HEALTH COVERAGE FOR FAMILIES LEAVING WELFARE

HEARING

BEFORE THE

SUBCOMMITTEE ON HUMAN RESOURCES

OF THE

COMMITTEE ON WAYS AND MEANS

HOUSE OF REPRESENTATIVES

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HEALTH COVERAGE FOR FAMILIES LEAVING WELFARE

TUESDAY MAY 16, 2000

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HUMAN RESOURCES,
Washington, D.C.

The Subcommittee met, pursuant to call, at 10:00 a.m., in room B–318 Rayburn House Office Building, Hon. Nancy L. Johnson (Chairman of the Subcommittee) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HUMAN RESOURCES

FOR IMMEDIATE RELEASE
May 9, 2000
No. HR–20

CONTACT: (202) 225–1025

Johnson Announces Hearing on Health Coverage for Families Leaving Welfare

Congresswoman Nancy L. Johnson (R–CT), Chairman, Subcommittee on Human Resources of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on maintaining the health insurance coverage of children in families leaving the Temporary Assistance for Needy Families (TANF) program for work. **The hearing will take place on Tuesday, May 16, 2000, in room B–318 Rayburn House Office Building, beginning at 10:00 a.m.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. Witnesses will include representatives from the Administration, Congressional Research Service, advocates, researchers, and State administrators . However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

In 1997, after an increase of about 4.5 million in the previous five years, the number of children on Medicaid dropped. Observers studying this drop in children's enrollment have determined that it may be associated with the replacement of the Aid to Families with Dependent Children (AFDC) program by the TANF program in 1996. Before 1996, families qualifying for the AFDC cash welfare program were automatically enrolled in Medicaid in nearly every State. But as States transitioned from the AFDC program to the new TANF program beginning in 1996, the welfare rolls declined rapidly. By 1997, they had declined by over 20 percent and by the end of 1999, they had declined by over 50 percent. Given the close link between enrollment in the cash welfare program and enrollment in the Medicaid program, the decline in Medicaid rolls after implementation of the TANF program may not be surprising. However, the welfare reform law included a requirement that States delink the eligibility process for cash welfare and Medicaid and required States to provide transitional Medicaid to individuals leaving welfare for work.

Recent studies have shown that States can take a series of administrative actions to halt and even reverse the decline in children's Medicaid enrollment. These administrative actions include ensuring that the families leaving the welfare rolls understand that they are still qualified for Medicaid, making continued enrollment in Medicaid as family-friendly as possible, sending clear and simple notices about eligibility and application requirements to families, and making announcements and forms available in Spanish and other languages.

In announcing the hearing, Chairman Johnson stated: "When we passed the 1996 welfare reform law, we were intent on ensuring that children would remain eligible for health coverage after their mother left welfare for work. Now we must be certain that States are implementing the Federal statutes so that children actually receive the coverage to which they are entitled. Our hearing will show that several States have already implemented programs that achieve this very important goal."

FOCUS OF THE HEARING:

The hearing will examine the recent decline in children's enrollment in Medicaid and the successful policies that selected States are now implementing to reverse the decline.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should submit *six (6) single-spaced copies of their statement, along with an IBM compatible 3.5-inch diskette in WordPerfect or MS Word format, with their name, address, and hearing date noted on a label*, by the close of business, Tuesday, May 30, 2000 , to A.L. Singleton, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Subcommittee on Human Resources office, room B–317 Rayburn House Office Building, by close of business the day before the hearing.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be submitted on an IBM compatible 3.5-inch diskette WordPerfect or MS Word format, typed in single space and may not exceed a total of 10 pages including attachments. **Witnesses are advised that the Committee will rely on electronic submissions for printing the official hearing record.**

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. A witness appearing at a public hearing, or submitting a statement for the record of a public hearing, or submitting written comments in response to a published request for comments by the Committee, must include on his statement or submission a list of all clients, persons, or organizations on whose behalf the witness appears.

4. A supplemental sheet must accompany each statement listing the name, company, address, telephone and fax numbers where the witness or the designated representative may be reached. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press, and the public during the course of a public hearing may be submitted in other forms.

Note: All Committee advisories and news releases are available on the World Wide Web at 'http://www.waysandmeans.house.gov".

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Chairman JOHNSON. Good morning. The purpose of today's hearing is to review whether children whose mothers leave welfare are getting the Medicaid coverage to which they are entitled and, if

not, to examine policy and programs to ensure that these children continue to receive Medicaid.

Our previous hearings have established that since the enactment of the 1996 welfare reform law, the rolls of TANF have declined steadily, that employment by single mothers, especially never-married mothers, has increased greatly and that poverty has declined every year since 1995. But our hearings have also suggested that many eligible children are not receiving Medicaid or food stamps. Thus, we want to conduct this hearing to focus on documenting the Medicaid problem and on possible solutions.

Let me state clearly that I think the Federal statutes are not the problem. Chairman Bliley, John Chafee and I, including many others, worked very hard to ensure that no child would lose Medicaid coverage as a result of the welfare reform. I have not seen evidence that the reason for declining enrollment of children is flaws in the Federal statute but, just in case, we have asked Jean Hearne of the Congressional Research Service to begin our hearing by reviewing the criteria.

We are also fortunate to have a panel of highly qualified witnesses to describe what has happened at the State level to contribute to these declines.

If I have read the reports correctly, the major causes of the decline are administrative. Some people that would have entered welfare in the past do not now often even join the rolls, and many others have left after fairly short stays. It is more difficult to ensure that these families know they are eligible and to track them so that they can be helped to maintain their eligibility.

We have invited States that have taken the strong administrative action necessary to ensure that families know that they are eligible and that State procedures make it as easy and convenient as possible for them to apply for Medicaid and maintain their eligibility once they join the rolls. As we will see, these States—Florida, Indiana and Oklahoma—have shown that aggressive State action can increase the number of children getting coverage.

I am happy that the administration is here, because I want to know what can be done by the Federal Government to ensure that all States produce the results that Florida, Indiana and Oklahoma have achieved. More specifically, we want to know if the administration has demonstrated adequate leadership on this issue and whether there are specific actions the administration should be taking to increase children's Medicaid enrollment. The problem of declining Medicaid enrollment is very, very important and, as this hearing will show, can be solved.

A major reason for conducting this hearing is that Ben Cardin and I want to bring national attention to the actions that must be taken at the State and Federal level to ensure that children continue to get Medicaid coverage. Only by facing up to the Medicaid problem and solving it can we be certain that the 1996 welfare reform law will continue to fulfill its problems. Ben.

May 15, 2000

Ms. Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration
200 Independence Ave., SW
Washington, D.C. 20201

Dear Administrator DeParle:

The nation's Governors consider health insurance a critical support for helping low-income families succeed in the workplace by remaining healthy, employed, and on a path toward career advancement. We recognize that not all families leaving welfare for work start in jobs that offer a health insurance benefit or can afford the coverage sponsored by their employers. Thus, Governors have implemented strategies to inform Medicaid-eligible families leaving welfare, as well as those not in contact with the welfare system, about Medicaid's availability and how to apply. States have also taken steps to ensure the timely and accurate redetermination of families who continue to qualify for Medicaid coverage. We would like to share some of these state approaches with you and have attached information prepared by the National Governors' Association that describes some of the activities underway.

We also appreciate the attention the Health Care Financing Administration has given to this issue through its efforts to identify promising state practices for Medicaid redetermination and broader Medicaid enrollment activities. You may be aware that the Kaiser Commission on Medicaid and the Uninsured recently released data showing an increase in Medicaid enrollment by 1.4 percent, or 320,000 people, between June 1998 and June 1999. There is also evidence to suggest that for every child now enrolled in the State Children's Health Insurance Program, states are enrolling another child in Medicaid. Thus, about 4 million more children have access to health insurance coverage today than in 1997. Governors' strong efforts can certainly be attributed, at least in part, to the Medicaid program's continuous enrollment climb.

The "delinking" of the Medicaid and Temporary Assistance for Needy Families (TANF) programs under the welfare reform law of 1996 was an added challenge and one states have been working diligently to address. Many states updated their automated eligibility systems, retrained frontline TANF and Medicaid staff, and expanded outreach and promotion efforts to accurately enroll eligible families in the Medicaid program who may have been inadvertently overlooked as a result of delinking.

Governors' hard work has been paying off and we believe this will be demonstrated in the attached descriptions. Please keep in mind that this is by no means a comprehensive list of all initiatives underway, nor is it a prescription for state policy and practice. Rather, it presents a sampling of strategies states are implementing and options for those considering similar efforts.

Once again, we appreciate your efforts to make access to Medicaid for eligible low-income families a priority. We look forward to our continued joint commitment to address issues surrounding TANF/Medicaid delinking and to find ways to make the lack of health insurance less of a barrier for low-income working families.

Sincerely,

RAYMOND C. SCHEPPACH

Aggressive State Actions Contribute to Rise in Medicaid Enrollment

Governors "efforts to insure children and families are reaping results. A study released last week by the Kaiser Commission on Medicaid and the Uninsured showed Medicaid enrollment increasing by 1.4 percent, or 320,000 people, between June 1998 and June 1999. There is also evidence to suggest that for every child now enrolled in the State Children's Health Insurance Program, states are enrolling another child in Medicaid. Thus, about 4 million more children have access to health insurance coverage today than they did in 1997. And, Governors" strong efforts can be attributed, at least in part, to the Medicaid program's continuous enrollment climb.

Following the "delinking" of the Medicaid and Temporary Assistance for Needy Families (TANF) programs, many states enhanced their Medicaid outreach and enrollment efforts, as well as exercised new policy options to enroll more families in the Medicaid program. The welfare reform law of 1996 severed the link between

Medicaid and welfare eligibility that, under the prior Aid to Families with Dependent Children (AFDC) program, meant all individuals receiving welfare payments were automatically eligible families who left TANF retained coverage, as well as make coverage available to qualified low-income families who were never in contact with the welfare system, states continue to take steps to improve their Medicaid enrollment processes, expand Medicaid promotional efforts, and align Medicaid policies to better parallel welfare reform "work first" goals. Some states have even expanded Medicaid eligibility to cover more low-income working families who are not offered health insurance by their employers. Others partially subsidize employer-sponsored insurance for low-income working families who cannot afford the premiums or copays. Governors consider health insurance to be a critical support for keeping families healthy and on the job, and they are taking innovative steps to ensure eligible families receive Medicaid coverage.

Some approaches states are taking to ensure that lack of health insurance coverage does not pose a barrier to self-sufficiency include:

- easing the Medicaid application and redetermination processes;
- expanding health insurance outreach and promotional campaigns;
- helping employers inform workers about Medicaid;
- updating and streamlining computer eligibility systems;
- training agency staff to improve Medicaid (TMA);
- covering employer-sponsored health insurance premium through Medicaid;
- paying employee shares of employer-sponsored coverage with TANF maintenance-of-effort (MOE) funds; and
- Offering Medicaid to more low-income working families with children.

- **Easing the Medicaid application and redetermination processes.** Many states are simplifying Medicaid application and redetermination processes to ensure families are not discouraged from seeking Medicaid because of complicated enrollment procedures. States are also working to guarantee that eligibility is redetermined accurately and in a timely manner. For example, Massachusetts administers a shorter, four-page mail-in application for its Mass Health program Arizona, Kansas, and Vermont are some of the states that no longer require Medicaid recipients to meet face-to-face interviews when reenrolling children in Medicaid.
- **Expanding health insurance outreach and promotional campaigns.** Most states promote Medicaid availability and how to apply. These outreach efforts include billboards and posters placed where eligible families are most likely to see them; print media, radio, and television public service announcements; information distributed through public and private providers of social services, child-care providers, schools, and employers; and Medicaid staff made available to enroll people at community events. Delaware sends Medicaid staff to enroll eligible families at community fairs, festivals, hospitals, medical centers and correctional facilities.
- **Helping employers inform workers about Medicaid.** Employers, particularly small businesses and firms that employ individuals at relatively low wages, may find financing employee health care to be extremely costly. However, many of these employers may hire employees who are eligible for transitional Medicaid (TMA) or that have children who qualify for the State Children's Health Insurance Program (SCHIP) or another poverty-related Medicaid category. Minnesota informs employers about Medicaid availability through mass mailings, presentations to small businesses, and job expos, information provided to recently laid-off employees, paycheck inserts, and other activities.
- **Updating and streamlining computer eligibility systems.** Many states are updating their information systems to improve the extent to which potentially eligible low-income families who are either outside the welfare system, diverted from welfare, or have had their welfare case closed due to increased earnings or another reason, are accurately identified for and enrolled in Medicaid. For example, Georgia's online System for the Uniform Calculation and Consolidation of Economic Support Services (SUCCESS), screens for an applicant's potential eligibility for Medicaid, TANF, and food stamps all at once. If an applicant is ineligible for one category of Medicaid, SUCCESS will automatically identify other Medicaid categories in which the family may qualify.
- **Training agency staff to improve Medicaid enrollment.** Some states are using Medicaid staff to crosstrain staff in other agencies, one-stop career centers, community health clinics/treatment centers, homeless shelters, and other locations on how to link qualified individuals with health insurance coverage. For example Indiana retrained TANF eligibility determation staff on the importance of ensuringthat families eneroll in TMA after they leave cash assistance. As a result, many local offices increased their followup of families missing redetermination appointments.

In additin to improving Medicaid outreach and enrollment *procedures*, several states are also revising *Policies* to help low-income working families obtain health insurance.

• **Lengthening the period families can receive transitional Medicaid.** States are using the new flexibility in the welfare law to lengthen the period a family may receive Medicaid after going to work by disregarding a portion of their earnings from the eligibility calculation. For example, a state could disregard all of a Medicaid recipient's earnings below a certain level (such as the poverty level) for a limited period of time (such as six months). Once this period expires, a family becomes eligible for an additional twelve months of TMA. New Jersey, North Carolina, and South Carolina are a few of the states that have disregarded certain levels of income to provide TMA for an additional 12 months.

• **Covering employer-sponsored health insurance premiums through Medicaid.** Some states developed programs under Section 1115 waivers to subsidize employer-provided health care for families who cannot afford the premiums for health insurance offered at work. In January 1999, Massachusetts expanded its MassHealth program under a Section 1115 Waiver to assist low-income working adults with incomes up to 200 percent of the federal poverty level (FPL) to purchase their employers' health insurance provided they are working for an employer with fifty or fewer full-time employees.

• **Paying employee shares of employer-sponsored coverage with TANF MOE funds.** While federal TANF funds cannot be used for medical services does count toward the TANF maintenance-of-effort (MOE) requirement if it is consistent with a TANF purpose (such as supporting work). A state, therefore, could pay the employee share of employer based health insurance for some period of time or up to a specified income level for former welfare recipients or even needy families (as defined by the state) who have never been on welfare. For example, under its new TANF state plan, West Virginia will provide a maximum subsidy of $125 a month to help former West Virginia Works Works recipients with incomes below 185 percent of the FPL who exhaust their TAM purchase health insurance coverage through ther employer for themselves and their spouses.

• **Offering Medicaid to more low-income working families with children.** A few states are using welfare law flexibility to expand coverage to include low-income working families outside of welfare programs who lack affordable health insurance. This is achieved by providing more generous earnings disregards not only for Medicaid recipients but for applicants as well so that a family that is already working may apply and be eligible for Medicaid. In fall 1998, Rhode Island's Medicaid program, Rite Care, began disregarding income so that working parents with incomes up to 185 percent of the FPL would be eligble. The District of Columbia's DC Healthy Families program provides coverage for parents and children with incomes up to 200 percent of the FPL.

Governors are taking the lead to ensure eligible low-income families have access to Medicaid through a wide range of initiatives, including eligibility determination, staff training, systems enhancements, and outreach. They are also finding ways to make lack of health insurance less of a problem for some low-income families by partially offsetting employer-offered insurance or expanding temporary eligibility for Medicaid. With such efforts to improve Medicaid access taking place across tha nation, the trend in rising Medicaid enrollment is likely to continue.

***The NGA Center for Best Practices will publish a report presenting more detailed policy and program options and state examples for improving access to Medicaid and transitional Medicaid in the next month.

Mr. CARDIN. Thank you, Madam Chair. Thank you very much for holding these hearings.

We have talked on many occasions about our concern that those eligible for Medicaid be, in fact, enrolled in the Medicaid Program, and when you take a look at what has happened since welfare reform on Medicaid enrollment, it leads you to just one conclusion and that is that the number of children who are eligible for Medicaid has declined as a result of the Welfare Reform Act, that there is a relationship between welfare reform and the number of children who are covered by Medicaid.

The number of poor children covered by Medicaid declined by 1.3 million between 1996 and 1998, down from 9.1 million to 7.8 million. This decline far exceeds the reduction in child poverty over the same time period or the various projections on how many children would be eligible for Medicaid coverage. And when you take a look at those that have traded welfare for employer-based coverage there has not been the equivalent increase. Nearly 30 percent of the children leaving TANF were uninsured within 11 months of exiting the rolls. The vast majority of these children were statutorily eligible for Medicaid.

Now, when you take a look at what has happened around the Nation, I am sure that in some States this has happened because of neglect. They have not spent the resources or changed the computer programs or went through all that was necessary to make sure that we didn't lose children eligibility in Medicaid as we implemented the welfare reform proposals. Considering the fact that Congress provided 90 percent of the Federal match for States' expenditures associated with delinking Medicaid and TANF eligibility, this lack of oversight is particularly disconcerting. Other States, I am sorry to observe, I think intentionally went in the wrong direction by linking the eligibility criteria for TANF, Medicaid and food stamps, which is clearly inappropriate.

Madam Chair, in regards to your comments that the Federal Government doesn't share in some of this responsibility, let me make an observation I think that we do have some culpability in this area. When you look at what we have done with immigrant families in this Nation, I think we have intimidated a lot of people in applying for benefits that they are entitled to.

Also, I must say that the Federal eligibility critical for Medicaid has become increasingly complex over this period of time. For example, families that leave welfare for work only receive their second 6 months of transitional Medicaid if they prove they have incomes of less than 185 percent of the poverty level. This additional redetermination places one more barrier between families and health coverage. It serves little purpose, since very few welfare leavers have obtained incomes twice the poverty level within a year of exiting public assistance.

Madam Chair, 3 years ago, Congress passed the CHIPs program on a bipartisan basis to ensure that needy children have access to health care. We need to work to ensure that welfare reform does not undercut that critical goal.

Madam Chair, let me just say I look forward to all of the witnesses that are going to be testifying today, but I particularly want to welcome our colleague and friend Pete Stark. He has been one of the real champions in this Congress about providing universal health coverage for children, and I certainly agree. My only objection is it should be universal coverage of health insurance, period.

I look forward to hearing from all of the witnesses today so that we can try to develop strategies that work, look at some of the States that have been successful in getting more children enrolled in the Medicaid Program that are eligible, and try to come out with some bipartisan recommendations to make sure that more of our children are covered by health insurance.

Chairman JOHNSON. Thank you.

Mr. Stark, it is a pleasure to have you on that side of the table.

STATEMENT OF HON. FORTNEY PETE STARK, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. STARK. Thank you, Madam Chair. Thank you for this hearing and allowing me to have an opening statement and, indeed, to testify.

My temptation would be—to remind some of my colleagues that I was one of, I guess, four or five—all but one Democrat who opposed this welfare reform bill, and in the department probably three of the leading experts in welfare in the country resigned from our President's administration in protest to his signing it. But that is done, and it is the law of the land, and I don't think that is the issue—the underlying focus of the welfare reform bill I don't think is the issue.

The focus of the welfare reform bill was on adults, and it ran all of the way from the extreme, I suppose, from people who felt that adults who accepted welfare have the wrong religion or they are bad people to extreme liberals like myself who think that we ought to give everyone a guaranteed minimum income as President Nixon first suggested and then we would not have this problem.

Somehow, the topic of children got lost in all of that, and I am going to suggest this morning that it doesn't make any difference. Children are not shiftless by birth, and they don't make the decisions, and they are not responsible for their own health insurance, and you can go on. The kids are a by-product of whatever we have done, for better or worse.

And I don't think that there is any quarrel here, just a couple of things that I think we can agree on. I don't think that anybody in this room disputes that in today's delivery of medical care to not have insurance or be part of a program means you don't get first-rate medical care. You may get it later at the emergency room. But I think to be uninsured or outside of a program like the military or some other program is to infer that a child does not get proper medical care.

And I would further ask you to stipulate with me that every dollar we can spend in the first couple years of a chilled's life in the aggregate will save the community $5 between the time they are 3 and the time they are 20.

Now the unfortunate thing is that we can't get any budgets going for that, but I don't think that there is a physician or a person that is involved in health care work that denies that we save money as a community. The trouble is that we are not required by law to pay for it, so we don't get a budget saving.

Now we get into an area where there may be some disagreement, and you will hear a lot of witnesses talk a lot today about why kids—why there are more uninsured kids or, if there are not more, I don't think that we are going to get any argument that there are somewhere around 10 or 11 million kids without health insurance. Is that growing or declining? Either way, it is a little bit——

The bad number is that there are 10 million, give or take a million, kids out there without insurance today. Regardless of who their parents are or regardless of how you feel that the government should intrude in their lives, that is not a good thing for our soci-

ety. It is going to cost us money as a society. It is going to cost us productivity. Because kids who are sick don't learn, as well as a whole host of things that we know are wrong.

And I am going to suggest that maybe this is a systemic or a problem that we can't resolve through a bunch of legislation. We have the CHIP program to see if we can bring kids in, and it hasn't worked. I have 15,000 kids in my district or the county in which my district resides and—who are eligible, we estimate, for CHIP; and we have only have a thousand signed up; and we can't find the other 14,000. I hear bad program, the social service is not doing it, a lot of immigrant families—I have heard all of the excuses. Nonetheless, I still have 14,000 kids not in the program.

