of what counts as income or resources can be used to expand coverage to working parents more broadly.

An Example: Covering Working Parents with Income Below Poverty

Consider a state that covers a mother with two children if her countable income falls below the state's July 16, 1996 income standard of \$463 per month (or about 41 percent of the federal poverty line). If the state wants to expand Medicaid to working parents with income below the federal poverty line (\$1,138 a month for a family of three in 1998), it could establish a larger disregard for earned income.⁽⁹⁾ If it adopted an earned income disregard of \$676 per month, a family of three with earnings at the poverty line would be treated for purposes of Medicaid eligibility as having countable income of \$462 a month (\$1,138 - \$676 = \$462). The family, therefore, would be eligible for Medicaid under the state's July 16, 1996 income standard of \$463 a month.

There is no dispute about states' authority to adopt broader disregards to expand Medicaid eligibility. For example, the Health Care Financing Administration has approved Pennsylvania's decision to disregard 50 percent of earnings for parents who find work while they are receiving Medicaid. Moreover, states already have extensive experience using their flexibility to define what counts as income or resources to expand Medicaid for other populations. In the past, states have used a provision directly parallel to the new option to expand coverage for children and pregnant women.⁽¹⁰⁾

Reasons to Consider Covering Working Parents

The concern that low-income working parents are at high risk of being uninsured is not the only reason states have for considering expanding Medicaid coverage to working parents. Some further reasons are the following:

- **Federal Medicaid Matching Funds Are Now Available** — In the past, states could provide health

insurance coverage to working parents only if the states were willing to use their own funds entirely or to pursue a waiver of federal law that would allow them to expand Medicaid to this population. The new option allows states to receive federal Medicaid matching funds to expand coverage for this group

Additional Examples of How States Can Use the New Opportunity

- To expand coverage to working parents with income below 150 percent of poverty (by disregarding a larger portion of earnings)
- To provide extended transitional Medicaid assistance to parents entering the workforce (by providing a time-limited disregard for earnings)
- To eliminate the resource test for families (by disregarding assets)

without a waiver. The federal government will finance anywhere from 50 percent to 80 percent of the cost of expanding coverage for low-income parents, with the exact portion determined by each state's regular Medicaid matching rate.

- The Number of Uninsured, Low-Income Working Parents Is Likely to Grow** — Over the next several years, the number of parents working in low-wage jobs is likely to increase as welfare caseloads continue to contract because of new welfare program requirements and the strong economy. Many of the parents who leave welfare will become uninsured. According to a recent review of the literature, studies "show unequivocally that fewer than half of women who leave welfare have health insurance three years later."⁽¹¹⁾
- Coverage Promotes Work and May Reduce the Need for Welfare** — Providing ongoing health care coverage to low-income working parents will make leaving welfare and entering the low-wage job market a more viable option for many parents. Moreover, the opportunity to receive regular health care could promote job retention among low-income working parents by helping them to avoid illnesses that might cause them to miss work. For some parents in need of ongoing medical care, coverage will eliminate the need to choose between forgoing essential health care in order to keep a job and leaving a job to qualify for Medicaid.
- It Gives Low-Income Working Parents the Same Access to Health Care as Parents Who Are Not Employed** — In the past, the policy of offering Medicaid only to families who were receiving welfare (with narrow exceptions) meant that low-income working parents were uninsured at much higher rates than their unemployed counterparts. One study found that in the early 1990s working single mothers with income below 200 percent of poverty were uninsured at twice the rate of their non-working counterparts.⁽¹²⁾ While a parent now can qualify for Medicaid without going on welfare, she still must have extremely low income in most states, making it hard for an employed parent to qualify for coverage. States that expand coverage under the new opportunity will be addressing this inequity by giving working parents more access to coverage.

→ helping leave welfare to go to work
→ employed

Expanding Coverage for Parents in Two-Parent Families May Be a Problem in a Minority of States

The majority of states can use the opportunity extended to them under the welfare law to expand coverage for *both* single-parent and two-parent families. However, some 19 states and the District of Columbia are limited in the extent to which they can expand coverage for parents in *two-parent* families.