But let's go to us old folks. In SSI we probably don't have half—Ron can give me the number. How many eligible for SSI participate? Not half. And we have Social Security writing Medicare books at a 4th grade level because that is the level that they think the understanding is.

In the QMB/SLMB plan, 60 percent of those eligible get their Medicare extra benefits. These are seniors who arguably ought to be able to read by the time they are 65. And out of the SLMB, which is the people between 100 to 120 percent of poverty, only 10 percent of those eligible are signing up. Does it come as a great surprise that maybe we are not signing up all eligible kids?

For whatever reason, and it is not just Federal Government, some States do better. New York basically kicked kids out of Medicaid when they shouldn't have. So you can look around and you will hear from the administration and other bureaucrats today who say it is everybody else's fault. Fault is a useless concept in this regard.

There are 10 million or 11 million kids without insurance. I think we can do something about that. It may not take the form that I am about to suggest to you, but I want to suggest its fundamental concept is something that this Committee might consider.

Senator Rockefeller and I have introduced a bill called Medikids, something like that. Very catchy, Medikids. And it is basically Medicare for all children, but the concept grew this way. We said we are messing around with all of these programs to try to get kids insured, and it isn't working. How about we just say that every child, when the child is born, is in a program.

Now, I can hear my good friends on the right saying, whoa, that is Big Brother in spades, and it is. But this is merely a question of identifying that each child gets medical care because—first of all, you charge the parents. Without going into details of what Medicaid is, the idea is that it is the ultimate safety net. If the parents have group health insurance, the kids are out of it.

It is done through the Tax Code, so you can do it for every month or every day that the kids have other insurance, the parents don't have to pay. I think it is $20 a month per child. That pays a quarter of the child. The cost is a thousand bucks a year on average per child to give them, basically, Medicaid-type benefits.

We say, wait a minute. If the parents have group insurance where they work, as I do with Federal employee benefits, I just tack that onto my tax return, and I reduce the thousand dollars or the $20 a month that I would otherwise pay. If I am out of work

for 6 months during the year, my insurance drops, my child automatically goes back into the Medicaid Program during that period. It is the ultimate fail-safe for a child without other insurance being in a program.

It doesn't cost much the first year because we phase ours in starting with all of the children born the first year. The second year, we take all of the kids born and 2 years old. So it costs a half billion the first year. The kids pretty much divide up into $500,000. It costs $500 million the first year, and so at the end of the 20th year, you are spending $10 billion a year. Yes, that costs, and that is the share that the parents are not paying through a premium.

We could vote tomorrow to waive the phone tax and darn near pay for this for a long time, just to show you that it would be pretty easy to pay for it, and I have not had one letter of complaint in the almost 30 years I have been in Congress about the phone tax. We are going to waive it tomorrow, and I am just suggesting that there is money around at the level of this amount if we want to fund health insurance for kids.

But I want to come back to the underlying concept, and that is that all the programs that we have that require application, almost every child that goes into an emergency room gets into the CHIP program because the hospitals are really tough about making sure that they get paid. So they find out whether the child will qualify and the parents qualify and get them admitted.

But whether we do it through schools or States or counties, it doesn't work. It doesn't work for SSI, it doesn't work for QMB or SLMB. In every one of those cases, you can say, they are adults. Why should we be Big Brother?

I am not sure that we have to say that for children. I think perhaps on a bipartisan basis we can say that's OK. Children—we don't punish them. They are not at fault. If there is a reason to have a social contract and it saves the country money——

So I guess what I am saying is, whatever we do, could we make the enrollment of children in this program automatic so that the default is that the child has the insurance and then they have to get out through private insurance or otherwise? And that, basically, is the basis of what I am urging on my colleagues today.

We can solve this problem. I don't think we are going to solve it with a new kind of rule or program or getting after whether it is Health and Human Services or whether it is the State Social Services Commission. Whether it is in Louisiana or Wisconsin or Maryland or Connecticut, I don't think—it differs in every state. We could resolve that problem somehow right here if we could come forward with a program that says from the git-go every child is in. Now State, you get them out. That is a different issue, and that is the basis of my testimony.

Thank you for letting me plead my case, Madam Chair.

[The prepared statement follows:]

Statement of Hon. Fortney Pete Stark, a Representative in Congress from the State of California

Madam Chairman and Members of the Subcommittee:

• Families leaving welfare for work are among the most vulnerable in America. They deserve the best we can give them. Yet study after study shows that states have not done well by these fragile families, particularly when it comes to Medicaid.

• A 1999 Families USA study found that as of 1997, an estimated 675,000 parents and children lost Medicaid coverage and became uninsured as a consequence of welfare reform. An October 1999 report by the Center on Budget and Policy Priorities found that between 1996 and 1998, the number of poor children covered by Medicaid fell by 1.3 million, with only about half of that decline attributable to the drop in the number of children living in poverty. And from 1995 to 1998, monthly Medicaid enrollment declined by 12% in California, 18% in Florida, and 29% in Wisconsin, according to work by Marilyn Ellwood of Mathematica policy Research.

• We also know that overall, the number of children who have any source of health insurance is not increasing, a despite enactment of the State Children's Health Insurance Program in 1997.

• Some of the witnesses today will point out that in some states, Medicaid enrollment drops appear to be slowing or halting. But will 11.1 million children lacking health insurance in 1998 and far higher rates of uninsurance among non-elderly adults, we still have a long way to go.

• Advocates and researchers point out that virtually all children in families leaving welfare remain eligible for Medicaid or CHIP, as do many of their parents. This is because most states now extend coverage to children in families with incomes up to 200% of the poverty line, and most families leaving welfare are taking low-wage jobs that are well below this level, Also, parents taking low-wage jobs that do not offer health insurance should remain eligible for Transitional Medicaid coverage. But many are instead being erroneously terminated.

• Many of these terminations appear to be a case of benign neglect by states. Advocates charge they have failed to adequately train caseworkers, provide information to recipients, or revise computer systems on the issue of continuing Medicaid eligibility for individuals leaving, losing, or in some cases, being diverted from cash welfare.

• There is no good excuse for these failures, since the 1996 welfare law provided states with $500 million to help them figure out how to delink the AFDC program is extremely generous, at 90%, states have still drawn down only $125 million of this funding. This suggests that the Administration needs to require that this money gets spent on programs that result in clear information being disseminated to families about their Medicaid eligibility, that streamline application procedures, and that make parents aware that even if they become ineligible for Medicaid assistance, their children in all likelihood can continue to be covered.

• Advocates are finding that in too many cases, caseworkers are not telling families that they are still eligible for Medicaid even if they are not receiving cash assistance. Under law, families have a right to file a Medicaid application and have it processed within 45 days. This information should be made part of the standard,routine assessment of all families who are leaving welfare, Local welfare offices have a fundamental responsibility to get this basic information out to all families, many of whom have heard about the welfare law's restrictions and assume they also apply to Medicaid.

• On the issue of improper diversion, the infamous New York City experience simply must not be repeated or tolerated. Until advocates raised concerns, city officials were effectively prohibiting individuals applying for cash assistance from also applying for health insurance and food stamp benefits during their first office visit. This illegal and thoroughly despicable practice was only stopped when a judge issued an injunction ordering the city to cease and desist.

• The consequences of failing to ensure that eligible families continue to have coverage under Medicaid are serious, because these individuals are at high risk of becoming uninsure. Analysis by the Center on Budget and Policy Priorities that is based on state leaver studies finds that in most states, fewer than one in six children and parents who have left welfare are enrolled in private coverage. These studies also show that more than one in five children are uninsured after leaving welfare. The situation for their parents is worse, with close to half of parents in leaver studies lacking coverage. This results in unmet medical needs that are documented in some of the state leaver studies. This results in unmet medical needs that are documented in some of the state leaver studies.

• The federal government has an obligation to reverse these dismal trends. And while there are many ways of making incremental improvements, such as guaranteeing transitional Medicaid for a full year, there are also bolder steps that we can take.

• For our kids, I believe that the most straightforward way to accomplish the goal of providing all children with health insurance is to create a federal fallback program for all children who have no other source of coverage. That's the aim of a proposal I introduced on May 4 with Senator Rockefeller, the "MediKids Health Insurance Act of 2000." It's a simple bill that would provide children not enrolled in any

other health insurance program with benefits that would be similar to those available to children under Medicaid now. Children could still get their health benefits through their parents' employer, Medicaid, or CHIP. But all children would have the permanent safety net of the MediKids program.

• I hope that my colleagues on both sides of the aisle will join me in support of this proposal, which over time could become a universal health insurance program for children like Medicare is for seniors and desabled people.

• Thank you for allowing me to testify today.

Chairman JOHNSON. Thank you. I think the concept of opt-out rather than opt-in is an interesting one. I think we have to have that choice in Medicaid rather than Medicare because the coverage is broader in Medicaid.

Mr. STARK. Our bill is the Medicaid benefits. And we anticipate, quite frankly, the kids would drop out of Medicaid. It would eventually go away and become this by default.

Chairman JOHNSON. You have the additional problem of how much you draw family coverage out from under the private sector. My experience with Medicaid as a program to provide health insurance for children has not been encouraging, and the depth of the antagonism of working parents to have their kids in a federally funded program has surprised me. When we visited Florida, this Subcommittee, we asked the workers specifically about that, and they preferred to wait until they could qualify for their employer-provided plans.

We have taken quite a bit of time, and I don't want to defer the other panels, but these are the kinds of problems that we would have to deal with to go to an opt-out.

Mr. CARDIN. If the Chair would yield, the next witness will be testifying that 55 percent of the Nation's children who live in poverty are covered by Medicaid—which means 45 percent are not. An overwhelming majority of those kids are not covered by any other insurance. It underscores when you have an affirmative obligation to enroll there are an awful lot of children that are not getting covered. It underscores the importance of your testimony.

Chairman JOHNSON. Mr. Watkins.

Mr. WATKINS. I would like to say, Madam Chair, I understand, and I have been going through an experience somewhat by choice. And I say that because my wife and I just brought a little family up to our area, two daughters, 4 and 6. I thought it would be great if we would help them get a job where they had health care, and we did. We got them a job. I even signed them a note to try to get them a place to live so they can start having a home. They were there less than 2 months, and this past month they made the decision that they were not going to be there. This is the first time these children had insurance. It is the first time—we would have seen that they got a college education. But they opt out to go back.

Let me say I grew up in dirt-poor poverty, and I understand lots of time the thinking, but I don't know, a lot of it is by choice. I don't know how we work that through. Because little Jeanette and little Isabel, their future is really going to be affected.

Mr. STARK. But it wasn't the kids' choice.

Mr. WATKINS. But the parents' choice. They had no care or concern for their own children. They had a home and health insurance coverage—for the first time ever. It was the parents that just——

So I don't know how you get there sometimes with a lot of this. You want to make sure you are able to help lift them out of this living condition, you know. Are you poor white trash? We all know education is the greatest way to lift people out of poverty, so if you can just make it so that they don't want to get out of it—you have to have some kind of incentive for them to come out of it. I don't know. My wife and I work with all kinds of situations.

Mr. STARK. My only sense is, if we can't deal with the parents, ought we to punish those kids if we can provide them health insurance for the kids or health care. Think of it that way. We require that they be vaccinated if they go to school. Put the parents aside. For whatever reason, the parents are not fulfilling the role as you and I see it. But I don't think anyone of us would disagree that we would prefer that those kids got medical care.

And I am suggesting a structure so that the parents don't have to apply. If they are kids and they are there, they have got a way to get their medical care so when they walk into a clinic the clinic knows that the little kids—they know that there is health insurance there so they get their vaccination or treatment.

Mr. WATKINS. I see where you are coming from, but the incentive for them to get out of it, for the parents to want them to get out of that condition—I want to help them crawl out of that, and I can work with you to try to figure out a way. Thank you.

Chairman JOHNSON. Thank you.

I would like to call Jean Hearne, Specialist in Social Legislation, Congressional Research Service.

I want to say that the law does currently actually require States to cover—which means to me that the States could be registering at birth if they wanted to—requires States to cover all children under age 6 and any pregnant woman up to 133 percent of poverty and all children up to 17 under a hundred percent of poverty. Next year, it will be 18 and after that 19. There is a mandate in place, and to some extent we are struggling with the problem of mechanisms rather than statute.

STATEMENT OF JEAN HEARNE, SPECIALIST IN SOCIAL LEGISLATION, CONGRESSIONAL RESEARCH SERVICE, LIBRARY OF CONGRESS

Ms. HEARNE. Good morning, Chairman Johnson and Members of the Committee. My name is Jean Hearne, and I am a Specialist in Social Legislation of the Congressional Research Service. This morning I am going to provide a brief overview of the major ways in which children can obtain coverage under the Medicaid Program.

The Medicaid Program offers a generous package of health care services for certain groups of low-income persons. Historically, program eligibility was linked to actual or potential receipt of cash assistance under a welfare program. However, beginning in the eighties, through a series of legislative changes, the Medicaid Program was expanded to provide protection for other groups of individuals with no ties to the welfare system. This trend culminated with the 1996 welfare reforms that formally delinked eligibility for

Medicaid from the receipt of cash assistance for certain covered groups.

The requirements of Federal law, coupled with decisions by individual States in structuring their Medicaid Programs, determine who is actually eligible in a given State. In general, Federal law places limits on the categories of individuals that can be covered and establishes specific eligibility rules for each category. Over 50 distinct population groups are included in the law as potentially eligible.

Within these parameters, States are given additional options. In 1998, States reported that the Medicaid Program covered 20.8 million children and young adults under the age of 21. This group includes 55 percent of the Nation's children who live in poverty and about 19 percent of all children in the U.S.

The primary pathways to Medicaid for low-income children are the following four:

First, children and families who meet the financial and categorical rules under the State's former AFDC Programs in effect on July 16, 1996, are eligible for Medicaid even if they do not qualify for cash grants under the new TANF programs. This categorical group was created as part of the welfare reform legislation to ensure that all low-income families that would have qualified for Medicaid under the old AFDC Program continue to qualify for Medicaid after welfare reform. States were given the flexibility to alter the income and resource standards and methods; and, as of 1999, a number of States have done so in order to realign Medicaid eligibility with eligibility for the new TANF programs.

The second major pathway is children receiving Supplemental Security Income. Subject to one important exception, States are required to cover all children receiving SSI, a major pathway to Medicaid coverage for children with special health care needs. The major exception occurs in so-called 209(b) States. Those States use more restrictive income or resource standards or definitions of disability than are used in the SSI Program. If a State chooses the 209(b) option, it must also allow individuals to spend down into Medicaid eligibility by deducting incurred medical expenses from income. In 1998, 11 States had elected the 209(b) option.

The third major pathway to Medicaid for children is through one of the three poverty-related groups. These are children who qualify for Medicaid even though they are not enrolled in TANF or SSI.

First, States are required to cover children under age 6 and pregnant women who are in families with income below 133 percent of the poverty level.

The second poverty-related group is a mandatory coverage group for children under the age of 17 living in families with income below poverty. This group is being phased in 1 year at a time so that all children under 19 and living in poverty will be eligible for Medicaid in 2002.

The last poverty-related group is an optional group of infants and pregnant women in families with income below 195 percent of poverty. Last year, 41 States and the District of Columbia chose to extend coverage to some or all pregnant women and infants in that category.

The final major pathway is through section 1902(r)(2) and section 1115 demonstration waivers. Section 1902(r)(2) is a Medicaid provision that allows States flexibility in defining methods for counting income and resources for some categories of Medicaid eligibles. Section 1115 demonstration waivers allow States to test new approaches for providing health care coverage. While the two provisions are very different from each other, they bear one major similarity. They are used by States to allow a significant number of individuals to obtain Medicaid coverage who would otherwise not qualify for the program.

In 1999, there were 26 States altogether that have extended Medicaid to some children in families with income or assets too high to otherwise qualify through the use of one of those provisions.

While the four pathways I described represent the major routes to Medicaid eligibility for children, there remain a number of other eligibility categories in use by States through which smaller numbers of children obtain their benefits. Many of those groups represent unique categories of children and sometimes entire families that have been singled out in the statute for protection against the high cost of health care. Those groups are summarized in my written testimony.

Thank you.

Chairman JOHNSON. Thank you very much, Ms. Hearne.

[The prepared statement follows:]

Statement of Jean Hearne, Specialist in Social Legislation, Congressional Research Service, Library of Congress

MAJOR ROUTES

The Medicaid program provides coverage for a generous package of health care services for certain groups of low-income persons. Historically, program eligibility was linked to actual or potential receipt of cash assistance under a welfare program. However, beginning in the 1980's, through a series of legislative changes, the Medicaid program was expanded to provide protection for other groups of individuals with no ties to the welfare system. This trend culminated in the welfare reform legislation of 1996 (the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 or PRWORA) when the Aid to Families with Dependent Children (AFDC) program was replaced by the Temporary Assistance for Needy Families (TANF) program. In establishing TANF Congress formally de-linked eligibility for Medicaid from the receipt of cash assistance for certain covered groups.

The requirements of federal law, coupled with decisions by individual states in structuring their Medicaid programs, determine who is actually eligible in a given state. In general, federal law places limitations on the categories or groups of individuals that can be covered and establishes specific eligibility rules for each category. Over 50 distinct population groups are included in the law as potentially eligible. Within these parameters, states are given additional options. For example, the Medicaid statute allows states to choose the upper age limit for certain optional categories of children (up to age 18 or 19 or 20 or 21). States then create the precise definition of this pathway. Contributing to the complexity of the Medicaid program are financial criteria. Medicaid is a means-tested entitlement program. To qualify, applicants' income and resources must be within certain limits, most of which are determined by states, again within federal statutory parameters. Further complicating this picture is the flexibility states have in defining countable income and assets. Consequently, income and resource standards vary considerably among states, and different standards apply to different population groups within a state. In general, individuals in similar circumstances may be automatically eligible for coverage in one state, be required to assume a certain portion of their medical expenses before they can obtain coverage in a second state, and not be eligible at all in a third state.

The result of all of the flexibility is an unfathomably large number of eligibility "pathways" onto the Medicaid program. The specific criteria of each pathway may vary from state to state and some children could qualify for Medicaid through more than one in any given state. The following testimony will attempt to simply describe only the most important pathways to Medicaid for children defined as either those that cover the largest number of children or that cover the largest number of children with special health care needs. The accompanying written testimony will include a more complete description of eligibility pathways for children.

In 1998, states reported that the Medicaid program covered 20.8 million children and young adults under the age of 21. This group includes 55% of the nation's children who live in poverty and about 19% of all children in the U.S. The primary pathways to Medicaid for low-income children are the following four:

Persons who would be eligible for cash assistance under the old AFDC program.

Children (and families) who meet the financial and categorical rules under the states' former AFDC programs (in effect on July 16, 1996) are eligible for Medicaid even if they do not qualify for cash grants under the new Temporary Assistance for Needy Families (TANF) program. This categorical group was created as a part of the welfare reform legislation enacted in 1996 to ensure that certain low-income families do not lose their Medicaid eligibility as a result of welfare reform. For this group, PRWORA gave states the flexibility to adjust the 1996 income and resource standards in three ways: states may lower their income standards, but not below those used for AFDC on May 1, 1988; states may increase their income and resource standards by an amount that is no more than the percentage increase in the Consumer Price Index (CPI); or states may use less restrictive income and resource methodologies than those in effect on July 16, 1996.

The 1996 income standards for AFDC programs are well below the current federal poverty level (FPL). For example, the AFDC payment standards in effect on July 16, 1996 range from about 14% of the current FPL in Alabama to nearly 86% in Connecticut. The median level nationwide relative to the current definition of poverty is about 44%.[1] In addition, for most eligibility categories in most states, individuals must have resources (also called assets) valued at less than a specified amount (typically $1,000 for an adult with one or more dependent children) to be eligible for Medicaid. In 1996, most states excluded from this calculation the family's home and up to $1,500 equity value in an automobile. In addition, states were permitted to exclude basic maintenance items essential to day-to-day living, such as clothing and furniture.

But a number of states have established more generous standards for determining Medicaid eligibility than those in place in 1996. As of 1999, twelve states have taken advantage of the flexibility offered under welfare reform to re-align Medicaid eligibility with eligibility for the new TANF programs.[2] They have done so by using less-restrictive methods for calculating income and/or resources. In doing so, those states *effectively* raised income and resource standards in determining eligibility for Medicaid. An example of this is a state that disregards any income in excess of the AFDC payment standard in effect in July of 1996 for determining Medicaid eligibility for TANF recipients.

Children Receiving Supplemental Security Income (SSI).

Subject to one important exception, states are required to cover all children receiving SSI, a major pathway to Medicaid coverage for children with special health care needs. In 1999, over 850,000 blind and disabled children received SSI, and participation in the Medicaid program among this group is expected to be close to 100% since a person becomes entitled to Medicaid benefits upon being found eligible for SSI without any additional action required. While this is not a large group of Medicaid children, Medicaid represents a very important source of funding for the care of this special needs population.

Unlike the former AFDC programs or today's TANF programs, income and resource standards for SSI do not vary by state. Parents' income is considered when determining SSI eligibility and benefits for children. SSI requires some of the income of ineligible family members (i.e., parents) be deemed available to meet the basic needs of children before extending eligibility to those children.

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[1] See Appendix Table 1 in Schneider, etal.: *Medicaid Eligibility for Families and Children*. Washington, DC: The Kaiser Commission on Medicaid and the Uninsured, September, 1998

[2] See *States' Implementation of Selected Medicaid Provisions of the Personal Responsibility and Work Opportunities Reconciliation Act of 1996*. A joint project of the Center for Law and Social Policy and th Center on Budget and Policy Priorities, January 2000.

The major exception to automatic coverage for SSI recipients occurs in so called "209(b)" states. States may elect the option, described in section 209(b) of the Social Security Act Amendments of 1972, allowing them to use income and resource standards that are no more restrictive than those in effect in 1972. If a state chooses the 209(b) option, though, it must also allow individuals to "spend down," that is to deduct incurred medical expenses from income in determining Medicaid eligibility. In 1998, 11 states had elected the 209(b) option for Medicaid, applying more restrictive income and resource standards and/or methodologies than those applicable under SSI.

Poverty-Related Children.

Another major pathway to Medicaid for children is through one of three poverty-related groups. These are groups who, prior to welfare reform, did not qualify for cash welfare assistance. The first group is a mandatory coverage group -that is, states are required to extend coverage to children under age 6 and pregnant women who are in families with incomes below 133% FPL.

The second poverty-related group is another mandatory coverage group for children born after September 30, 1983 living in families with income below poverty. This group is being phased-in one year at a time so that all children under 17 and living in poverty are eligible for Medicaid in this federal fiscal, those under age 18 will become eligible in fiscal year 2001, and those under age 19, in fiscal year 2002.

The last poverty-related group includes infants (under age 1) and pregnant women who are in families with income between 133% and 185% of the FPL. This group is considered an optional eligibility category. Last year, 41 states and the District of Columbia had extended coverage to some or all pregnant women and infants in this category.

Section 1902(r)(2) and Demonstration Waivers.

The Medicaid statute includes a number of provisions that provide states with additional flexibility. Two of those provisions include one that provides states flexibility in defining methods for counting income and assets (authorized under Section 1902(r)(2) of the Social Security Act), and another that allows states to create demonstration projects (authorized under Section 1115 of the Social Security Act) to test new approaches for providing health care coverage. The two provisions are very different from each other, but they bear one major similarity—they are sometimes used by states in ways that allow a significant number of individuals, who would otherwise not qualify for the program, to obtain Medicaid coverage.

Section 1902(r)(2) and Section 1115 have been present in statute for many years, but the use of those provisions to extend coverage to individuals not otherwise eligible for Medicaid grew in popularity among the states during the 1990s. Although precise numbers are not available, a significant number of children are covered through these two mechanisms. This number could potentially grow even larger over time. (Medicaid data do not track children qualifying for Medicaid as a member of one of these groups, so estimates of their number are not available.)

Section 1902(r)(2) of the Social Security Act allows state Medicaid programs to submit a state plan amendment to use more liberal methods for calculating income and resources for some categories of Medicaid eligibles. Most states that have chosen to implement Section 1902(r)(2) have done so only for children. In addition, most states using the flexibility created by Section 1902(r)(2) do so by disregarding certain types or amounts of income to extend Medicaid to children in families with earnings that are too high to qualify for one of the other eligibility groups, or have assets that exceed allowable levels.

Demonstration waivers are authorized in Section 1115 of the Social Security Act. Under this provision, states are able to waive some Medicaid requirements to create demonstration projects that promote the objectives of the Medicaid statute. Through a fairly cumbersome application process, a number of states have used such waivers to enact broad-based and sometimes state-wide health reforms. Demonstrations under this provision need not be statewide. A number of the demonstrations extend comprehensive health insurance coverage to low-income children (among others) who would otherwise not be able to obtain Medicaid.

In 1999, there were 12 demonstration projects operating under Section 1115 to extend Medicaid to populations not otherwise eligible for the program and 26 states altogether that use either Section 1902(r)(2) or a demonstration waiver to extend Medicaid to children in families with income or assets too high to otherwise qualify.

While the above pathways represent the major routes to Medicaid eligibility for children, there remain a number of other eligibility categories in use by states through which smaller numbers of children obtain their benefits. Many of the following groups represent unique categories of children (and sometimes entire fami-

lies) that have been singled out in the statute for protection against the high cost of health insurance or health care.

ADDITIONAL PATHWAYS

AFDC-related groups:

Transitional Medical Assistance. An increasingly important eligibility group for families with children is called "transitional medical assistance" or TMA. TMA was created to address the concern that the loss of Medicaid for individuals who could successfully obtain employment would provide a disincentive to seek and to keep jobs. States are required to continue Medicaid for six months for families that were covered by Medicaid under the welfare reform provisions (Section 1931) in at least three of the last six months preceding the month in which the family lost such assistance due to increased hours of employment, increased earnings of the caretaker relative, or the family member's loss of a time limited earned income disregard. States have the option of extending Medicaid coverage for an additional six months for families that were covered during the entire first 6-month period, and are earning below 185 % of the poverty line. The provisions authorizing transitional medical assistance for the above groups sunset as of September 30, 2001.

A small additional group of TMA eligible persons are those who lose Medicaid coverage under Section 1931 because of increased child or spousal support. Families eligible for this 4-month extension must have been receiving Medicaid under Section 1931 in at least 3 of the preceding 6 months.

Other AFDC-related Groups. While the AFDC program no longer exists, a number of Medicaid eligibility groups that are tied to the states' former AFDC rules remain in existence. These rules continue to apply today because of the PRWORA provision requiring Medicaid coverage for people who would have qualified for the former AFDC programs. Among those mandatory coverage groups are certain job opportunities and basic skills (JOBS) participants; and certain children for whom adoption assistance agreements were in effect or for whom foster care payments were being made under Title IV-E of the Social Security Act.

"Ribicoff Children". As with the medically needy, "Ribicoff children," named for the former Senator that sponsored legislation authorizing coverage for this group, is a coverage path that is gradually diminishing in importance as more children are included under the poverty-related coverage categories. Ribicoff children are children under 21 who meet income and resource requirements for AFDC but who otherwise are not eligible for AFDC. Included in this category are often children who are in state-sponsored foster care, or who are institutionalized or inpatients in psychiatric facilities.

Ribicoff children must be under the age of 21. Because they may be older than children qualifying as a poverty-related child (through age 18 in 2002), the Ribicoff pathway may remain an important optional category for older children even after the poverty-related categories are fully phased in.

SSI-related groups

Recipients of State Supplemental Payments (SSP). Many states, recognizing that the SSI benefit standard may provide too little income to meet an individual's living expenses, supplement SSI with additional cash assistance payments. States that choose to offer state supplemental payments (SSP) may also offer Medicaid coverage to those SSP recipients who would be eligible to receive SSI but for income. In 1999, all but 7 states provided some amount of supplementary payments. In some of those programs, certain children who do not receive SSI qualify for SSP and Medicaid through the SSP pathway.

Optional Coverage of Institutionalized Persons Under a Special Income Level—the 300% Rule. States have another option for covering certain individuals with incomes too high to qualify for SSI or SSP. These persons must (1) require care provided by a nursing home or other medical institution, (2) meet the states's resource standard, and (3) have income that does not exceed a specified level. Medicaid law requires that income for these persons be no more than three times the basic SSI payment level. For 2000, the limit was $1,536 per month (3 multiplied by the SSI benefit of $512).

Optional Coverage of Noninstitutionalized Disabled Children. For a child under the age of 21 and living at home, the income and resources of the child's parents are automatically considered available for medical care expenses, that is, they are "deemed" to the child. If the same child is institutionalized, however, after the first month away from home, the child no longer is considered to be a member of the parents' household and only the child's own financial resources are considered available for care. The child then is able to qualify for Medicaid. This policy has re-

sulted in some children remaining in institutions even while their medical needs could be met at home. This situation was dramatized in 1982 by the case of Katie Beckett, a ventilator-dependent child who was unable to go home because she would no longer have been eligible for Medicaid. Medicaid law contains a provision that allows states to extend Medicaid coverage to certain disabled children under 18 who are living at home and who would be eligible for Medicaid if in a hospital, nursing facility, or intermediate care facility for the mentally retarded and as long as the cost of care at home is no more than institutional care.

Children Receiving SSI as of August 22, 1996. In addition to delinking Medicaid from the receipt of cash assistance, the PRWORA also established a new definition of childhood disability for receipt of SSI benefits. Under the new definition, some children would lose their SSI and Medicaid eligibility as well. In 1997, Congress created a Medicaid requirement that states continue Medicaid coverage for those disabled children who were receiving SSI on the date of enactment of PRWORA.

Other Pathways to Medicaid

Medically Needy. The medically needy are persons who fall into one of Medicaid's eligible categorical groups but have income that is too high qualify to for coverage under that group. States can choose to cover the medically needy by setting income standards for this group that are no higher than 133.33% of the state's AFDC payment standard (medically needy income standard) in place on July 16, 1996 (or as subsequently modified). Individuals (or families) qualify for this category by having income that falls below that medically needy standard, or by incurring medical expenses that, when subtracted from income, result in an amount that is lower than the medically needy income standard. Persons qualifying for medically needy coverage must also meet the states' AFDC resources standards.

Children can obtain Medicaid coverage through this eligibility pathway if the child resides in a state that elects to offer medically needy coverage. However, this eligibility path is becoming less significant as a route for children because of the major expansions for children in poverty-related groups as described above. Some families with older children or with very large medical expenses, who are otherwise ineligible for Medicaid may still qualify for medically needy coverage.

Optional Coverage of Persons Needing Home and Community-Based (HCB) Care.

States have an option of covering persons needing home and community based services, if these persons would otherwise require institutional care that would be paid for by Medicaid. These services are provided under waiver programs authorized in Section 1915(c) of Medicaid law. The programs, often referred to as home and community-based care waiver programs, require states to make special application to HCFA for the programs they wish to operate. With approval, they may provide a wide variety of nonmedical, social, and supportive services that have been shown to be critical in allowing chronically ill and disabled persons to remain in their homes. States are using waiver programs to provide services to a diverse long-term care population, including children, the elderly, and others who are disabled or who have chronic mental illness, mental retardation and developmental disabilities, and AIDS. With an approved HCB waiver program, states may cover persons needing home or community-based care on the basis of being medically needy or meeting the 300% rule, without deeming the income of other family members available to the qualifying person. This is especially important for children with special care needs who are able to live at home with their parents only if they can receive Medicaid support.

Targeted Low Income Children Authorized under the State Children's Health Insurance Program (SCHIP).

SCHIP was established by the Balanced Budget Act of 1997 under a new Title XXI of the Social Security Act. The program, while completely separate from Medicaid, allows states to access SCHIP funds to cover targeted low-income children through private health insurance that meets specific standards for benefits and cost-sharing, or through their Medicaid programs, or through a combination of both.[3] SCHIP is included here, because many states have, in fact, extended Medicaid coverage to targeted low-income children, albeit they pay for that coverage with Title XXI funds.

[3] Under limited circumstances, states have the option to purchase a health benefits plan that is provided by a community-based health delivery system, or to purchase family coverage under a group health plan as long as it is cost-effective to do so.

Title XXI defines SCHIP-eligible children as those who are not eligible for Medicaid or covered under a group health plan or other insurance and in families with incomes that are either: (1) above the state's Medicaid financial eligibility standard but less than 200% of the federal poverty level, or (2) in states with Medicaid income levels for children already at or above 200% FPL, within 50 percentage points over the state's current Medicaid income eligibility limit for children. Within those broad statutory requirements, each state can define the group of targeted low-income children who may enroll in SCHIP.

As of January 1, 2000, the Health Care Financing Administration had approved SCHIP plans for all 50 states, the District of Columbia and five territories. Twenty-four states use Medicaid expansions, 15 have state programs, and 17 combine a Medicaid expansion and a separate state program.

Other Considerations.

A final provision, already mentioned above, deserves some elaboration. In establishing the post-welfare reform link to Medicaid for individuals who would be eligible for AFDC under the rules in effect in 1996, the PRWORA gave states the flexibility to adjust the methods used for calculating the amount of income and resources an applicant has available to them. More specifically, Section 1931(b)(2)(C) allows states to use more generous income and resource methods than those used for determining eligibility for AFDC in 1996. This provision is parallel in structure to Section1902(r)(2). A recent survey of Medicaid eligibility practices following welfare reform suggests that many states use section 1931(b)(2)(C) to create methodologies that are parallel to those used under the states' TANF programs. In other words, while PRWORA delinked Medicaid and AFDC, it created a provision that allows states to "re-link" eligibility for those programs.

In the near term, the flexibility afforded by Section 1931(b)(2)(C) is not likely to become a major pathway for children to travel to the Medicaid program. Children with income too high to qualify for cash assistance have a number of other pathways to Medicaid. On the other hand, this provision may hold important promise for extending coverage to the parents of children who have fewer alternative pathways to Medicaid or for simplifying Medicaid eligibility while at the same time qualifying entire families to coverage -an option that could help to raise participation in a program that has become increasingly complex for states to administer and for qualifying family members to navigate.

MAJOR PATHWAYS TO MEDICAID FOR CHILDREN

1. Children Eligible for Cash Assistance Under the AFDC Program.

Children (and families) who meet the financial and categorical rules under the state's former AFDC programs (in effect on July 16, 1996) are eligible for Medicaid even if they do not qualify for cash grants under the new Temporary Assistance for Needy Families (TANF) program. This group was created as a part of the 1996 welfare reform to ensure that all low-income families that would have qualified for Medicaid under the old AFDC program continue to qualify for Medicaid following welfare reform. Many states use a provision allowing flexibility in calculating income and resources for this coverage group. As of 1999, twelve states have taken advantage of this flexibility to re-align Medicaid eligibility with eligibility for the new TANF programs.

2. Children Receiving Supplemental Security Income (SSI)

Subject to one important exception, states are required to cover all children receiving SSI, a major pathway to Medicaid coverage for children with special care needs. The major exception to automatic coverage for SSI recipients occurs in so called "209(b)" states. Those states use income and resource standards that are no more restrictive than those in effect in 1972. If a state chooses the 209(b) option, though, it must also allow individuals to "spend down" into Medicaid eligibility. In 1998, 11 states had elected the 209(b) option.

3. Poverty-Related Children.

Another major pathway to Medicaid for children is through one of three poverty-related groups. These children qualify for Medicaid even though they are not enrolled in TANF or SSI:

a) States are required to cover children under age 6 and pregnant women who are in families with incomes below 133% FPL

b) In 2000,states are required to cover children under age 17 living in families with income below poverty. This group is being phased-in one year at a time so that

all children under 18 and living in poverty will be eligible for Medicaid in 2001, and all children under age 19 will be eligible in 2002.

c) States can choose to cover infants (under age 1) and pregnant women who are in families with income below 185% FPL. Last year, 41 states and the District of Columbia had extended coverage to some or all pregnant women and infants in this category.

4. Section 1902(r)(2) and Demonstration Waivers.

Section 1902(r)(2) (of the Social Security Act) is a provision that allows states flexibility in defining methods for counting income and resources. Demonstration waivers allow states to test new approaches for providing health care coverage. The two provisions are very different from each other but both are often used by states in ways that allow a significant number of individuals to obtain Medicaid coverage who would otherwise not qualify for the program. In 1999, 26 states used Section 1902(r)(2) and demonstration waivers to extend Medicaid coverage to children in families with income or assets too high to otherwise qualify.

Chairman JOHNSON. In your folder is a summary of the pathways for your reference. The thing that strikes me is that we actually, under the law, are covering essentially all children or will be in the next year or two under a hundred percent of poverty and all children under 6 under 133 percent of poverty. And, as I read your testimony, roughly half the States through the 1902(r)(2) waiver possibility are serving people above 133 percent of poverty. Why then is it—does it appear to be true that 45 percent of kids in poverty aren't participating? Is that an administrative problem? Is that a legal problem? How much has to do with the 24 States that are not using 1902(r)(2) waivers and therefore are seeing poor families that have high assets or higher assets than the law allows cut out of the program? Do you have any idea about who that 55 percent is?

Ms. HEARNE. My understanding is that there are a large number of reasons that children and their parents don't enroll who may otherwise be qualified for the program, including administrative difficulties and concerns that the program still maintains some welfare stigma for some families.

Another thing to keep in mind, while States have these other flexibilities in the law, many of them use them in very modest ways, so there may not be large-scale expansions in those States under the two options.

Chairman JOHNSON. Thank you.

Mr. Cardin.

Mr. CARDIN. Thank you very much for your testimony.

Have you noticed any differences among the States or are some States using some of their demonstration authority or seeking demonstration authority or doing things that are more creative in an effort to get more children enrolled in their Medicaid Programs?

Ms. HEARNE. My understanding is that there are lots of different approaches that States are using. I can't really recite any of those now, although I understand that there will be——

Mr. CARDIN. We have some other panelists who will be talking about that. If you look at the statistics, and I understand that you have looked at the statistics, you have 45 percent of the children below poverty not enrolled in Medicaid.

Ms. HEARNE. Right.

Mr. CARDIN. And those 45 percent would be eligible to participate in the Medicaid Program?

Ms. HEARNE. Right.

Mr. CARDIN. We don't know about the other pathways as to how successful we have been. I am sure that there are additional children who would fall under the other pathway that have not enrolled. But that is a significant number of children who have not enrolled. Do we have any idea how many of those children have no health insurance?

Ms. HEARNE. I don't have that with me, but I can obtain that number and get back to your staffperson.

Mr. CARDIN. I appreciate that.

Ms. HEARNE. I would guess that it is more than 50 percent.

Mr. CARDIN. It would be useful if we can get that number.

Do you have the numbers that fall under the different pathways as to eligibility?

Ms. HEARNE. Medicaid reporting data does not clearly distinguish how children qualify for the program. So States report in kind of big buckets of kids that you can't really separate out into these pathways.

Mr. CARDIN. Do you have any idea as to—I assume that the pathway for income eligibility is the largest single category?

Ms. HEARNE. The two major categories are kids qualifying on the basis of formerlly receiving AFDC or receiving TANF now, and the second are the poverty-related—the three groups.

Mr. CARDIN. Do you know how many children who are eligible because of receiving TANF before would not be eligible under the current income categories?

Ms. HEARNE. No, I don't.

Mr. CARDIN. You don't have that information.

Thank you very much. There are some other questions that I am going to want to try to get information back from you, but if it is all right, Madam Chair, I will try to do that by written questions to you.

Just one last comment. As I listened to your testimony, it was anything but easy to understand—if I am a person trying to get my child covered and you give me this pathway list, it is not easy for me to understand whether I am eligible or not. So relying on the family to know whether they are eligible for Medicaid, if a State puts out this pathway, here it is, figure it out, you are going to have a lot of people that never get into the Medicaid system. You are not dealing with a group that is sophisticated with these sections of the Code or the income levels that are the different poverty levels. I do think part of the problem is the complexity that we put into the Code that we need to take a look at.

Thank you.

Chairman JOHNSON. Are there other questions?

Mr. WATKINS. I would like to make a comment. The stigma of welfare is probably, in a great majority of the cases, a lot of them, but you have to reach down and say, number two, there are a lot of parents—the example that I just went through a while ago, there are parents that are irresponsible. I don't think it is a lack of love but lack of knowledge or understanding or alcohol or drugs or other cases.

As Ben indicated, thinking here of how—I am wondering if you can tie them with education. When they hit the age of five and go into school, education is the best way to lift them out of poverty and try to get something working along that line; or with the paycheck, if they can go to work, their kids would be small. But the stigma of welfare still affects a lot of people from not doing it, but maybe working with education and keep them in school—it is a big problem.

Chairman JOHNSON. Thank you.

Mr. McCrery.

Mr. MCCRERY. Ms. Hearne, you may not be prepared to answer this question, but I see you are a specialist in social legislation. Can you tell us what the poverty rate in the United States has done in the last say 5 years?

Ms. HEARNE. It has risen some over the last 5 years, but, currently, it is just over $14,000 for a family of——

Mr. MCCRERY. No, the percentage of the population that is living in poverty in the United States, has that percentage gotten greater in the last 5 years or are there fewer people as a percentage of our population?

Ms. HEARNE. I don't have that number with me, but I can get back to you this afternoon.

Mr. MCCRERY. Thank you.

Chairman JOHNSON. Mr. Stark.

Mr. STARK. Thank you, Ms. Hearne. You may know the answer to this and maybe we should, but the transitional Medicaid assistance, as you know, sets a year before we have to reauthorize TANF, so we have a year in which people would not have the transitional Medicaid assistance, right?

Ms. HEARNE. That is correct.

Mr. STARK. Any idea why we did that? How much would it cost to extend that so we keep the traditional Medicaid assistance until we reauthorize TANF?

Ms. HEARNE. I haven't seen a CBO cost estimate of that expansion.

Mr. STARK. I am told that it is maybe 300 million or 400 million bucks.

How about the legislative history, how we ended up that way?

Ms. HEARNE. I don't know the answer to that.

Mr. STARK. It does cause a problem for one small group of people. Do you have any recommendations? Do you have any idea how many people are apt not to be covered because of that?

Ms. HEARNE. My understanding is that that second 6-month period is not used that extensively because it is fairly administratively onerous. So, to that extent, it may not be quite as lively used as one would hope.

Mr. STARK. OK. What does that mean in terms of the number of people?

Ms. HEARNE. I don't know the number.

Mr. STARK. Madam Chair, maybe our staff at some point could enlighten us, but we do have kind of a glitch there.

Chairman JOHNSON. We do have a glitch there.

As you can guess and as I know, the issue was money. And we did take $500 million and put it in a special fund to give States

a 90-10 match to deal with the administrative cost. This issue, once you delink benefits, you are going to have new administrative things.

Looking ahead, we preferred to use the money that way because that would give us time to see what were the problems. And we are seeing what those problems are, and through this hearing we will begin to look at the administrative issues. We certainly will deal with it.