The issue arises because in these 19 states and the District of Columbia a parent in a two-parent family generally can qualify for Medicaid only if the principal wage earner in the family works fewer than 100 hours a month. This eligibility restriction — a remnant of standard AFDC family composition rules from July of 1996 that generally allowed states to cover only single-parent families and a limited number of two-parent families — precludes some states from expanding Medicaid to a two-parent family in which the principal wage earner works 100 or more hours a month. The majority of states are not affected by this restriction because they secured waivers of the "100-hour rule" from the Department of Health and Human Services prior to enactment of the welfare law, and under the welfare law they may apply these waivers in their Medicaid programs. It is only the District of Columbia and the 19 states that did not receive such waivers that must continue to apply the 100-hour rule when determining the Medicaid eligibility of two-parent families. ¹³

Conclusion

Low-income working parents are at high risk of being uninsured because their jobs often do not offer affordable employer-sponsored coverage, and in most states they have very limited access to Medicaid. If states do not take action, the number of uninsured low-income parents is likely to grow as changes in welfare programs and the strong economy increase the number of parents in low-wage jobs that do not offer health insurance. States now have the opportunity to receive federal matching funds to address the problem by expanding Medicaid coverage for low-income working parents. States that expand Medicaid will be offering vital support to low-income working parents, allowing many either to avoid having to apply for welfare or to shorten their stays on cash assistance. This will assure more equitable treatment for families that are trying to survive in the low-wage job market.

End Notes:

1. For a more detailed discussion of these issues and an explanation of the new opportunity, see Jocelyn Guyer and Cindy Mann, *Taking the Next Step: States Can Now Take Advantage of Federal Medicaid Matching Funds to Expand Health Care Coverage to Low-income Working Parents* (Washington, D.C.: Center on Budget and Policy Priorities, July 1998).
2. Based on Center analysis of 1997 March Current Population Survey data. "Parents" include all adults living in a household with children.
3. Philip F. Cooper and Barbara Steinberg Schone, "More Offers, Fewer Takers for Employment-Based Health Insurance: 1987 and 1996," *Health Affairs*, 16(6) (1997). The percentage of workers with wages at or below \$7 per hour who have "access" to employer-based coverage is somewhat higher — 55 percent in 1996 — because some low-wage workers are offered coverage through the employer of a family member.
4. Federal law requires states to provide Medicaid to children under the age of six with family income below 133 percent of the poverty line, as well as to older children born after September 30, 1983, with family income below 100 percent of poverty. The requirement to phase in coverage of older children assures that by the year 2002 all children under the age of 19 will be eligible for Medicaid if they have family income below the poverty line. At present, the requirement means that states must cover children between the ages of six and about 14 with family income below the poverty level. These are federal minimum requirements; a majority of states have expanded coverage above these eligibility standards, and more can be expected to do so as a result of the child health block grant included in the Balanced Budget Act of 1997.
5. Parents who are pregnant or disabled or who are experiencing extremely high medical bills may also be able to secure coverage at higher income levels.
6. Federal law requires states to extend Medicaid to families that otherwise would lose coverage because of an increase in earnings, the lapse of an "earnings disregard," or an increase in child support. Medicaid coverage for families that otherwise would lose eligibility because of child support income continues for four months, while coverage for families that otherwise would lose eligibility because of earnings continues for six months and may be extended for an additional six months if the family's gross income (not including child care expenses) is below 185 percent of the federal poverty line. Twelve states have received waivers to extend TMA for longer than 12 months, typically increasing the period of coverage to 18 months or 24 months. See Jan Kaplan, *Transitional Medicaid Assistance* (Washington, D.C.: Welfare Information Network, December 1997).
7. A recent survey of former welfare recipients conducted by the state of South Carolina found that nearly two-thirds (63 percent) of the adults who left welfare in January, February, and March of 1997 were uninsured when surveyed in October, November, and December of 1997. The vast majority of these adults are likely to have met TMA eligibility criteria. They were generally receiving Medicaid when on welfare and 63 percent of them reported that they left welfare because they got a job or earned too much money.
8. See section 1931(b)(2)(c) of the Social Security Act which allows states to use income and resource methodologies that are less restrictive than the methodologies they used on July 16, 1996 when determining the eligibility of families under the category that replaced the automatic eligibility link between AFDC and Medicaid. Since children in low-income working families generally are already eligible for Medicaid under other categories, an expansion of coverage under section 1931 will primarily help the parents in such families. In some states, older children without alternative routes to coverage may also benefit from an expansion of coverage under section 1931.
9. Under this approach, the amount of the disregard would vary by family size to allow the effective eligibility standard to correspond to the poverty line for families of all sizes. To prevent eligibility from eroding over time, the size of the disregard and/or the state's income threshold would need to be adjusted to reflect changes in the federal poverty level. For example, New York recently adopted a Medicaid disregard policy that varies with family size and over time to assure continued Medicaid coverage of working poor parents.
10. Specifically, states have relied on section 1902(r)(2) of the Social Security Act, which allows them to adopt less restrictive income and resource counting rules when determining the Medicaid eligibility of pregnant women and so-called poverty-level children.
11. Robert A. Moffitt and Eric P. Slade, *Health Care Coverage for Children Who Are on and off Welfare*, The Future of Children, Welfare to Work, Volume 7, No. 1 (California: The David and Lucile Packard Foundation, 1997).