It is not unlike the problem we just met with—that we just dealt with in the welfare-to-work program, where, actually, the administrative definitions meant that the program wasn't serving the populations that we intended it to serve.

I think the complexity of this extension is going to have to be one of the issues that we have to look at. But at the time we did welfare reform, it was more important to give States money to deal with the administrative costs and 90/10 split which we didn't do in the whole program in order to try to guarantee that the benefits would flow knowing that it would be a more complicated problem.

Mr. STARK. Knowing that the Chair is aware of this problem, I will sleep better.

Mr. CARDIN. It is interesting, I think the Chair is correct, we really wanted to help the States in the administrative side, but it is somewhat disappointing when you take a look at the results on enrollment in Medicaid that the performance numbers are certainly very, very disappointing. So here we are. We took money away from providing extra help to families that are trying to play according to rules and coming off of welfare, and they need some help because the job doesn't provide the health insurance, and we did that so the States would have an easier time in dealing with the transition problems in moving from AFDC to TANF, and now we don't—have a large number of children who are without any health insurance. Something went wrong.

Chairman JOHNSON. Thank you very much. I appreciate your factual foundation, Mr. Hearne.

Chairman JOHNSON. I would like to call the first panel, Cindy Mann, Director, Family and Children's Health Programs Group, HCFA Center for Medicaid and State Operations; Marilyn Ellwood, Senior Researcher, Mathematica Policy Research; Ronald Pollack, Executive Director, Families USA; Barbara Lyons, Vice President, Commission on Medicaid and the Uninsured, Kaiser Family Foundation. Thank you for being here.

It has been a significant disappointment to many of us that there has been this collapse in the provision of Medicaid benefits to eligible children, and we will start with Cindy Mann.

STATEMENT OF CINDY MANN, DIRECTOR, FAMILY AND CHILDREN'S HEALTH PROGRAMS, CENTER FOR MEDICAID & STATE OPERATIONS, HEALTH CARE FINANCING ADMINISTRATION

Ms. MANN. Good morning, Chairman Johnson, Congressman Cardin and Subcommittee members. I appreciate the opportunity to share some of our observations from HCFA and concerns about how welfare reform has affected Medicaid enrollment and to tell

you what HCFA has been doing to promote enrollment among low-income families with children who are eligible for Medicaid.

Let me start this morning by saying that there is good news and bad news. Let me start with the good news.

The good news is that I agree with the Chair, which is that when Congress and the President worked on the final details of the welfare law they understood that Medicaid coverage was going to be impacted by the welfare changes that were being considered at the time, and they took a very important step to protect Medicaid eligibility for families with children. This happened, in large part, because of Chairman Johnson's strong interest and concern. She played a very central role in ensuring that guarantee in the final bill.

The second piece of good news, which is related to the first piece of good news, is that the provision adopted in the bill that was crafted by Congress to delink Medicaid eligibility from welfare eligibility can and does work. And I think we have examples of some States that have demonstrated that it can and that it could work and that it should work with proper attention and implementation. In fact, we have enough good news from the American Public Human Services Association and the NGA that, in collaboration with HCFA, we are having a best practices conference on June 9 on this matter to share information on how to implement this provision as effectively as possible.

The third aspect of the good news, which is often overlooked, is that the provision that created the delinking provision in the welfare law that established this guarantee provides States with some new options—some important new options that have bearing on the conversation that we have had so far this morning.

One, it gives States some new options to simplify Medicaid eligibility; and, second, it gives States the option to provide Medicaid coverage to a broader group of low-income working families; and many States have already started to take advantage of those options.

I don't know if people here have picked up the healthy families application in the District of Columbia, but D.C. now covers, under this new provision, families up to 200 percent of poverty, and it does so in a simple, two-page form, basically using a gross income standard. It has collapsed many of its categories that Jean went through and created a simpler program for families and children.

Other States have taken similar steps to expand coverage to low-income working families. Wisconsin has done so. Missouri has done so. Rhode Island and Connecticut have adopted legislation and are planning to implement, as has New York, Ohio, and California. So, there are a lot of new opportunities available to States under the delinking provision, but, of course, the story is not all good news.

Implementation problems do appear to have contributed to a decline in Medicaid enrollment among parents and children in some States. We are greatly concerned about instances in which Medicaid-eligible children and parents may have lost coverage.

To help you understand a little bit about what is happening, let me first try and explain, in practical terms, how Medicaid and welfare eligibility worked before the delinking and how it is supposed to work now.

Since the beginning of the Medicaid Program, as you probably are aware, Medicaid eligibility for families was linked to eligibility and receipt of cash assistance. If you were on AFDC, you were on Medicaid; and if you were a family with children and you weren't receiving AFDC, for the most part, you simply weren't eligible for Medicaid. Medicaid came as an appendage, essentially, of your AFDC entitlement, and, so, when your AFDC case closed, so did your Medicaid case, in most cases, because it would have ended as a family unit.

Since the late eighties, that story has changed somewhat because of the new pathways to eligibility that have been created particularly for children and for pregnant women. However, there was no independent pathway to Medicaid eligibility for families with children until the delinking provision was established in 1996. Until then, welfare was the only route to Medicaid coverage for a family in most States or certainly the predominant route.

Part of that function of linkage between welfare and Medicaid is not eligibility linkage, but a systems linkage. Because Medicaid came along with AFDC, States had no reason to set up a separate infrastructure in their States to determine Medicaid eligibility for families because that eligibility rose or fell with eligibility determination for cash assistance. And that actually is part of the problem that we are facing now in terms of implementing delinking.

Right now, what has to happen is, when a family applies for Medicaid and TANF and the agency determines that the family is not eligible for TANF, or the family is diverted to another service and doesn't need TANF, or the family decides to withdraw the application from TANF, Medicaid eligibility should still be determined independently. And the delinking provision ensures that there is a category, in the law, for that eligibility to be determined, but that is not necessarily how systems worked before 1996.

Similarly, when a cash assistance case closes, eligibility for Medicaid does not necessarily end because of the loss of cash assistance. Whether it is because a parent has gone to take a job or whether a family has hit a time limit or for any other reason, the cash assistance is closed. Medicaid needs to be determined independent of eligibility for cash assistance based on the resources and the income limits established in each State.

You will hear from my colleagues on the panel today about some of the data that we have been looking at to tell us what has been happening in States, and I will defer to them largely on the data. I will tell you that the data that HCFA collects, the 2082 data from States, shows that while overall Medicaid enrollment has pretty much held steady, that there has been a decline for families with children, a slight decline, and that Medicaid enrollment for kids during the last 3-year period has declined for children and adults by about 2.1 percent and for children it has remained basically level after having dropped in 1996.

The national numbers, though, I would really caution you mask considerable variation across States. You will see when you look at State-by-State enrollment data that some States have seen their enrollment rise robustly and some States have seen their enrollment decline significantly, and you will hear from the State panelists later about the situations in their States.

There are a lot of reasons for those fluctuations. Some of them are the immigrant-related issues that were talked about earlier. Some are related to a drop in the poverty rate and rise in incomes and the availability, at least in some localities, of private insurance coverage. Some are systems problems with respect to cash assistance and delinkage.

Let me turn to what HCFA has done.

Chairman JOHNSON. If you can summarize. We want to get through everybody.

Ms. MANN. We have been very concerned about this issue. We have issued considerable guidance since the 1996 law was enacted. In late 1996, the President instructed HCFA to do eligibility reviews in every State to look at this issue, and those reviews started last fall and have been continuing. We have looked at State-by-State eligibility policies and practices with respect to this issue. We have also been urging and working with Congress to help continue to make available that $500 million to help States finance the cost of systems changed for delinking.

On April 7, we issued guidance to all States directing them to look at their policies and their practices and to determine whether anybody had been improperly terminated and, if so, to reinstate coverage for those individuals. And the letter also directs States to consider their computer systems and ensure that those systems do not improperly terminate coverage and to streamline their redetermination systems.

I am pleased to say that the guidance—no State has actually thanked us for the guidance—has been well-received by States. They have said that it provides some clear instructions to them and that they truly do believe that if people have been improperly terminated that they indeed should be reinstated to coverage.

We look forward over the next few months to working with States as our reviews are completed and as States move forward in implementing this guidance to ensure that the problem which has been identified by this hearing is a problem that we can put behind us and ensure that all eligible families have coverage.

Chairman JOHNSON. Thank you.

[The prepared statement follows:]

Statement of Cindy Mann, Director, Family and Children's Health Programs, Center for Medicaid & State Operations, Health Care Financing Administration

Chairman Johnson, Congressman Cardin, distinguished Subcommittee members, thank you for inviting me to discuss the impact of welfare reform on Medicaid. President Clinton has continued to stress the importance of ensuring that everyone who is eligible for Medicaid is enrolled, and we greatly appreciate this opportunity to discuss our actions and concerns.

The historic welfare reform law, along with the new State Children's Health Insurance Program created in 1997, has enabled States to greatly expand health care coverage eligibility and help more low-income people make the transition from welfare to work. It broke the link between cash assistance programs and eligibility for Medicaid. It also explicitly guaranteed that children and families who would have qualified for Medicaid through receipt of cash assistance would continue to be eligible for Medicaid.

Overall national statistics on Medicaid enrollment are encouraging, but there is variation among States. The most recent statistics from all States show that total Medicaid enrollment is about the same now as it was before welfare reform. However, we know that many eligible families are not enrolled; and we share your con-

cern about instances in which State practices have resulted in eligible individuals losing health care coverage.

We have taken a series of actions to ensure that States comply with the welfare reform law and address its impact on Medicaid enrollment. Most recently, we instructed all States to review Medicaid terminations and re-enroll improperly terminated individuals. We also asked States to ensure that their computer systems and eligibility processes have been modified so that families eligible for Medicaid do not inappropriately lose coverage when their eligibility for cash assistance ends.

Last year we worked with Congress to ensure the continued availability of the $500 million fund created to help States afford needed changes.

The President, in addition to aggressively promoting SCHIP outreach efforts, has proposed several additional steps to further expand health care coverage among low-income families and strengthen programs that provide health care for the uninsured. And we are committed to continuing to work with States to ensure that no eligible individuals are denied Medicaid coverage.

BACKGROUND

Congress and the President together kept the pledge to "end welfare as we know it" through the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. This historic law broke the link that made families automatically eligible for Medicaid if they received cash assistance through the Aid to Families with Dependent Children program, which was replaced with the Temporary Assistance for Needy Families (TANF) program

The link was broken because we all knew that welfare programs were changing, and neither Congress nor the Administration wanted those changes to result in the loss of health care coverage. At the insistence of the President, Chairman Johnson of this Subcommittee, and many other members of Congress, great care was taken to assure that Federal law continued to guarantee Medicaid eligibility for children and families who formerly qualified for Medicaid through receipt of cash assistance. Health care coverage can be critical in helping people make the transition from welfare to work and keeping them healthy so that they can work. This is especially important in entry-level jobs that may not provide employer-based health insurance.

Thus, the welfare reform law requires that States must still provide Medicaid to all people who would be eligible for welfare under the State's Aid to Families with Dependent Children plan that was in effect on July 16, 1996, prior to the enactment of the welfare reform legislation.

They also must provide Medicaid to children who lost Supplemental Security Income cash assistance when disability rules changed, as well as other statutorily defined groups, including low-income elderly and disabled people.

The 1996 law also gave States new options for providing Medicaid coverage to low-income working families. This was followed by a regulation issued by HCFA in 1998 allowing States to cover parents in two-parent families. The Balanced Budget Act of 1997 (BBA) built upon the welfare law changes and created the State Children's Health Insurance Program (SCHIP), which gives States wide flexibility in providing health care coverage to children in families that earn too much to qualify for Medicaid but not enough to purchase private sector insurance. The BBA also gave States two new Medicaid options—presumptive eligibility for children and 12-month continuous eligibility—to improve coverage among poor families.

These changes have created important opportunities for States to provide health care coverage to low-income families as they move off welfare and into the workforce. States have responded with eligibility expansions, simplified enrollment procedures, and creative outreach campaigns. The result is that millions more low-income children and parents are now eligible for coverage through Medicaid or the new SCHIP program.

Meeting Challenges

The delinking of welfare and Medicaid has created challenges and opportunities in ensuring that those who are eligible for Medicaid coverage get and retain it. Acknowledging the new administrative burden on States that might result from delinking, the welfare reform law included $500 million for enhanced matching funds to help States cover the increased costs, such as outreach, associated with delinking welfare and Medicaid. Since enactment of welfare reform, we have worked with States and others to undertake substantial efforts to improve Medicaid outreach and increase the participation of eligible children and families.

Consistent national data on Medicaid and SCHIP coverage for families leaving welfare does not yet exist, although this will continue to be an important area of research being funded by the Department of Health and Human Services (HHS).

The most recent statistics show that, overall, total Medicaid enrollment has fluctuated only slightly, dropping in 1997, rising in 1998, and is now about the same—41.4 million—as it was before welfare reform. Among low-income adults and children nationally, Medicaid enrollment declined slightly by about 2.1 percent (620,000 individuals) during the three-year period from 1995 to 1998. Among children, it peaked at 20.5 million in 1996, then remained relatively level in the following two years at 20.1 million in 1998 for a total enrollment drop of 1.3 percent (270,000).

HHS-funded studies show significant state-to-state variation in enrollment trends, with Medicaid enrollment rates for adults ranging from 24 to 76 percent three months after leaving cash assistance, and enrollment dropping further by as much as 10 to 20 percent in the year after leaving.

Improvements in the economy, such as that we have enjoyed for the past six years, contribute to rising incomes and falling welfare and Medicaid caseloads. It is also important to note that overall, the number of people under the poverty level who are uninsured has not increased since 1996 and the poverty rate has declined. One particularly encouraging finding is that the number of non-disabled adults enrolled in Medicaid (primarily parents and pregnant women requiring TANF benefits) actually increased in 1998. And, at the same time, more than 2 million children are now enrolled in SCHIP.

As Marilyn Ellwood notes in her testimony, people losing Medicaid when leaving cash assistance has always been an issue, even before the passage of welfare reform. Other research, dating back to the 1980s, has shown that people who leave welfare often return to the cash assistance rolls. This "cycling" pattern of cash assistance usage has also contributed to periodic losses of Medicaid coverage, both for the adults and for their children.

In this context, Ellwood's finding that in 1995 between 49 percent and 65 percent of adults who left cash assistance were not enrolled in Medicaid after six months is not surprising, even if it is disappointing. In the five states she studied, the turnover rate for adults ranged between 26 and 40 percent.

Breaking Medicaid's link with cash assistance, along with the guarantee of Medicaid for certain families with children regardless of cash assistance status and Medicaid expansions, should help to reduce cycling on and off Medicaid. This will help allow Medicaid to operate more effectively as a health insurance program. By and large, thanks to Transitional Medical Assistance, the 1996 eligibility guarantee, and recent eligibility expansions, people leaving cash assistance are eligible for Medicaid. Our challenge now is to ensure that the law is implemented properly and that Medicaid eligibility is based on a family's income and assets, and not on their status as welfare recipients.

Working with States

As mentioned above, there is wide variation among States in enrollment trends. Some States have done an excellent job of maintaining Medicaid coverage for individuals leaving cash assistance rolls. Other States have done an excellent job of outreach to individuals eligible for Medicaid or SCHIP. But in other States, there have been problems that we are working hard to address.

We are greatly concerned about instances in which administrative inaction or improper procedures by States have resulted in eligible individuals being denied access to Medicaid, or in their losing Medicaid coverage or Transitional Medical Assistance that they are guaranteed by law. For example:

- Some public assistance staff failed to inform individuals applying for cash assistance and Medicaid that they could be eligible for Medicaid even if they did not want to pursue or were not eligible for cash assistance under TANF;
- Some States have used joint application forms for both cash assistance and Medicaid and improperly denied health care coverage to individuals who were eligible for Medicaid but not eligible for cash assistance; and
- Computer systems in some States improperly removed individuals from Medicaid rolls when closing their cash assistance cases.

We have taken and are continuing to take several steps to help States adjust to the changes and address specific situations in which eligible individuals were denied Medicaid coverage. And we are working with States to find new ways to reach children and families outside, as well as through, the welfare system. Our efforts to help States address these types of concerns began shortly after the welfare reform law was enacted.

- In 1997 and 1998, we sent a series of letters to States that provided guidance on how to comply with the new rules and ensure health care coverage for those eligible for Medicaid. We also revised our Medicaid manual for States to update guidance on the new law.

• In June 1998 we sent a letter specifically reminding States of the new rules. Since TANF agencies often administer eligibility determinations for the Medicaid program, we wrote this letter with the Administration for Children and Families and sent it to both TANF and Medicaid agencies.

• In February 1999, we and the National Governors' Association launched the Insure Kids Now campaign, with a national toll-free number, 1–877–KIDS NOW, that links callers to their own State SCHIP and Medicaid programs, and a www.insurekidsnow.gov web site.

• In March 1999, we and the Administration for Children and Families issued a 28-page *Supporting Families in Transition* guidebook for States with information on getting and keeping people enrolled in Medicaid when they are leaving or are diverted from welfare.

• Last August, we began conducting site visits to all 50 States to review Medicaid enrollment policies and systems. We are sharing results with States to help them identify best practices and resolve any identified problems.

• Last Fall, we worked with Congress to lift the expiration date for States to spend the $500 million set aside to help them change systems and conduct outreach to address concerns related to delinking of Medicaid and welfare, and in January we sent a letter urging States to take advantage of this extension.

• Last December, HHS published proposed regulations that would take Medicaid and SCHIP enrollment figures into consideration when awarding bonuses to States for success in welfare reform efforts and issued guidance that States would not qualify for performance bonuses unless they certified they were in compliance with Medicaid (and Food Stamp) requirements.

• Last month, we sent a letter to all State Medicaid Directors with additional guidance on what they must do to review Medicaid terminations and re-enroll individuals who were improperly terminated. For example, they must review computer systems and eligibility processes to ensure that they do not improperly deny Medicaid benefits to eligible people. They also must review records to be sure children losing SSI benefits because of the new disability definition did not lose benefits guaranteed them by the BBA, and reinstate anyone improperly terminated from Medicaid. The letter also included guidance on streamlining processes for reviewing whether individuals are eligible to continue receiving Medicaid and ensuring that computer systems do not result in improper terminations. Several States are already reinstating coverage for improperly terminated individuals, and we have received a generally receptive response to the April letter from other States.

• On June 9, we will hold a conference with the National Governors' Association and the American Public Human Services Association on best practices for ensuring that eligible individuals are not denied Medicaid coverage.

Next Steps

To build on these efforts, the President's fiscal 2001 budget invests $5.6 billion over the next ten years to reach and enroll millions of children who are eligible for, but not enrolled in, Medicaid or SCHIP. It would:

• provide new options to States to find and enroll uninsured children through schools;

• expand presumptive eligibility for children by allowing additional sites, such as child care referral centers, to immediately enroll low-income uninsured children in these programs while their applications are being processed; and,

• require States to make the Medicaid enrollment process for children as simple as it is in SCHIP.

The Administration has also proposed investing $85 billion over 10 years to improve health insurance access and affordability. This would directly impact the very population affected by welfare reform and expand coverage to at least 5 million additional uninsured Americans by:

• providing a new, affordable health insurance option for families through the SCHIP;

• accelerating enrollment of uninsured children in Medicaid and SCHIP;

• expanding health insurance options for Americans facing unique barriers to coverage;

• strengthening programs that provide health care directly to the uninsured;

• expanding Medicaid and SCHIP to include an option to cover children through age 20; and

• expanding Medicaid and SCHIP so there is a single, simple eligibility standard for low-income families may be the best way to overcome the complexity and stigma that have limited enrollment.

CONCLUSION

Helping States ensure that all eligible individuals are enrolled in Medicaid and SCHIP is an integral part of making welfare reform work. Health care coverage can be critical in helping families work towards self-sufficiency. 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 eligibility.

We will continue to work with States as they work to reinstate individuals who have been improperly terminated, and revise computer systems and enrollment procedures to ensure that eligible individuals are not denied coverage. And we look forward to working with this Congress to enact the President's proposals to further expand coverage and health care for low-income and uninsured Americans. I thank you again for holding this hearing, and I am happy to answer your questions.

Chairman JOHNSON. I would remind our guests that your entire statement is included in the record. We have a system of a 5-minute red light.

Marilyn Ellwood.

STATEMENT OF MARILYN ELLWOOD, SENIOR FELLOW, MATHEMATICA POLICY RESEARCH, INC., CAMBRIDGE, MASSACHUSETTS

Ms. ELLWOOD. Thank you, Madam Chairman and Members of the Committee, for the opportunity to talk with you today.

My name is Marilyn Ellwood. I am a Senior Fellow with Mathematica Policy Research. Over the last 2 years, I directed two studies analyzing the relationship between welfare and Medicaid, and I want to briefly talk about those.

In the first study, we used Medicaid administrative data in five States to see if families leaving welfare were staying on Medicaid. That table is included at the end of the testimony that I have provided.

If you look at it, you will see that we found that many welfare leavers were not saying on Medicaid. In fact, 3 months after leaving welfare, close to half or more of the children and the adults in every State had also left Medicaid. We expected that many of the parents wouldn't stay on Medicaid, but we were very surprised to see the result for children, given all of the other pathways to coverage that States have.

In the second study, I visited five States, interviewing Medicaid and welfare staff at both the State and local levels to see if there were policy or operational problems that might be contributing to declines in Medicaid enrollment. I want to review three findings from that effort.

First, welfare staff are having trouble understanding how their responsibilities for Medicaid fit into welfare reform, especially with all of the talk about welfare and Medicaid being delinked. This is a big problem since Medicaid Programs still really depend on welfare staff to educate families about the Medicaid Program. Welfare staff are pivotal to making sure that families who are formally or informally diverted from welfare know that they can apply for Medicaid.

They also need to help families leaving welfare for work continue on the Medicaid Program. Yet the staff I talked to are struggling

with these responsibilities because they don't quite understand how the welfare program can be pushing people out the door while the Medicaid Program wants to keep them in. And, in fact, one person said to me that Medicaid was really not part of welfare reform since staff don't get credit for keeping people on Medicaid.

A second finding is that Medicaid rules are getting more and more complicated over time, from Federal legislation, State decisions and, in some instances, litigation. More than one welfare staffer said, I have given up trying to explain Medicaid to people. It is too complicated. Many States have dozens of different Medicaid eligibility groups, each with their own set of rules.

I think both welfare reform and CHIP have contributed to this complexity. As an example, to implement the Medicaid rules associated with welfare reform, California sent 120 pages of instructions to the counties. As another example, in some States with separate CHIP programs, one child in a family is covered under Medicaid while the second child in that same family will only qualify for the separate SCHIP program. We should all imagine the difficulty of explaining that to a parent.

A third finding is that State Medicaid Programs also have a host of administrative problems—lengthy application forms, face-to-face meeting requirements, office hours that don't fit the schedules of working people, and poorly performing computer systems. The redetermination process can be just as time-consuming as the initial application and, as a result, retention is a major issue. Many families simply drop off the Medicaid rolls each month when they fail to complete needed forms, even though they continue to qualify.

What can be done to fix these problems? I think States are really hoping that SCHIP outreach efforts will help them address Medicaid enrollment declines. And no doubt they will help some, but I think it will take a lot more than that.

One of the first things I think needs to be done is that Medicaid needs to be part of the welfare reform agenda. And since welfare is the doorway to which many families first get onto the Medicaid Program, as part of this you might think of having State welfare programs track the proportion of families leaving welfare who qualify for Medicaid or work-related health insurance and let that be one of the measures of welfare reform success.

We also need to make the eligibility process simpler, and an obvious place to start would be simpler rules for Medicaid. In particular, Medicaid rules for the very poorest families should not be more complicated than the rules States use for higher income children under the CHIP program. It doesn't seem fair for CHIP to be easier than Medicaid.

As a final comment, I think State Medicaid Programs need to rethink their mission similar to the rethinking that guided welfare reform efforts, but Medicaid's mission could be quite different from welfare reform. For States that are really serious about reducing the number of uninsured, a fair measure of Medicaid success would be the extent to which they enroll all low-income children and families in Medicaid that qualify and keep them enrolled as long as they don't have access to any other form of affordable health insurance.

Thank you.

[The prepared statement follows:]

Statement of Marilyn Ellwood, Senior Fellow Mathematica Policy Research, Inc.

Thank you, Madame Chairman and members of the committee, for the opportunity to talk with you today. My name is Marilyn Ellwood. I am a Senior Fellow with Mathematica Policy Research in Cambridge, Massachusetts. In my very first job out of college, I worked as a member of the eligibility staff with the DeKalb County Welfare Department in Georgia. That was in 1967, the year Medicaid was first implemented. A few years after that I moved on to a research job, and, over the last twenty-five years, I have done many studies of the Medicaid program, with several focused on eligibility issues. Recently, when it became apparent that Medicaid enrollment was beginning to decline, I directed two studies analyzing the relationship between welfare and Medicaid.

In the first study, my colleague Carol Irvin and I used Medicaid administrative data for 1995 from five states (Alabama, California, Florida, Michigan and New Jersey) to see if families leaving welfare stayed on Medicaid. All of these states were already showing declines in welfare and Medicaid enrollment in 1995, even though they were at different points with regard to welfare reform. The table included with this testimony shows that in each of these states, many welfare leavers did not stay on Medicaid and were at risk of becoming uninsured. Across the five states, from 49 to 67 percent of adults were no longer enrolled in Medicaid three months after leaving AFDC. The results for children were not much different. Three months after leaving AFDC, the proportion of children not enrolled in Medicaid ranged from 47 to 58 percent across the states. While we expected a sizable proportion of parents leaving welfare might not continue on Medicaid, this result was no expected for children, given the availability of the poverty-related expansions in all the states. This pattern is troubling, since other researchers have found that while not all persons leaving welfare and Medicaid lose their insurance coverage, a significant number of welfare leavers become uninsured. It is worth noting that the rates of the uninsured have not gone down over the last few years.

In the second study, I visited 5 states (California, Colorado, Florida, Minnesota, and Wisconsin), interviewing Medicaid and welfare staff at both the state and local levels, to see if there were policy or operational problems that might be contributing to declines in Medicaid enrollment. Let me review three findings from that effort. First, welfare staff are struggling with their responsibilities for Medicaid, now that the link between Medicaid and welfare has been severed. Second, Medicaid rules have become so complicated that welfare and Medicaid staff, as well as families, have trouble understanding them. Third, Medicaid eligibility is plagued by a host of administrative problems, ranging from lengthy redetermination forms to poorly designed automated eligibility systems.

Challenges in Severing Welfare and Medicaid

The first finding is that welfare staff are having trouble understanding how their responsibilities for Medicaid fit into welfare reform. Even though welfare and Medicaid have been severed, state Medicaid programs are still incredibly dependent on welfare staff to educate families about differences in welfare and Medicaid rules. Welfare staff are pivotal to making sure families who are formally or informally diverted from welfare apply for Medicaid, and they are also responsible for helping families who no longer receive welfare benefits continue on Medicaid. Yet, many welfare staff struggle with these responsibilities, because Medicaid priorities for maintaining or even expanding enrollment can seem to conflict with the objectives of reducing welfare dependency. Focus groups and surveys are showing that many families do not understand that welfare and Medicaid rules are different, and that many believe that the new welfare rules, like time limits and work requirements, apply to Medicaid as well. It appears that helping families maintain health insurance coverage has not been a priority in welfare reform. Indeed, several welfare staff reported that Medicaid was not a priority, since they did not get "credit" for signing families up for Medicaid.

Complexity of Medicaid Rules

A second finding is that Medicaid rules have become incredibly complicated over time as a result of federal legislation, state decisions, and in some instances, litigation. Though well intentioned, there rules make eligibility difficult to understand. More than one welfare staffer said, "I've given up on trying to explain Medicaid to my clients. . .it's just too complicated." Many states have dozens of different Medicaid eligibility groups, each with its own set of rules. Both welfare reform and the

State Children's Health Insurance program, or SCHIP, have contributed to this complexity. To implement the new Medicaid rules associated with welfare reform, California sent 120 pages of instructions to countries. As an example of the complexity, in some states, one child in a family will quality for Medicaid, while another in the same family will not, although the second child will qualify for the separately administered SCHIP program. Imagine trying to explain that to a parent.

Medicaid Administrative Issues

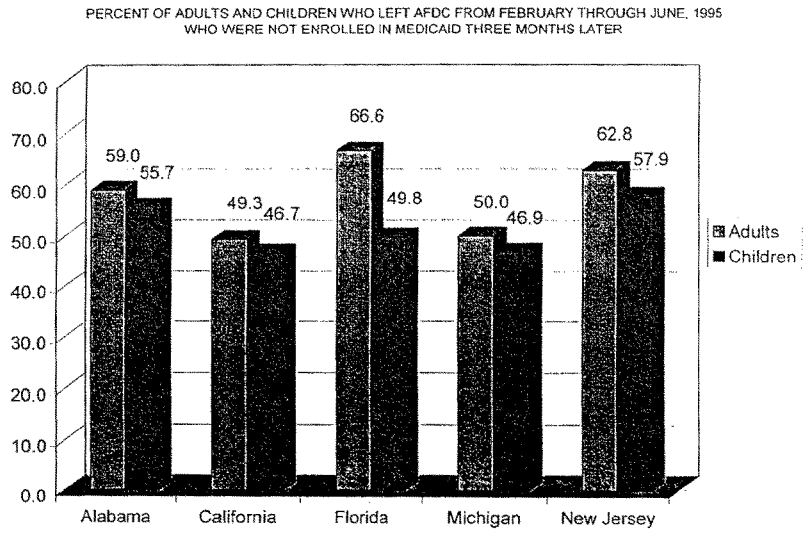
A third finding is that state Medicaid programs also have a host of administrative problems, including lengthy application forms, face-to-face meeting requirements, and office hours that do not fit with the schedules of working families. The redetermination process can be just as time consuming as the initial application. As a result, retention has become a major issue. Many families simply drop off the Medicaid rolls each month, when they fail to complete needed forms, even though they may continue to qualify. Making matters worse, the automated eligibility systems in many states (which handle applications for Medicaid, welfare and food stamps) are woefully inadequate—in part because they are primarily designed and operated to meet welfare, not Medicaid, needs. Systems errors have sometimes led to families being erroneously terminated from Medicaid. Medicaid administrative staff report that the management of these automated systems is beyond their control, and that Medicaid needs are never a top priority. They especially complain about the systems-generated notices and other correspondence sent to applicants and beneficiaries about Medicaid. Notices often include so many legalisms and acronyms that it is difficult for a family to know if they are still on Medicaid or not. One worker said that she finally told her clients to quit reading the notices and just call her instead.

Potential Solutions

What can be done to fix these problems? States are hoping that SCHIP outreach efforts will help them address Medicaid enrollment declines. But, it will take a lot more than that. To start, concern about Medicaid needs to become a welfare priority, since welfare continues to the doorway through which many families first become enrolled in Medicaid. Welfare staff need to focus on educating families about how Medicaid works. Getting families on Medicaid and helping to keep them on, as long as they qualify, needs to become a part of welfare reform objectives. As part of this, state welfare programs could be strongly encouraged, or even required, to track the proportion of families leaving welfare who continue on Medicaid or qualify for work-related health insurance.

We also need to make the eligibility process easier. An obvious place to start would be simpler rules for Medicaid. In particular, Medicaid rules for the poorest families should not be more complicated than the rules states use for higher income children in their SCHIP programs. Other steps to improve the eligibility process include shorter application and redetermination forms, easier to understand notices, and greater use of mail and telephone. States should also consider improvements to their automated eligibility systems, using the enhanced federal matching funds available thought the welfare reform legislation for systems improvements.

As a final comment, I think Medicaid programs need to rethink their mission, similar to the rethinking that guided welfare reform efforts. Participation rates would improve if a key measure of program success became enrolling all low-income families in Medicaid that qualify and keeping them enrolled, as long as they do not have access to any other form of health insurance. However, for this to happen, states will have to become comfortable with the idea that Medicaid might become a long-term program of health insurance for many of the working poor.



Chairman JOHNSON. Mr. Pollack.

STATEMENT OF RONALD F. POLLACK, EXECUTIVE DIRECTOR, FAMILIES USA

Mr. POLLACK. Good morning. I am delighted to join this distinguished panel to focus on the losses of health coverage that resulted from welfare reform.

About a year ago, Families USA released its first report about the impact of welfare reform on health coverage, and we found that approximately 1 million people in the period from 1995 to 1997 lost coverage in Medicaid, and about 675,000 of those people became uninsured.

More recently, we issued a report based on data received from the States. We looked at 12 States, the 12 States with the largest number of uninsured children: Arizona, California, Florida, Georgia, Illinois, Louisiana, New Jersey, New York, North Carolina, Ohio, Pennsylvania and Texas. We looked at the interaction between CHIP and welfare reform, and we found that there are significant improvements in outreach being undertaken in the CHIP program which we thought was very optimistic.

But, as Cindy Mann said, there is some good and bad news. The bad news is that the losses in Medicaid in these States exceeded the gains that were made in the CHIP program. I want to give you some examples.

There were several States that were winners that added children. There were several States that were losers. The three States with the largest losers were—first Texas which lost 193,400 children from public coverage, 14.2 percent. California lost 121,788, or 4.2 percent. Ohio lost over 40,000.

There were some winners as well. There were net gains in some States. North Carolina added almost 79,000 children. New York added almost 51,000 children. Louisiana added over 35,000 children.

The net effect in these 12 States was that there were about 755,000 children who gained admission to the CHIP program, but there were 975,000 children who lost Medicaid coverage. So there was a net loss of 220,000 children.

I think we are probably now at a position where the CHIP gains are probably netting out so more children are many added than we are losing. But, obviously, when CHIP was enacted in 1997, our purpose was to try to make sure that 3 to 4 million children would be added to the rolls so, instead of at that time 10 million children being uninsured, we should be closer to 6 million. Unfortunately, today there are 11 million children who are uninsured, of which 7.5 million children are below 200 percent of the federal poverty line.

But if I leave you one message here, it is that—if there is a mixed dream about children, with some good and some bad—coverage for parents is a real nightmare. We will be releasing a report next month that will take a look at the 15 States with the largest number of uninsured adults, and there—unlike children, for which there is a safety valve, namely the CHIP program—there isn't much of a safety value for adults. And so, as they get dropped from the Medicaid rolls, they don't have a cushion to make sure that there are reductions in such losses.

I can share the figures for one State, Florida, which is by no means the worst, but if is a State whose figures we already relased. In Florida, we looked at the coverage of parents from the period of January 1996 to December 1999, and the figures we received from the State of Florida was that almost 83,000 parents lost Medicaid coverage. And this is very important because low-wage workers, who are the group that we are really focusing on, don't do very well in the employer-based system we have today.

If you look at the statistics, you'll see that less than half of those who work below $7 an hour in income receive an offer of coverage through their employers. That does not mean that they get coverage. They have an offer of coverage.

What makes it more troublesome is that, for low-wage workers, they actually have to pay a higher amount in premiums than higher-paid workers. I am not saying that they pay a higher percentage of their income. I mean they pay higher dollars in premiums. And so they suffer a double blow. They are less likely to get coverage offered; and to the extent that they have it offered in the workplace, they pay a higher amount.

Let me leave you with this one statistic. In two-thirds of the States, 32 States to be exact, if you are a parent and you work at the minimum wage, $5.15 an hour, you are considered to have too much income to qualify for Medicaid if you work full time. That really is not much of an incentive to move from welfare to work.

I look forward to talking later with you about what are some of the administrative and legislative solutions that can be implemented so that—both with respect to children and parents—we can show some improvements in these troubling developments. Thank you.

Chairman JOHNSON. Thank you very much, Mr. Pollack.
[The prepared statement follows:]

Statement of Ronald F. Pollack, Executive Director, Families USA

Madam Chairwoman and Members of the Committee:

Thank you for inviting me to testify today. Families USA is a national non-profit organization dedicated to the needs of health care consumers. We have been engaged in research and advocacy about the impact of TANF changes on the Medicaid program for some time. As an organization that focuses exclusively on health care issues, we have not been engaged in any evaluations of the successes and failures of welfare reform except for the issue we are here to discuss today—the impact that these changes have had on families' insurance status.

In May of 1999 Families USA released a report titled "Losing Health Insurance: The Unintended Consequences of Welfare Reform." This study was prompted by reports we began receiving from around the country of Medicaid declines for low-income families. Our analysis found that, as of 1997, approximately 675,000 parents and children lost Medicaid coverage and were uninsured because of changes associated with welfare reform. In October 1999 we released a subsequent report titled "One Step Forward, One Step Back: Children's Health Coverage after CHIP and Welfare Reform." This report examined the 12 states with the largest number of uninsured children and found that children's enrollment in federal-state health programs (Medicaid and SCHIP) declined by 2 percent between 1996 and 1999. While SCHIP enrollment was increasing during this period, these gains were offset by reductions in children's Medicaid coverage—largely due to welfare reform.

We believe that there are three ways that eligible families are not receiving the Medicaid coverage to which they are entitled. The first is when people move from welfare to work. Most people making this move wind up in entry-level jobs that provide minimal salaries and no health care coverage. After they leave welfare, most parents should remain eligible for Transitional Medicaid (TMA) coverage—and their children are most likely still eligible for Medicaid or SCHIP. Yet many of these families are not receiving federally supported health coverage after their TANF case is closed. These terminations—many of which are clearly erroneous—are happening in significant numbers. Washington State alone identified approximately 100,000 family members who lost their Medicaid when their TANF case was closed.[1] As families start to meet their time limits in TANF, this problem may become even more severe unless states move quickly to address it.

Second, when families apply for welfare, they are often diverted from filing an application as part of the states' attempts to reduce cash assistance. Many families and some caseworkers are unaware of the fact that families are still eligible for Medicaid even if they are not receiving cash assistance, and that families have a right to file a Medicaid application and have that application processed within 45 days.

And finally, the significant publicity around welfare restrictions has convinced many families that they are no longer eligible for Medicaid, and, as a result, many families are not coming to welfare offices to apply for cash assistance and/or Medicaid. A recent study of families eligible for or receiving Medicaid by the Kaiser Commission found that over 70 percent believed there are time limits on Medicaid, even though this is not true.

While outreach and simplification efforts in SCHIP and children's Medicaid will help to reach some of the children who lost coverage due to welfare reform, the intent of the SCHIP legislation was to reduce the number of uninsured children—not to compensate for welfare reform losses. SCHIP would be even more successful if a large part of its enrollment growth was not simply compensating for losses among lower-income Medicaid children.

Moreover, these efforts will do nothing to address the significant numbers of parents who are losing Medicaid coverage inappropriately. Families USA is currently working on a report that examines states' own data with respect to parents who lost Medicaid between January 1996 and December 1999. Our preliminary findings indicate that these numbers will be dramatic. In Florida alone, where we have already released our data, enrollment of low-income parents dropped by 82,682 during this time period. We know from work done by the Urban Institute and others that only about one-fourth of parents moving from welfare to work have employer-sponsored health insurance so it is fair to assume that the vast majority of parents who lost Medicaid are now uninsured. Many of these parents should have received Transitional Medicaid (TMA) for at least six months if they left Medicaid due to increased

[1] "Thousands Owed Medicaid," *Spokesman Review*, Spokane, WA, September 15, 1999.

earnings. If they did not have increased earnings, then they are most likely still eligible under the Section 1931 family coverage category.[2] For far too many parents, the reward for moving from welfare to work is the loss of their health insurance coverage.[3]

I would like to turn now to ways these problems could be addressed at the federal and state levels. As you know, the Health Care Financing Administration (HCFA) issued guidance on April 7th to the states about reinstatement of erroneously terminated families, requirements related to the redetermination process, and the need to fix computer systems that have not been properly delinked. We believe that HCFA should enforce this guidance and the requirements of Section 1931 aggressively, and we urge Members of Congress to communicate with their Governors that they expect the federal law to be upheld.

States must also move aggressively to fix problems associated with delinking cash assistance from Medicaid. With prodding from advocates, a few states—namely Washington, Pennsylvania, and Maryland—have developed comprehensive plans to reinstate families wrongfully terminated and to fix problems in their computer systems that are causing illegal terminations. We believe that Washington State, in particular, is a good model for other states to look to as they develop their plans to comply with the HCFA guidance. Washington State, as I mentioned, had a significant problem with erroneous terminations, but after negotiating with advocates, agreed to reinstate these families and alter their computer systems to prevent the problem from reoccurring.

Money is already available to the states to fix many of these problems. Last year Congress extended the life of the so-called "Medicaid-TANF delinking fund" which was created in the welfare reform legislation to help states cover costs associated with delinking. These funds can be used by states to pay for reprogramming computer systems, training caseworkers, and doing outreach. Most states still have considerable sums remaining in their allotments, and most activities are funded at a 90/10 federal/state match.

States must also turn their attention to simplifying and streamlining outreach and enrollment procedures in their Section 1931 family coverage Medicaid category as they have done in their child-only Medicaid category. In general, states' requirements for enrollment in family-coverage Medicaid are significantly more onerous than requirements for child-only Medicaid. For example, only 8 states still have an assets test for their child-only Medicaid category, but 40 have an assets test in their Section 1931 category. This creates a barrier for parents and their children who are enrolling through the Section 1931 family-coverage category. The good news is that many simplification efforts for children and their parents do not require changes in federal law; states are able to do so already.

Also, states should take advantage of the opportunity created by Section 1931 to expand their eligibility levels for low-income parents. Currently eligibility levels for parents are extremely low. In almost two-thirds (32) of the states, parents are deemed to have too much income to qualify for Medicaid if they are working full time at the minimum wage ($5.15 per hour). The median state eligibility standard for parents is at 61 percent of the poverty level. Nine states have already expanded eligibility, and others are currently considering similar expansions. Beyond the obvious benefit of allowing parents to remain eligible as they move to low-paying jobs, these expansions also effectively break the historical link between Medicaid and welfare. And research has shown that covering parents will result in more children getting covered.

Finally, while the statutory requirements of Section 1931 are clear, we believe there is much more Congress can do to ameliorate the situation and create incentives for families to go to work. The first is to extend and simplify Transitional Medicaid, which is due to expire on September 30, 2001. Current statutory reporting and eligibility requirements are complex, burdensome on families, and confusing. We believe that the best way to reform TMA would be to require 12 months of continuous coverage when a family leaves Section 1931 Medicaid due to increased earnings. This would ease state administration and greatly simplify outreach and education efforts. An additional year of health coverage is the least we can do for families making the difficult transition from welfare to work.

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[2] P.L. 104–193 created the Section 1931 eligibility category for families based on income and resource standards established by each state and that eligibility is unaffected by the receipt of cash assistance.

[3] The only scenario under which a parent could properly lose their Medicaid, because of a TANF sanction, is in a state that has elected to terminate coverage for parents who fail to meet work requirements. Only 13 states have adopted this work sanction. Children cannot be sanctioned in any situation.