12. Pamela Farley Short, *Medicaid's Role in Insuring Low-Income Women* (New York: The Commonwealth Fund, May 1996).

13. The jurisdictions without a statewide waiver of the 100-hour rule are Alaska, Arkansas, Colorado, District of Columbia, Florida, Kentucky, Louisiana, Maine, Missouri, Nevada, New Hampshire, New Jersey, New York, North Dakota, Oklahoma, South Dakota, Tennessee, Utah, Virginia, and Wyoming.

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To: Gary Claxton
Date: April 8, 1998
Fax #:
Pages: 2, including this cover sheet
From: Cindy Mann
Subject: 100-hour rule

Currently, few states are aware of the option to expand coverage to working-poor parents through section 1931. However, we know of interest in expanding coverage to parents through this option in Maine, Rhode Island and Michigan (and to a lesser extent in Connecticut). The RI legislature had a hearing on the issue last week. The states with AFDC-U waivers can expand coverage to parents in two-parent families (see attached list of states with and without waivers), but Maine, for example, does not have a waiver and cannot expand coverage to two-parent families that do not satisfy the 100-hour rule. Over time, we expect that more states will become aware of the opportunities to expand coverage (we are releasing a paper on this soon; we have done some forums on this — one with HCFA — and are working with APWA to do more). Without the 100-hour regulation, some states will be prevented from taking advantage of the option to cover parents in two-parent families, limiting the potential reach of this effort and creating an equity issue among states.

→ If they had a waiver before

The equity issue is demonstrated by contrasting two states that have already used the opportunity created by section 1931 to expand coverage to parents. Pennsylvania, which has a waiver of the 100-hour rule, covers parents, including parents in two-parent families, with income up to about 74 percent of the poverty line. New York covers parents, including those in two-parent families, up to 100 percent of the poverty line. It appears, however, that New York's current policy of covering parents in two-parent families may be in conflict with the 100-hour requirement since NY (we believe) does not have a 100-rule waiver. (It may be that NY is paying for this coverage with state dollars.)

The additional issue to consider in terms of states' need for this regulation is the question of alignment with TANF rules. The more easily states can align their TANF and Medicaid eligibility rules, the more likely it is that they will continue to enroll people through a single application process. According to the Urban Institute's survey of states, all states other than Kentucky, Maine, Mississippi, Missouri, New Hampshire, Oklahoma, Pennsylvania and South Dakota have dispensed with the 100-hour rule in their TANF programs (although California and Indiana has the rule for applicants, not for recipients). However, of the 42 states that have already dropped

the 100-hour rules in their TANF programs, 12 states — Alaska, Arkansas, Colorado, Florida, Louisiana, Nevada, New Jersey, New York, North Dakota, Utah, Virginia and Wyoming — cannot align their Medicaid rules to cover parents in two-parent families under Medicaid because they do not have a pre-existing AFDC-U waiver.

**States With an AFDC Waiver that Allows Them to Expand Medicaid Coverage
for All Two-Parent Families Without Regard to the "100-Hour Rule"**

Alabama	Iowa	North Carolina
Arizona	Kansas	Ohio
California *	Maryland	Oregon
Connecticut	Massachusetts	Pennsylvania
Delaware	Michigan	Rhode Island
Georgia	Minnesota	South Carolina
Hawaii	Missouri	Texas
Idaho	Mississippi	Vermont
Illinois	Montana	Washington*
Indiana *	Nebraska	West Virginia
	New Mexico	Wisconsin

* Indicates that a state has a waiver of the 100-hour rule for recipients, but not for applicants. It appears that HCFA may nevertheless allow these states to disregard the 100-hour rule for both applicants and recipients.

States Without 100-Hour Rule Waivers

Alaska	New Jersey
Arkansas	New York
Colorado	North Dakota
District of Columbia	Oklahoma
Florida	South Dakota
Kentucky	Tennessee
Louisiana	Utah
Maine	Virginia
Nevada	Wyoming
New Hampshire	

As a result of the 100-hour rule, a four-person family in which the employed parent works at the minimum wage must have income below \$6,180 (38 percent of the federal poverty line) in order to qualify for Medicaid.

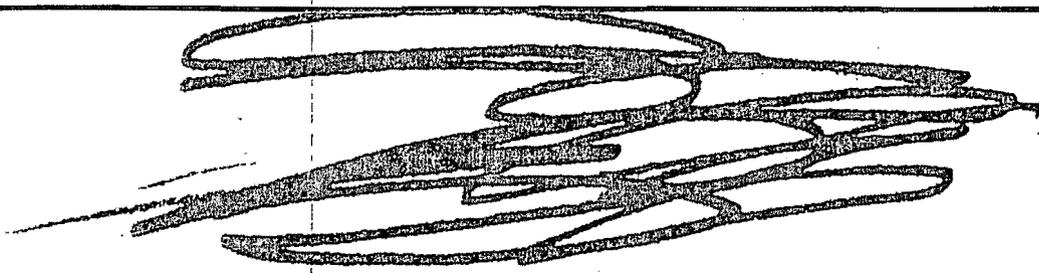
STATE	States that Dropped the 100-hour Rule (in TANF)	States with AFDC Waiver to Drop the 100-hour Rule
ALABAMA	1	1
ALASKA	1	
ARIZONA	1	1
ARKANSAS	1	
CALIFORNIA	dropped for recipe	waiver for drop recipe only
COLORADO	1	
CONNECTICUT	1	1
DELAWARE	1	1
DISTRICT OF COL		
FLORIDA	1	
GEORGIA	1	1
HAWAII	1	1
IDAHO	1	1
ILLINOIS	1	1
INDIANA	dropped for recipe	waiver for drop recipe only
IOWA	1	1
KANSAS	1	1
KENTUCKY		
LOUISIANA	1	
MAINE		
MARYLAND	1	1
MASSACHUSETTS	1	1
MICHIGAN	1	1
MINNESOTA	1	1
MISSISSIPPI		1
MISSOURI		1
MONTANA	1	1
NEBRASKA	1	1
NEVADA	1	
NEW HAMPSHIRE		
NEW JERSEY	1	
NEW MEXICO	1	1
NEW YORK	1	
NORTH CAROLINA	1	1
NORTH DAKOTA	1	
OHIO	1	1
OKLAHOMA		
OREGON	1	1
PENNSYLVANIA		1
RHODE ISLAND	1	1
SOUTH CAROLINA	1	1
SOUTH DAKOTA		
TENNESSEE	1	
TEXAS	1	1
UTAH	1	
VERMONT	1	1
VIRGINIA	1	
WASHINGTON	dropped for recipe	waiver for drop recipe only
WEST VIRGINIA	1	1
WISCONSIN	1	1
WYOMING	1	

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Supporting Families in Transition

A Guide to
Expanding Health Coverage in
the Post-Welfare Reform World