Second, Congress should extend certain options, like 12-month continuous eligibility, to parents. Currently, states are only permitted to offer 12-month continuous eligibility to children. This would allow a state to enroll the whole family for 12 months with no separate redetermination for parents needed.

And finally, we believe that the high levels of uninsurance among low-wage working families will not be addressed until Congress takes action to extend coverage to all families below 200 percent of poverty. Employment-based coverage for low-wage working families is often not offered and, if it is, it is often unaffordable. Only 43 percent of employees working for $7 or less per hour are offered health benefits by their employer. And in firms where the typical wage is less than $7 per hour, the average monthly employee contribution for the lowest-cost employer plan is $130 per month as compared to firms where the typical wage is more than $15 a hour where the average monthly employee contribution required is $84.

Covering these families would be most efficiently accomplished through an expansion of the Medicaid and CHIP programs similar to the FamilyCare proposal in the President's budget this year. We urge you to consider such an expansion to provide essential support to low-wage working families who are struggling to make ends meet.

Chairman JOHNSON. Ms. Lyons.

STATEMENT OF BARBARA LYONS, PH.D., VICE PRESIDENT, HENRY J. KAISER FAMILY FOUNDATION, AND DEPUTY DIRECTOR, KAISER COMMISSION ON MEDICAID AND THE UNINSURED

Ms. LYONS. Thank you for the opportunity to testify on how welfare reform has affected Medicaid coverage of low-income families.

I am Barbara Lyons. I am Vice President of the Henry J. Kaiser Family Foundation and Deputy Director of the Kaiser Commission on Medicaid and the Uninsured. The Commission is a major initiative of the Kaiser Family Foundation and conducts analysis on health care coverage and access issues facing the low-income population.

Today I want to emphasize several findings that have emerged from studies that we have conducted.

First, Medicaid is an important source of health coverage for low-income families. In fact, Medicaid is the only source of health coverage for the poor. When poor families don't have Medicaid, they are generally uninsured, suffer worse access to care and poorer health outcomes.

Our research shows that families understand the importance of Medicaid coverage, low-income parents overwhelmingly think that Medicaid is a good program and that Medicaid coverage helps them access doctors and helps them pay for prescription drugs when their children are sick.

In recognition of the important health benefits of Medicaid coverage, policy efforts have been directed at expanding the program's reach beyond its initial welfare origins to more broadly support low-income families. However, the recent declines in Medicaid coverage are cause for concern. Between 1995 and 1997 the number of kids and parents who had health insurance through Medicaid fell by over 1.6 million, including 500,000 children. These declines were steepest for welfare reform-related enrollees and were not offset by increases in coverage through other Medicaid categories.

Our research has identified four factors that have contributed to these declines.

First, there is confusion over the Medicaid rules. As we heard earlier, they are confusing. The recent policy changes that have occurred have resulted in misunderstanding among low-income families about whether they qualify for Medicaid and, importantly, whether welfare rules also apply to Medicaid coverage. Many parents incorrectly believe that Medicaid benefits are time limited and only available to families receiving welfare, not working families.

Second, inappropriate administrative action has, as Marilyn Ellwood referred, resulted in ineligible families losing Medicaid coverage. Updating computerized eligibility systems to reflect current policy has been a major challenge for the States and in the interim some families have received incorrect information which has resulted in the loss of Medicaid coverage.

Third, the Medicaid enrollment process is often not accessible to working families. The major barriers to Medicaid enrollment reported by parents are hurdles in the administrative process. Lengthy application forms, required face-to-face interviews at offices and substantial documentation requirements are significant barriers that deter low-income families from initiating and completing Medicaid application. The Federal rules here are minimal, leaving States with substantial opportunities to simplify enrollment, but States have often been slow to implement the streamlined procedures that are necessary when working families are applying for Medicaid.

Finally, many families who succeed in getting through the enrollment process initially subsequently lose coverage despite the fact that they continue to be eligible.

Our most recent data, which will be discussed in the next panel, shows an upturn in Medicaid enrollment in 12 out of 21 study States during last year. Some States have expanded eligibility, engaged in outreach, improved enrollment procedures to successfully reach more low-income families eligible for Medicaid and CHIP. Despite these gains, Medicaid enrollment in June, 1999, remained below June, 1997, levels in most States.

In conclusion, I want to emphasize that Medicaid plays a critical role in ensuring access to care for low-income families. Reaching Medicaid's full potential as a health coverage program remains a critical challenge. To accomplish this goal, Medicaid needs to be viewed as a health insurance program for working families. The legislative authority is in place to make Medicaid and welfare policy work together to assure that low-income families are not penalized by losing their Medicaid when they go to work. If these efforts are broad and successful, the number of uninsured could be substantially reduced.

Thank you for the opportunity to testify today.

[The parpered statement follows:]

Statement of Barbara Lyons, Ph.D., Vice President, Henry J. Kaiser Family Foundation, and Deputy Director, Kaiser Commission on Medicaid and the Uninsured

Thank you for the opportunity to testify on how the Temporary Assistance for Needy Families (TANF) program has affected Medicaid coverage of low-income families. I am Barbara Lyons, Vice President of the Henry J. Kaiser Family Foundation and Deputy Director of the Kaiser Commission on Medicaid and the Uninsured. The bipartisan Commission, a major initiative of the Kaiser Family Foundation, con-

ducts analysis and sponsors research on health care coverage and access issues facing the low-income population.

Medicaid coverage is an important source of health insurance coverage for low-income families and helps them obtain needed health care services. Welfare reform has unfortunately contributed to unintentional declines in Medicaid enrollment and increased numbers of uninsured Americans. These gaps in Medicaid's coverage can be remedied and states currently have the tools to fix these problems in Medicaid coverage for low-income families. I will address the role that Medicaid plays for low-income families, the recent declines in Medicaid enrollment, and problems in assuring Medicaid coverage that resulted from welfare reform.

Medicaid is an Important Support for Low-Income Families

Medicaid is a major health coverage program for low-income people that is jointly financed by the federal and state governments and administered by the states within broad federal guidelines. Today, Medicaid covers 41 million Americans, including 21 million low-income children (nearly 1 in 4 of all children in the U.S.). Medicaid is the primary source of health coverage for the poor, covering 41 percent on the non-elderly population (Figure 1). Because Medicaid does not cover all the poor and covers fewer near-poor with incomes between 100 and 200 percent of poverty, almost a third of the poor and near-poor are uninsured. Without Medicaid, the number of uninsured would be much higher because employer-based health insurance is often not available or affordable for low-income working families.

The consequences of being without health coverage are far reaching for both children and adults. National surveys document that children who are uninsured are much less likely to have regular physician check-ups and to get needed medications, eyeglasses, mental health services and dental care. Uninsured children are 70 percent more likely than those with insurance to go without medical care for common childhood conditions such recurring ear infections and asthma. Uninsured children are also 30 percent less likely to receive medical treatment for injuries than those with health coverage. Uninsured adults face even greater barriers to care, often with serious health consequences.

Having Medicaid coverage makes health care accessible for low-income families. Poor children with Medicaid use health care services at rates comparable to children with higher incomes and private coverage, while uninsured poor children lag far behind (Figure 2). When families lose Medicaid and become uninsured, they are far more likely to have problems getting care than those who have continuous Medicaid coverage (Figure 3).

Families understand the importance of Medicaid coverage. The Kaiser Commission has conducted extensive survey and focus group research on low-income families. Overwhelmingly, this research shows that nine out of 10 low-income parents think that Medicaid is a good program. Low-income parents appreciate Medicaid because it provides access to health care services and is affordable. They know that Medicaid will help access doctors and pay for prescription drugs when their children are sick. Medicaid helps assure that children get a healthy start in life and that low-income working families are not saddled with burdensome medical bills.

In recognition of the value of Medicaid coverage, the federal government broadened eligibility criteria for children and pregnant women in the late 1980s. Eligibility for children and pregnant women is now based on family income related to the federal poverty level, rather than welfare criteria (Figure 4). States are required to cover pregnant women and preschool children in families with incomes below 133 percent of poverty and school-age children below 100 percent of poverty, with coverage for older teenagers (age 16 to 18) continuing to be phased in. By September 30, 2002, all poor children through age 18 will be eligible for Medicaid.

Medicaid is integral to efforts to assure access to health care services for low-income families in all states. Recent policy efforts have been directed at expanding the program's reach beyond its welfare origins to more broadly support low-income working families. These changes resulted in an additional 11 million low-income people, primarily children, being covered by Medicaid during the early 1990s. Medicaid's role emerged as an essential building block to expand coverage to reach low-income families who otherwise would be without health coverage and to stem the rise in the uninsured.

Recent Declines in Medicaid Coverage

The number of Medicaid enrollees grew steadily throughout the early 1990s increasing from 28.9 million in 1990 to 41.7 million in 1995 due primarily to increased coverage of children and pregnant women. Reversing these gains in expanding coverage to low-income families, Medicaid enrollment has declined in recent years with

an erosion in Medicaid's protections for low-income families (Figure 5). Since 1995 Medicaid enrollment has declined, dropping to 40.6 million in 1997.

Between 1995 and 1997 the number of children and parents who had health insurance through the Medicaid program fell by about 1 million, while the number of uninsured increased. During this period, total annual Medicaid enrollment fell by 5.5 percent for adults and 1.4 percent for children (Figure 6). Medicaid participation fell the most steeply for welfare-related beneficiaries. The number of Medicaid beneficiaries receiving cash assistance fell by 13 percent for adults and 11 percent for children from 1996 to 1997. Some individuals losing cash assistance remained enrolled in Medicaid under other eligibility categories, but not enough to offset the decline in cash assistance related enrollment (Figure 7).

The decline in Medicaid enrollment was unexpected—given the continued implementation of Medicaid eligibility expansions—and of concern, in the face of continued increases in the number of uninsured. Several recent studies examining the decline in Medicaid enrollment have identified welfare reform policies, obstacles in Medicaid eligibility and enrollment systems, and high employment rates as prominent reasons.

These trends emphasized the need to have timely Medicaid enrollment data. Based on states' own monthly Medicaid enrollment reports, the most recent data shows an upturn in Medicaid enrollment in 12 out of 21 study states between June 1998 to June 1999. These increases are, in part, related to eligibility expansions under Medicaid and CHIP to reach children at higher incomes, as well as efforts in some states to inform families about health coverage available through Medicaid and the new Children's Health Insurance Program (CHIP) and to make children's enrollment easier. Despite this recent upswing, Medicaid enrollment in June 1999 remained below June 1997 levels in all but six (Arkansas, Florida, Indiana, Massachusetts, New Mexico and Oklahoma) of the 21 study states (Figure 8).

Welfare Reform and Health Coverage of Low-Income Families

In enacting welfare reform, Congress did not alter the entitlement to Medicaid and intended to preserve Medicaid coverage. The new law says that states are required to continue to cover families who meet the welfare eligibility requirements in effect in the state as of July 16, 1996 and allows states to expand Medicaid to cover more low-income families. Prior to TANF, families receiving cash assistance were automatically enrolled in the Medicaid program.

The new law "delinked" eligibility for welfare and Medicaid, so receiving cash assistance now has no bearing on Medicaid eligibility. Instead, eligibility for low-income families is based on a new Medicaid category, Section 1931, that replaces the "AFDC-related" category. TANF beneficiaries are eligible for Medicaid, as are families who are not receiving welfare but meet Medicaid's eligibility rules. In addition, families leaving welfare to work are entitled to Transitional Medical Assistance (TMA) for 6 to 12 months. Many children in low-income families who are not receiving welfare are likely to be eligible for coverage through Medicaid's poverty-related categories or CHIP. Thirty-four states now provide coverage to children up to at least 200 percent of poverty through Medicaid or CHIP and today all states are required to provide Medicaid to children under poverty up to age 16.

Although fewer families are now applying for welfare, they may still be eligible for Medicaid for themselves or their children. Moving families from welfare to the workforce may have reduced the need for cash assistance, but has not eliminated the need for help with health insurance coverage. The availability of Medicaid is of vital importance to low-income working families because health insurance is expensive and insurance coverage or help in paying the premiums is not often provided by their employers. A key challenge is how to assure Medicaid coverage for eligible families who are no longer applying for cash assistance, as well as those who are transitioning from welfare to work.

Analysis by the Urban Institute shows that many parents who have left welfare have obtained low-wage jobs concentrated in service, sales and trade industries—the sectors least likely to provide job-based health coverage. These families often face serious struggles providing food for their families and paying their housing costs. A significant portion of parents who left TANF have disabilities or health conditions that may affect their ability to succeed in the workplace if they lose health coverage. Families leaving welfare are often not able to retain health coverage; 40 percent of women and 25 percent of children previously on Medicaid were uninsured one year later (Figure 9). Similar difficulties in securing health coverage are also faced by families with low-wage workers who have not received welfare assistance.

Although states also can extend greater Medicaid coverage to working parents to help assure family coverage, in most cases, adult eligibility remains tied to the welfare rules. Income levels for adults are often set considerably below the federal pov-

erty level and restrictive asset tests are commonly employed. In 32 states, a parent working full-time at a minimum wage job would not be eligible for Medicaid, even if they lack access to employer-based coverage. Thus, efforts to cover children at higher income levels have not often translated to their parents, resulting in coverage disparities within families.

The wide variation across states in Medicaid's eligibility, combined with differences in the availability of employer-based coverage, has led to wide differences in the uninsured rate among the states. State uninsured rates for their low-income populations (less than 200 percent of poverty; $27,300 for a family of three in 1998) range from a low of 15 percent in Vermont to 45 percent in Arizona and Texas. Despite the Medicaid expansions and efforts to broaden coverage for children, in 1998 nearly 8 million low-income children were uninsured. Fifteen states have over 27 percent of low-income children without any health coverage (Figure 10).

Problems in Assuring Medicaid for Eligible Families after Welfare Reform

Welfare reform resulted in a dramatic restructuring of goals in state welfare offices. Great emphasis was placed on securing employment and diverting families from cash assistance. This new focus resulted in a transformation of the case worker's role. Priorities shifted from determining eligibility for cash benefits to promoting employment among potential applicants. As this major redirection of welfare offices was occurring, considerably less attention was devoted to assuring that Medicaid coverage was reaching eligible families. Confusion about Medicaid eligibility rules, gaps in state information systems, and hurdles in the enrollment process precludes eligible families in many states from receiving Medicaid coverage.

These barriers to Medicaid enrollment can be surmounted under current law and some states have made progress in overcoming these problems. However, more effort needs to be put toward making Medicaid accessible as a health coverage program for low-income families. The Health Care Financing Administration (HCFA) has recently issued guidance that clarifies the steps that states must take to assure that eligible families are not losing out on Medicaid coverage in the face of welfare reform.

Confusion over Medicaid Rules

Changes to welfare, as well as immigration, policy have resulted in confusion among low-income families about whether they qualify for coverage. A national survey of low-income parents, conducted by the Kaiser Commission last year, revealed considerable misunderstanding about current Medicaid eligibility rules. Many parents believed that Medicaid benefits were time limited, not available to working or two parent families, and limited to families receiving welfare (Figure 11). Interviews conducted by Commission staff with case workers in three cities also revealed lack of understanding of Medicaid eligibility rules among case workers and little agency support to navigate these rules to assure Medicaid coverage for eligible families, despite an appreciation among the workers of the importance of Medicaid coverage. If the workers are confused, it is not surprising that many low-income families are confused as well.

Inappropriate Administrative Action

Due to the complexity of eligibility rules, most states depend heavily on their automated eligibility computer systems to process applications for Medicaid and welfare. Yet, these systems were often designed to meet welfare, not Medicaid, eligibility needs and, in some cases, incorrect information has been transmitted to enrollees about their Medicaid eligibility when the two programs were "delinked." State computer systems have sometimes automatically closed families' Medicaid cases when their welfare cases were closed, although states are required to separately determine whether or not a family is eligible for Medicaid under any eligibility category before terminating Medicaid coverage for any member of the family.

Because changing computer systems takes time, some states have employed temporary stop-gap measures, such as supervisor review of all TANF cases being closed, to avoid erroneous Medicaid terminations. The recent HCFA guidance outlines the specific steps that states must take to assure their computer systems are not inappropriately terminating Medicaid coverage. There is federal money available through Medicaid administrative funds, as well as the TANF $500 million fund, that states have used to varying degrees to update their computer systems.

Medicaid Enrollment Processes Are Not Accessible to Working Families

With the increased emphasis on work, Medicaid application and enrollment processes need to be designed with working families in mind. For most workers who

have job-based coverage, the enrollment process is facilitated by the employer. In contrast, to obtain Medicaid coverage for themselves or their children, low-income parents may have to take time away from work or other responsibilities to apply for Medicaid. Lengthy, complicated enrollment forms, required face-to-face interviews, and substantial documentation requirements are significant barriers that deter low-income parents from initiating and completing the Medicaid enrollment process (Figure 12). In addition, many working parents do not want to go to a welfare office to obtain health coverage for their family.

Hurdles in the Medicaid enrollment process often stand in stark contrast to efforts underway to facilitate CHIP enrollment. The implementation of streamlined enrollment procedures under CHIP has spurred a number of states to take similar action in their Medicaid programs for children (Figure 13). While a number of states now allow mail-in applications for children applying only for Medicaid or CHIP benefits, more lengthy applications and face-to-face interviews with staff are required in most states if parents or entire families are seeking Medicaid coverage. Federal requirements are minimal leaving states with substantial opportunities to simplify family eligibility and enrollment processes, but states have often been slow to implement streamlined procedures when families are applying for Medicaid coverage. This disparity in application processes for families may result in the poorest families facing the most stringent rules to obtain Medicaid.

Many families who succeed in getting through the Medicaid enrollment process, subsequently lose coverage, despite continuing eligibility. Federal rules require an annual re-determination that can often be done by mail. However, many states assess eligibility more frequently and require families to complete lengthy forms, go to the welfare office in person for an interview, and furnish many documents. Simplifying this process would help eligible families stay continuously covered.

Families Outside the Welfare System Are Left Out of Medicaid

The dramatic drop in families receiving cash assistance means that many uninsured low-income families may be eligible for Medicaid assistance, but have little connection to the welfare system. Historical enrollment approaches that rely on the welfare system as the primary route to Medicaid are not sufficient and may be counterproductive. New vehicles that reach and enroll eligible low-income families where they are—at work, school or day care—are needed.

Reaching these families is increasingly important, in light of welfare strategies that focus on diversion and work, as well as the recent burst in job growth that has led to greater employment, but not necessarily linked to health coverage. Only 54 percent of low-wage workers ($7 per hour or less) are offered health insurance coverage through their jobs compared to 96 percent of higher-wage workers (Figure 14). When health coverage is available, the monthly employee contribution for family coverage is considerably higher in businesses that employ many low-wage workers. Thus, low-wage workers may be unable to afford family coverage.

In this environment, the challenge to states is to make concerted efforts to inform eligible families about Medicaid, work with community-based organizations and employers to reach and enroll children and their parents, and implement the changes necessary to facilitate the enrollment process and keep families continuously covered. Barriers that impede Medicaid enrollment clearly exist today, but are not inherent to the program. These problems have practical, feasible solutions that all states can implement.

Conclusion

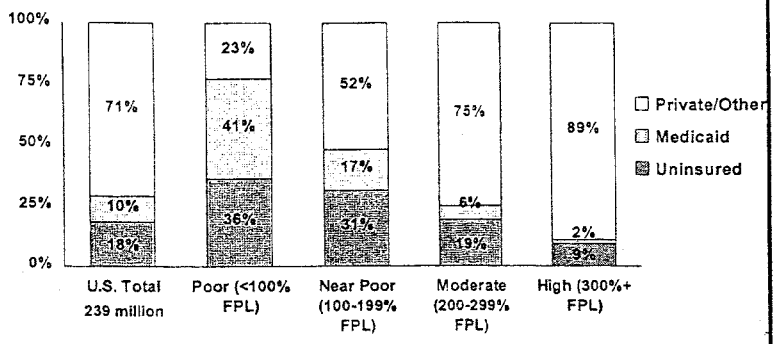
We need to recognize the important role that Medicaid plays today in assuring access to health care for the low-income population. Despite gaps in coverage, Medicaid is the major source of health coverage for children and parents in low-income families. Reaching Medicaid's full potential as a health coverage program for low-income families remains a critical challenge. Concrete steps need to be taken to assure that low-income families who are eligible for Medicaid can obtain Medicaid coverage, whether they are currently receiving welfare, are transitioning from welfare to work or have no connection to the welfare system.

To accomplish this goal, Medicaid needs be and operate as a health insurance program for working families that is distinct from welfare assistance. The legislative authority is in place to make Medicaid and welfare policy work together to assure that low-income families are not penalized by losing access to Medicaid coverage when they work. If these efforts are broad and successful, the number of uninsured in the United States could be substantially reduced.

Thank you for the opportunity to testify today. I welcome any questions.

Figure 1

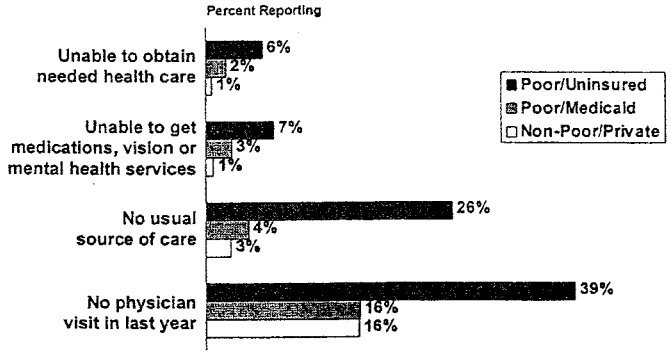
Health Insurance Coverage of the Nonelderly, by Poverty Level, 1998



Note: The federal poverty level for a family of three in 1998 was $13,650
Percentages may not total to 100 due to rounding
SOURCE: Urban Institute, 1999
DATA: Current Population Survey, March 1999

Figure 2

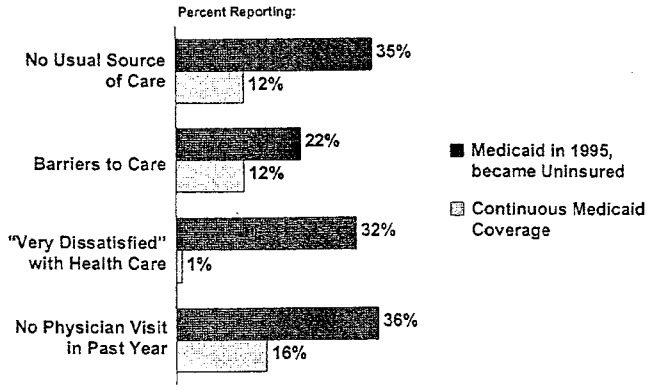
Children's Access to Care, by Insurance and Income, 1995



SOURCE: Newacheck et. al., 1998, data from 1995 NHIS.

Figure 3

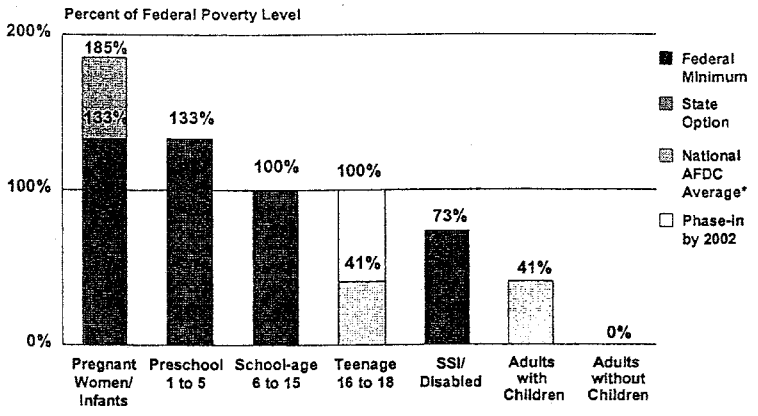
Effects of Losing Medicaid Coverage on Access to Care, 1995-1997



Note: Loss of coverage may have occurred in either 1996 or 1997. For those who did not lose coverage, the second measure was in either 1996 or 1997.
SOURCE: Kasper J, 1999
DATA: Kaiser Survey of Family Health Experiences

Figure 4

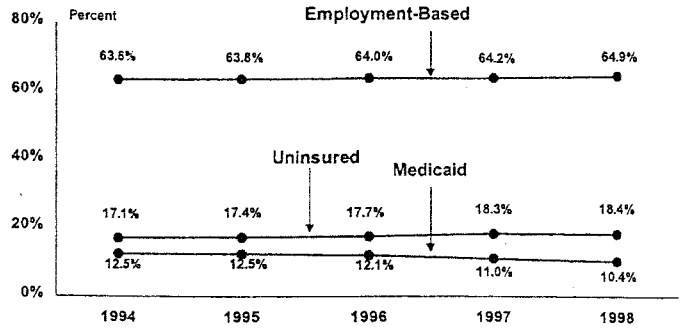
Medicaid Income Eligibility Standards, 1999



*AFDC average for 1996 is the standard used for Section 1931 eligibility
Note: Some states have increased eligibility through Sec. 1115 or Sec. 1902(r)(2) or SCHIP.
Federal Poverty Level is $13,600 for a family of three for 1999
SOURCE: National Governors' Association, 1999. Center on Budget and Policy Priorities, 1999.

Figure 5

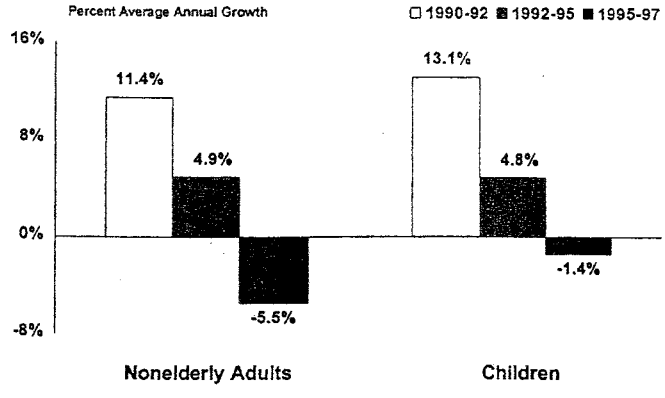
Trends in Coverage for the Nonelderly Population, 1994-1998



SOURCE: Urban Institute, 1999
DATA: Current Population Survey (March) 1995-1999

Figure 6

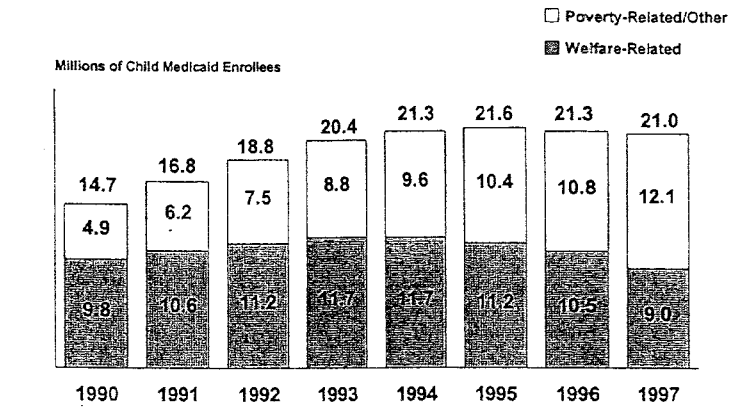
Rate of Growth in Medicaid Enrollment for Nonelderly Adults and Children, 1990-1997



SOURCE: Urban Institute, 1999

Figure 7

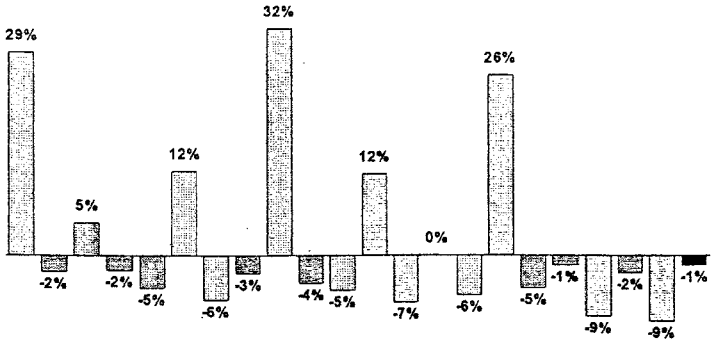
Medicaid Enrollment of Children, 1990-1997



SOURCE: Urban Institute analysis of HCFA 2082 data, 1999.

Figure 8

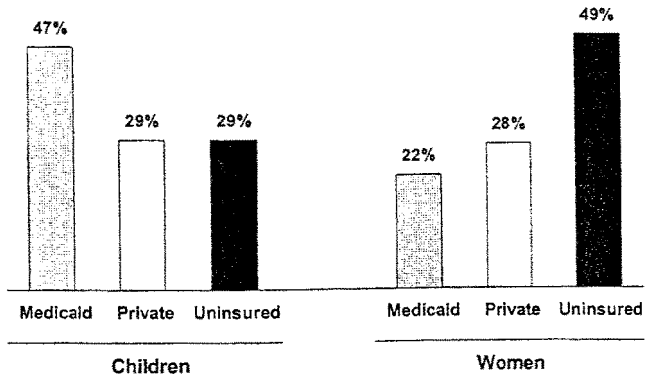
Percent Change in Monthly Medicaid Enrollment, Selected States, June 1997 to June 1999



SOURCE: Health Management Associates Survey for the Kaiser Commission on Medicaid and the Uninsured 1999.

Figure 9

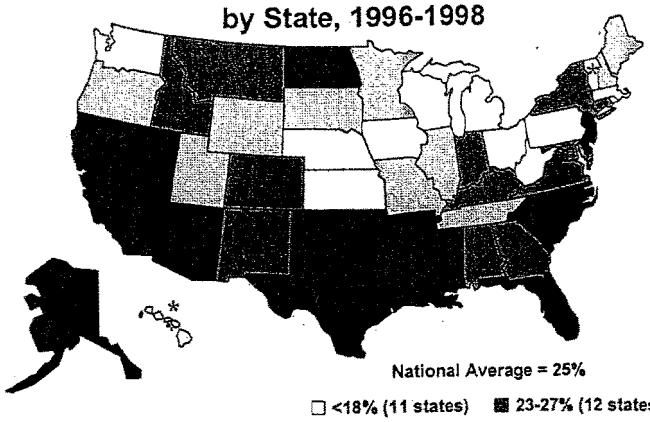
Health Insurance Coverage of Former Welfare Recipients One Year or More After Leaving Welfare*



*Sample of people who left welfare at some point between January 1995 and mid-1997
Note: Percentages do not add to 100% because some individuals had multiple sources of health insurance coverage and other public sources of coverage are not included in this figure.
SOURCE: Garrett B. and Holahan J, 2000.

Figure 10

Percent of Low-Income Children Who Are Uninsured by State, 1996-1998

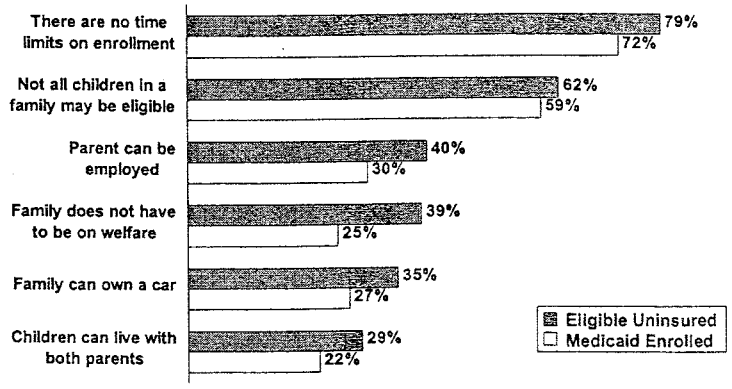


Note: Low-income defined as <200% of poverty level.
In 1998, 200% of poverty for a family of 3 was $27,300.
* Insufficient sample size for reliable estimate in Hawaii and Vermont.
SOURCE: Urban Institute, 1999
DATA: 3 year-pooled data from Current Population Survey (March) 1997-99

Figure 11

Confusion Over Medicaid Rules

Percent of surveyed parents who did NOT know that...

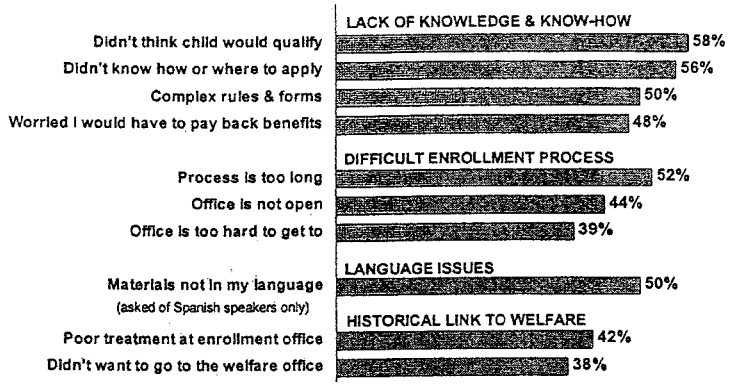


SOURCE: National Survey on Barriers to Medicaid Enrollment, Kaiser Commission on Medicaid and the Uninsured, 2000.

Figure 12

Reasons Parents Have Not Tried to Enroll Their Child

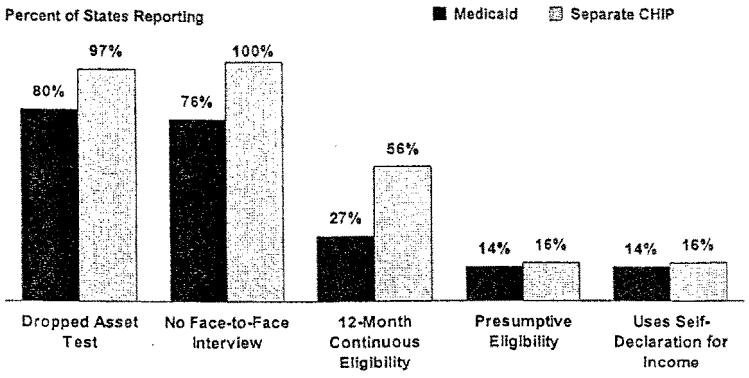
"Important" reasons reported by parents of eligible uninsured children who have never tried to enroll



SOURCE: National Survey on Barriers to Medicaid Enrollment, Kaiser Commission on Medicaid and the Uninsured, 2000.

Figure 13

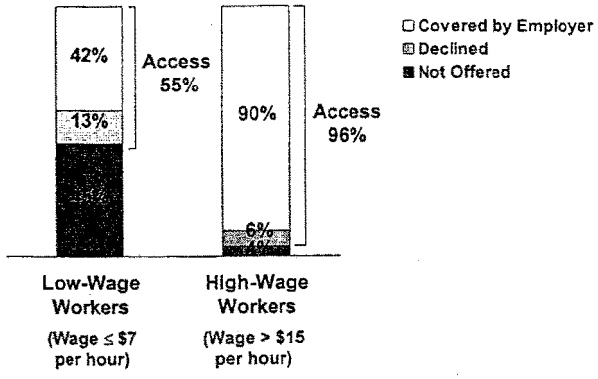
Simplifying Enrollment for Children: Medicaid and CHIP



NOTE: Percentages are based on a total of 51 state Medicaid programs (including the District of Columbia) and 28 separate state CHIP programs.
SOURCE: Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, 1999.

Figure 14

Access to Employer-Based Coverage for Low and High Wage Workers, 1996



Note: Access to job-based coverage includes through a worker's own job or a family member's job.
Annualized wage income (based on a 35-hour work week, 52 weeks a year) for low-wage workers would be ≤ $12,740 and for high-wage workers > $27,300.
SOURCE: Cooper P. and Schone B., 1997; Calculations based on data in Exhibit 2
DATA: MEPS 1996 and NMES 1987

Chairman JOHNSON. Thank you all very much for your testimony, and I certainly look forward to the testimony of the next panel so we can get a better insight as to what mechanisms are having an effect on overcoming the problem of delinking. I think delinking in the end was certainly the right answer.

Certainly one of the problems with the old welfare program was it kept people on welfare because they needed medical coverage, and we don't want to get back to that, although clearly we do want to realize the potential of all of the coverage laws that we have on the books to provide coverage.

According to the law, any child under poverty is eligible for coverage up to 17, 18, 19 and pregnant women and children up to 133 percent, and the disappointing enrollment—I was very interested in my colleague from California's comment in his county. We certainly have experienced the same thing in Connecticut. How do we get the current programs to be more effective in people's lives?

And I want to congratulate the administration, Ms. Mann, for a lot of different initiatives, and I was glad you ran them all down. I think all of the dialog between you and the States culminating in regulations that do clarify a number of things go to some of the problems that Ms. Ellwood alluded to.

I would like to ask Ms. Ellwood a couple of things. I want to keep it brief, because we want to get to the next panel and be done before noon.

On the issue of complexity, is there any difference between those 26 States that have used the more comprehensive waiver and some States that have better integrated CHIP with Medicaid?

I ask this question because there was a Rockefeller Institute study on how welfare reform was working, and it was on the early efforts, and it was very clear to me—in fact, quite stark—that those States that had totally cross-trained people to eligibility for benefits and also work and employment issues were doing a far better job of helping women move from welfare to work but also a much better job in supporting their families.

Is there any conjunction between the States that deeply integrated their bureaucratic approaches and those who use the waiver system and this issue of complexity? In other words, are those States using waivers? Are those States cross-training doing much better in terms of providing Medicaid benefits to people who come into the welfare to work system or not?

Ms. ELLWOOD. I'm sorry, I don't think that I can answer that. Perhaps Cindy, you know that.

Ms. MANN. I think there is a mix of strategies, and I actually think the next panel will identify some of the mix.

What I have seen that works in States is, on the one hand, integration of the staff so that Medicaid is part of the welfare reform message, that they know the rules. On the other hand, some States have found that outstationing Medicaid eligibility so that they are very separate and independent, not to the exclusion of the welfare office.

The other thing is the importance of systems changes. We have seen a lot of States with very antiquated systems, and their com-

puter systems have not kept up with the changes. Whereas some States have what are called cascading systems that trickle through the various categories with Medicaid and ensure that benefits are maximized and families have the support.

Chairman JOHNSON. Mr. Pollack?

Mr. POLLACK. I think there are different methods of systems integration that could help this problem.

First, integrating CHIP and Medicaid is very important, having the same application process, shortening the application. In California, there was—Congressman Stark would know—a 28, 29 page application. It has been shortened to two pages.

Mr. STARK. But it is twice as complicated in two pages as it was in 28.

Mr. POLLACK. More efficiently complicated in shorter pages. We certainly can do more to tie people into the school feeding programs. A lot of those people are eligible. We certainly can do more on things like presumptive eligibility where programs like WIC and Head Start can certify people on a temporary basis. In short, there are some systems changes that I think can help this problem.

Chairman JOHNSON. Thank you.

Mr. Cardin.

Mr. CARDIN. Thank you, Madam Chair. And I thank you for your testimony, and I appreciate what you are doing.

There seems to be here a major disconnect between good policy and incentives for good policy. If welfare reform is to succeed, it is not just the cash assistance. We need to deal with the earned income tax credit to make work pay, we need to deal with child care so families have safe and affordable places for their children to be, and we also have to have health insurance.

I was struck by the comment you made that people in the welfare departments get recognized for people getting off welfare but they don't for enrolling people in Medicaid. We took some steps in the TANF performance bonus to reward States that have better performance on enrolling families in food stamps and Medicaid, and I think that is the type of initiatives that we are going to need to take a look at. Because, frankly, I served for many years in the State legislature and know the pressure that is on the State Medicaid directors. It is fine for them to say let's correct our computer programs, but if that is going to mean a larger expenditure of State funds, the budget director is going to give them a bit of a fit.

Ms. Mann, I noticed that you had to send a directive out to the States saying, look, if you knock people off inappropriately, you have to put them back on. My question is, why do you knock them off inappropriately? It is one thing to say that families leaving welfare may not understand the rules concerning Medicaid eligibility, but our States should certainly understand the rules, and it should not take 4 years to correct a computer program that is knocking people off of receiving the health care that they deserve and are entitled to.

The point that Mr. Stark made, we require people to enroll and then we not only make it difficult for them to understand it and difficult to enroll but then we knock them off. We take action that prevents them from getting these benefits.

I would hope that we could figure out ways to really incentivize our States to do a much better job, to provide some financial incentives, to provide clear direction that we think children being enrolled in Medicaid is one of our goals or getting children health insurance is one of our goals, and it should not have to be in a waiver program, that we can get a simplified form that families can understand and fill out. There should be other ways to get to simplified approaches for families to understand that they are eligible for the Medicaid Program or the CHIP program. We should be a lot more seamless than we are right now so we get children health insurance so that welfare can succeed, getting families secure in a work environment.

Ms. Mann, I appreciate your comments.

Ms. MANN. I want to make it clear, Congressman, that States do have the flexibility under current law and don't need a waiver to simplify their application process, and many States have done so with children, but not necessarily with families with children, and that's where the welfare link has been the problem. There are a few States, Utah is one, Indiana is one, where the application for families with children has been simplified as well, but it is the exception not the rule.

But the flexibility is provided under Federal law, and States don't need a waiver in order to accomplish that. You are right. That is a critically important part of the challenge ahead.

And the other point is what Ms. Ellwood raised, States that have simplified the application process have not necessarily simplified the redetermination process. It is easier for some kids to get into the program, but then it is difficult to maintain eligibility.

Mr. CARDIN. If they can do it and some States aren't doing it, maybe you need a club rather than an incentive.

Mr. POLLACK. Two points. We talked earlier about the $500 million that was designed to help make the transition, but, unfortunately, a good number of the States have not used this money. And the Chair appropriately said there is a very favorable Federal-State match, 90 to 10, but to date only about 25 percent of those dollars have been spent by the States. A lot of States have not pulled that money down.

Second, I want to get back to a point that Mr. Watkins made earlier. There is a clear relationship between children's coverage and what the parents do. We know there is always a relationship between what happens to kids and what happens to parents.

At some point, we are going to have to take cognizance of the fact that when parents do not get enrolled in these programs because there are very different eligibility standards for those parents it will have some impact on whether the children enroll. If you can put the children in the same program with the same eligibility standards, you have a much better chance of improving our outreach to the children because it means that the parents get enrolled at the same time.

I know that is going to require some legislation or the States are going to have to make use of the current Medicaid matching formula. I think we need to provide some more dollars to the States to give them an incentive to make sure that the parents' eligibility standards match the eligibility standards for children.

Chairman JOHNSON. Thank you.

Mr. McCrery.

Mr. MCCRERY. Mr. Pollack, you mentioned that low-wage employees pay more in premiums for their insurance than high-wage employees. Do you know how our tax system treats low-wage employees vis-a-vis health insurance versus high-wage employees? Do you have any thoughts on that?

Mr. POLLACK. Well, there is no question that our current tax system does provide a greater tax break in terms of the treatment of employer-provided coverage for those at higher income brackets. There is no question that is true. That tax break is a regressive tax break. You are right about that.

But the point I was trying to make there is different. I think all of us expect that low-wage workers pay a higher percentage of their incomes on premiums because the denominator, their incomes, are lower. But, in fact, the numerator is actually higher. That is a rather startling finding.

Mr. MCCRERY. One reason is our convoluted insurance market. Most low-wage employees work for small businesses, and small businesses are in a different insurance market than GM or PGP or IP so they have to pay more for their insurance than those big companies and generally their margins are lower so they can't afford to pay as great a share of the premium as the largest companies. So it is a cascading effect that all falls on the low-wage employee to his detriment.

Mr. POLLACK. Mr. McCrery, you are right about that point.

I want to emphasize that these findings that the low-wage workers pay a higher amount of money on premiums, that is irrespective of whether they are in small employment situations or larger employment situations. If you keep those things constant, you will still find that those companies which essentially hire low-wage workers require those workers to pay more in premiums.

Mr. MCCRERY. That may be as well. But in addition to the tax system disadvantaging low-wage employees whose employers provide them insurance, it certainly disadvantages those whose employers who don't provide them insurance?

Mr. POLLACK. Sure.

Mr. MCCRERY. Because they have to buy their own insurance on the individual market. Not only do they pay higher premiums, they get no tax deduction and no exclusion from wages for purchasing that insurance, so they are really disadvantaged.

I say all of this to not take away from the focus of this hearing, because I think it is important to try to understand what is happening with respect to Medicaid and welfare reform, but I come from a State, Louisiana, who has for decades provided free health care, Charity Hospital in Louisiana, and anybody who wants health care can get it if they can get to Charity Hospital. We also have a fairly high Medicaid enrollment in Louisiana. We have done a pretty good job in getting people enrolled in Medicaid and keeping them enrolled, but a lot of our health indicators are down at the bottom.

I think the answer is not, generally speaking, to get more people into Medicaid, more people into a government health care program.

The answer is to raise the income level of people to get people out of poverty, which we are succeeding in doing.

I have the statistics that I asked about from the Census Bureau. The poverty rate among children has come down every year for the past 5 years. For the last year we have available is 1997—I am sorry, 1998, and 18.9 percent of children were in poverty, and that is too many, but it is the first year since 1980, since 1980, 20 years ago, that the poverty rate for children has been significantly below 20 percent. We are making progress. We are doing the right things I think to extricate folks from the bad health environment.

I believe that we ought to focus on getting people real insurance, private insurance; and to do that we ought to reexamine our tax system and the way we treat poor people in this country through the tax system and low-income workers particularly through the tax system. Reallocate what we are already spending through the tax system to help people who need help to get private insurance. I think people with private insurance are more likely to get preventive care and go to the doctor than they are if they are on a government program or if they have just available a free clinic or a Charity Hospital like we do in Louisiana.

Mr. POLLACK. Mr. McCrery, your comment about using the tax system for the population at large, I think can be an interesting discussion. For the lower income population, however, I don't think that the tax system is the most efficient way of expanding coverage. It may be at some point on the income scale—I don't know what that arbitrary figure is. At some arbitrary figure we may want to encourage people to obtain employer-based coverage through changes in the tax code. But to lower income people, many of whom don't pay taxes, it makes little sense.

Mr. MCCRERY. Let me interject, because we have to go vote. You misunderstood. I don't mean to use the tax system, I mean to recoup the money from folks like you and me and give it to low-income workers to get them insurance.

Mr. WATKINS. [Presiding.] Let me say I am chairing this because Ms. Johnson is voting. Mr. Stark.

Mr. STARK. I want to thank the panel for their contribution, particularly Families USA and the Kaiser Family Foundation, Mathematica and for the work that they do in trying to keep us informed.

I must say, Ms. Mann, that health and human services continues to—somebody over there must have that stamp with happy face, happy face. How anybody can call the fact that we still have 10 million kids uninsured encouraging? There has to be another word. Encouraging ought to be stricken from the bureaucratic vocabulary over there, because it is not encouraging at all. You may have to support a bankrupt welfare reform bill, but it really falls—it becomes almost ludicrous to have Health and Human Services come back here time after time and never once—never once in this administration since 1992 have they ever come back and said things are not so good.

I hate to tell you, except for the stock market, things are getting worse and particularly for children, and your department won't admit it or won't see it.

Now how the hell we are supposed to solve a problem if the administration department that is charged with overseeing it can't see the problem and figures that they can make the problem go away by just saying it is OK through, first of all, almost childish research? I have talked to a dozen families around the country. That is not research. And to come and tell us, because the Medicaid enrollment has dropped by 1.3 percent, we have encouraging results makes our job difficult.

We are just not getting—we get it from nongovernmental organizations, a much better look at what is going on; and it is disappointing that the executive branch of the government comes back and paints over, glosses over the problems. We are never going to solve them, and I hope that you can take this back right on up to Secretary Shalala. To put a happy face on the almost obscene treatment and condition of children which is getting worse through a program that our administration supported is difficult. I would like to think that we could admit at some point that we may have made some mistakes and set about correcting them, but if we cannot see the mistakes, we are never going to do it.

Mr. WATKINS. I have just one comment. We have a short-term goal, short term because of welfare reform, but in the long term we should be trying to get the income level up in this country and the insured and get them off. That is the thing. We don't want to get a welfare health system established.

I think there is a short-term and a long-term phase of this whole program. I hope we are in a short-term and long-term phase, and they are two different types of objectives.

I guess at this time you are dismissed, and we will take the second panel. Chairwoman Johnson is going to be back in a moment; and, if not, I am going to miss the vote.

I want to take the prerogative as the Chair to start from my left to your right. Ms. Mitchell, being from my home State, I want to make sure that I get back in time for her testimony and all of the good things that are happening in Oklahoma, but some things that I want to visit about.

So, Mr. Winstead, would you like to start?

First, I may need to recess until she gets back. Why don't we recess. She is on her way back, and I will go vote, and I will be back.

[recess.]

Chairman JOHNSON. [presiding.] Mr. Cardin will be here shortly, because of the constraints of the day. Let us begin.

The second panel is Dr. Vernon Smith, who is the Principal of Health Management Associates from Lansing, Michigan; Don Winstead, Welfare Reform Administrator, Florida Department of Children and Families; Kathleen Gifford, Assistant Secretary, Indiana Office of Medicaid Policy and Planning; and Lynn Mitchell, Oklahoma State Medicaid Director.

I appreciate your being here. It is impossible to evaluate the problems with Federal policy without hearing from the people like you that are out there trying to make the programs work. So, Dr. Smith, if you will begin.

STATEMENT OF VERNON K. SMITH, PH.D., PRINCIPAL, HEALTH MANAGEMENT ASSOCIATES, LANSING, MICHIGAN

Mr. SMITH. Thank you, Madam Chair.

My name is Vernon Smith. I am a former Michigan Medicaid Director and a Principal of Health Management Associates in Michigan. I want to make a couple of key points.

First, welfare reform was the most significant challenge that human services administrators have had to face since the beginning of Medicaid in 1965. Medicaid eligibility had always been a derivative of welfare eligibility. That changed. States had to create new systems for Medicaid eligibility separate from welfare. That was much more difficult than anyone imagined.

And as welfare reform was successful, the job of keeping eligible persons on Medicaid became more difficult. Medicaid had to overcome the misperceptions that the tough new welfare reform policies applied to Medicaid also, that Medicaid had work requirements or that Medicaid had time limits.

A year and a half ago, my colleagues at Health Management Associates and I conducted focus groups with human service administrators and Medicaid eligibility specialists around the country. These experts told us that they were very much aware of the problems. They had thought through the challenge, and they were very committed to trying to make things work better. They detailed to us that they already had under way changes in policy, simplifications, streamlining of procedures, systems, forms. They were initiating outreach often for the first time ever for Medicaid to find and enroll persons eligible for Medicaid, and they were seeking to change the image of Medicaid to reduce the stigma that had come from Medicaid's association with welfare over the years.

They wanted to give Medicaid a chance to support their efforts to get people to go to work and keep a job. These changes all take time and have taken a good deal of time.

Our most recent study published last month shows that these efforts are beginning to make a difference. We looked at Medicaid enrollment in 21 States over the 2 years from June 1997 to June 1999. In the first year, the year that ended in June 1998, enrollment declined in 18 of the 21 States we looked at. These 21 States included the 12 largest States plus 9 others to give some geographic balance. The three States that really stood out—and if you were to look at figure 4 attached to the testimony—these three States that really stood out were Arkansas, Massachusetts and Oklahoma. Each of these States was well ahead of its peers with major initiatives to expand eligibility and to streamline their eligibility processes.

In the second year of the study that ended last June, enrollment decreased in just eight of the 21 States in our study and increased in 13. Barbara Lyons mentioned that the study showed increases in 12. After the study was complete, New Jersey submitted data that showed that they had a small increase rather than a small decrease. The six States with the largest annual increases included the three that had increases in the prior year—that is to say Arkansas, Massachusetts and Oklahoma—plus the States of Florida, Indiana, and New Mexico. Again, these three States are among the leaders in adopting specific and comprehensive initiatives to ex-

pand eligibility, changing their procedures, making them simpler and initiating comprehensive outreach strategies.

In the process of adjusting to the delinking of Medicaid from welfare, Medicaid has become a very different program than it was before. Significantly, over the past 2 years, for the first time in its history, the data show that Medicaid has become a program in which over half of its beneficiaries are not on welfare.

So, to summarize, welfare reform has had a huge impact on Medicaid. However unintended, it has been very significant. Second, States are implementing many strategies to address the challenges and to improve the chances that those who are eligible for Medicaid will remain enrolled or become enrolled. Third, the success of these strategies is just becoming apparent in the program statistics. And, fourth, what is emerging in some States is a more streamlined mainstream health coverage program, shedding its image as just the health program for people who are on welfare.

These results are encouraging, particularly in States that were early adopters of these strategies, such as the three States represented on this panel.

Thank you.

[The prepared statement follows:]

Statement of Vernon K. Smith, Ph.D., Principal, Health Management Associates, Lansing, Michigan

Chairman Johnson and Members of the Committee:

I am Vernon K. Smith. I appear before you today as a researcher and consultant with Health Management Associates. Over the past two years I have examined current trends in the number of persons enrolled in Medicaid and in the State Child Health Insurance Programs (S-CHIP programs), and the factors influencing the trends. My perspective is that of an economist and former Michigan Medicaid director, whose 30-year career as a public official in Michigan State government focused on health care and Medicaid. I am pleased to be here today to discuss with you important issues relating to welfare reform and its impact on Medicaid, and especially its impact on the number of children and families for whom Medicaid provides health coverage.

My remarks are based primarily on research conducted over the past two years that is described in three published reports,[1] as well as ongoing research that will update those reports.

In enacting the historic welfare reform law four years ago (Personal Responsibility and Work Opportunity Reconciliation Act of 1996, P.L. 104–193) Congress specifically tried to protect eligibility for Medicaid. Medicaid and welfare eligibility were "de-linked." The expectation was that eligibility for Medicaid health coverage would continue for many adults who worked their way off welfare (through the "Transitional Medical Assistance" or TMA) and for most of the children (through poverty level categories of coverage for children).

However, when the national data for 1996 were released at the end of 1997, the data showed a drop in the number of persons enrolled with Medicaid. This was the first drop in Medicaid enrollment in over a decade. The drop was particularly surprising in the context of the welfare reform guarantees for Medicaid eligibility, and even more so in light of the very large increases in enrollment that immediately preceded it. The annual rates of increase in Medicaid enrollment were 11.3% from 1990 to 1992, and 5.2% from 1992 to 1995.[2] Over the seven years from 1988 to 1995, the number of persons on Medicaid increased by about 50% from about 28 million to almost 42 million.

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[1] See the following reports supported and published by the Kaiser Commission on Medicaid and the Uninsured: *The Dynamics of Current Medicaid Enrollment Changes*, October 1998 (Publication #2111); *Enrollment Increases in State CHIP Programs*: *December 1998 to June 1999*, July 30, 1999 (Publication #2153); *Medicaid Enrollment in 21 States June 1997 to June 1999*, April 2000.

[2] Brian Bruen and John Holohan, *Slow Growth in Medicaid Spending Continues in 1997*, Kaiser Commission on Medicaid and the Uninsured, November 1998.

It is a significant public policy issue as to why Medicaid enrollment dropped, and whether the sustained drop from 1996 to 1998 reflected a loss of Medicaid coverage for children and families who in fact were eligible to continue their coverage.

In 1998 HMA conducted focus groups of human service administrators and Medicaid eligibility specialists to learn what these experts believed to be occurring and why. The participants spoke from their personal experience and observations of what was happening in their states as welfare reform was being implemented. The descriptions led to the following conclusions:

FOCUS GROUP CONCLUSIONS ABOUT THE IMPACT OF WELFARE REFORM ON MEDICAID

1. In perception, Medicaid remained "linked" to welfare.

Recipients and applicants believed (incorrectly) that the new tougher welfare reform policies applied to Medicaid. The association with welfare led persons to believe Medicaid also was "temporary assistance," with time limits and work requirements. The stigma of welfare remained attached to Medicaid.

2. Work programs kept persons away from both welfare and Medicaid.

"Work First," "diversion" and other jobs programs channeled some welfare applicants away from applying for Medicaid, even though they may have been eligible for Medicaid. The focus on jobs, which was a major culture shift for welfare agencies, spilled over to Medicaid. Medicaid was not the priority.

3.Complex systems changes were needed to delink Medicaid from welfare.

When adults "worked their way off welfare," administrative procedures were not in place to continue Medicaid coverage for eligible adults and children. Recipients usually did not know to ask about continuing Medicaid.

4. Major changes created confusion.

New welfare rules created confusion for both recipients and eligibility workers. It took time to implement and understand new policies that separated Medicaid eligibility from TANF eligibility. During this transition, a significant number of working poor families believed they were not eligible for Medicaid when they actually were eligible.

Human service administrators and Medicaid eligibility specialists told us that, in mid–1998, they were aware that their systems were not doing a good job of making sure that eligible persons were able to maintain Medicaid coverage. They were quick to describe efforts already underway to fix the problems and make the systems work better. The focus group participants described several key strategies, including:

- Changing the name of the program to distance it from the stigma of welfare.
- Creating procedures to notify all persons leaving welfare that they or their children may be eligible to continue Medicaid coverage, and explaining how to apply.
- Developing specific information and outreach strategies to market the program as health coverage.
- Training workers on the new procedures, including emphasis on how health coverage supports the success of work programs. Our most recent study suggests that in several states such changes in policies and procedures are being implemented successfully. Together with expansions in eligibility levels, these initiatives are having a significant impact. The result is that Medicaid enrollment now appears to be increasing in many states, even as the number of persons on welfare continues to drop.

Our most recent study is based on analysis of Medicaid enrollment trends over the two-year period from June 1997 to June 1999. We looked at data for a total of 21 states, including the 12 states with the largest Medicaid enrollments. Medicaid enrollment in these 21 states represented 73% of the total for the U.S. in 1997.[3]

Over the two years for these 21 states, overall Medicaid enrollment combined dropped from 23.2 million in June 1997 to 22.9 million in June 1999, a decrease of 1.3%. In the first of these two years, enrollment dropped by 2.7%.

There are wide variations in specific state experiences over this two-year period. It is hard to draw a direct link, but the evidence seems to suggest that states with a priority on outreach, information, streamlining, training and eligibility expansions have been more successful in enrolling eligible children and families in Medicaid.

Key findings from this study include the following:

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[3]The 21 states included: AR, CA, FL, GA, IL, IN, IA, KS, MA, MI, NJ, NM, NY, NC, OH, OK, PA, TN, TX, UT, WI.

1. Enrollment Changes over the Year from June 1997 to June 1999

Medicaid enrollment dropped in 18 of the 21 states in this study, over the one-year period ending in June 1998. Only three of these 21 states had Medicaid enrollment increases over this year. These three states were Arkansas, Massachusetts and Oklahoma. These three states were among the first to initiate policies to find and enroll persons who were eligible but not enrolled in Medicaid, and to implement eligibility expansions designed to cover low income uninsured children and families.

Arkansas: Medicaid enrollment increased by 19% in the year ending June 1998 (and by 29% over the two study years). Arkansas implemented its ARKids First program to cover children to 200% of the poverty level, and also added coverage under a family planning waiver for women who had Medicaid coverage based on their pregnancy.

Massachusetts: Medicaid enrollment increased by 23% in the year ending June 1998 (and by 32% over the two study years). A significant part of the increase was in families, children and pregnant women. These groups increased by 33% in the 1997–98 period and by 48% over the two year 1997–99 period. Massachusetts expanded eligibility for working adults and children under a Section 1115 waiver under its MassHealth program.

Oklahoma: Medicaid enrollment increased by 10% in the year ending June 1998 (and by 26% over the two study years). The increase was primarily in families, children and pregnant women categories, which increased 16% in the 1997–98 period and by 41% over the two-year 1997–99 period. Oklahoma expanded eligibility for families and children and implemented a major outreach initiative to find and enroll eligible children.

2. Enrollment Changes in the Year from June 1998 to June 1999

Over the 21 study states, Medicaid enrollment increased from 22.6 million to 22.9 million, an increase of 1.4%, in the year ending in June 1999. Among the 21 study states over the year ending in June 1999, enrollment increased in 13 states, and continued to decrease in only eight states.[4]

Over the year ending in June 1999, significant enrollment increases occurred in states that implemented significant initiatives to improve coverage, streamline systems and find eligible adults and children. In addition to Arkansas, Massachusetts and Oklahoma, states with significant annual enrollment increases in the year ending June 1999 included the following:

Florida: Medicaid enrollment increased by 7%. The number of families, children and pregnant women on Medicaid increased by 11%. Florida streamlined and simplified its application process, and increased its focus on Transitional Medical Assistance for those leaving TANF.

Indiana: Medicaid enrollment increased by 23%, including an increase in families, children and pregnant women categories of 32%. Indiana implemented a comprehensive plan that included a new name for Medicaid (Hoosier Healthwise), expanded eligibility for families, streamlined enrollment, a major training and outreach campaign and hundreds of new sites for application for coverage.

New Mexico: Medicaid enrollment increased by 13%, including a 31% increase in the number in the category for children and pregnant women. New Mexico initiated a major comprehensive outreach campaign for "New MexiKids," the state CHIP program, with streamlined procedures for Medicaid and CHIP enrollment.

3. The Impact of Medicaid CHIP Expansions on Overall Medicaid Enrollment

A key question is the extent to which children who leave welfare are then enrolled in State CHIP programs. To the extent children are in Medicaid-expansion CHIP programs (who are also in Medicaid enrollment counts) then State CHIP programs account for part of the increase in Medicaid enrollment in the year ending June 1999. To assess the extent to which Medicaid expansion State CHIP program enrollment contributed to the increase in overall Medicaid enrollment, data for State CHIP programs were obtained for the six month period from December 1998 to June 1999, and compared to Medicaid enrollment over the same six-month period. Of the 21 states in this study, 15 states had Medicaid expansion CHIP programs. Increases in enrollment in these Medicaid expansion State CHIP programs directly accounted for 28% of the increase in Medicaid overall enrollment in the 21 study states over this six-month period.

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[4] Enrollment decreased in these eight states: IA, MI, NY, OH, PA, TX, UT, WI. Enrollment increased in these 13 states: AR, CA, FL, GA, IL, IN, KS, MA, NJ, NM, NC, OK, TN. Note that the report shows NJ as a state with a decrease in enrollment. Updated data provided by NJ after the report was prepared shows enrollment increased in NJ in the period from June 1998 to June 1999.

Anecdotal information from state CHIP programs indicates that State CHIP programs also have an indirect impact on Medicaid, in that a significant percentage of persons who apply for State CHIP programs are found eligible for Medicaid. To the extent that application procedures are coordinated and streamlined by states, such applicants may be easily enrolled in Medicaid.

CONCLUSION

Welfare reform created significant problems of coordination between the eligibility systems for welfare and Medicaid. Human service administrators and eligibility specialists have been aware of these problems, and in many states initiated major efforts to address them.

These efforts have been aimed at improving the image of Medicaid, streamlining application and enrollment procedures, expanding eligibility levels to extend coverage to children and families and targeting outreach toward persons eligible but not enrolled in Medicaid.

The states that have placed a priority on such efforts have been successful in enrolling eligible children and families in Medicaid. The result in 1999 was a reversal of the three-year decline in Medicaid enrollment in many states.

The major policy, program and system changes that reformed welfare fundamentally changed the relationship between welfare and Medicaid. The success of "delinking" welfare and Medicaid is being seen now in states that have stand-alone, streamlined and mainstreamed Medicaid-based health coverage programs. These Medicaid programs are less burdened by the stigma still attached to welfare-based programs, while providing "health insurance" coverage that supports the success of jobs-focused programs of temporary assistance for needy families.

The good news is that many states have taken action and as a result children and families who are eligible for Medicaid for their health coverage are now more likely to be enrolled.

Figure 1

Study Approach

Timely collection and aggregation of data on Medicaid enrollment directly from 21 individual states for five monthly periods between June 1997 and June 1999.

- Enrollment comparisons are point-in-time changes from one month to another, rather than the unduplicated yearly enrollment numbers reported nationally by HCFA and others.
- Total enrollment numbers include children enrolled in regular Medicaid (Title XIX) as well as those enrolled in Medicaid as part of a CHIP-expansion.
- Because of differences in the way states report their enrollment, it was not possible to aggregate across all study states for each major Medicaid eligibility group.

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Figure 2

21 States Included in Pilot Study

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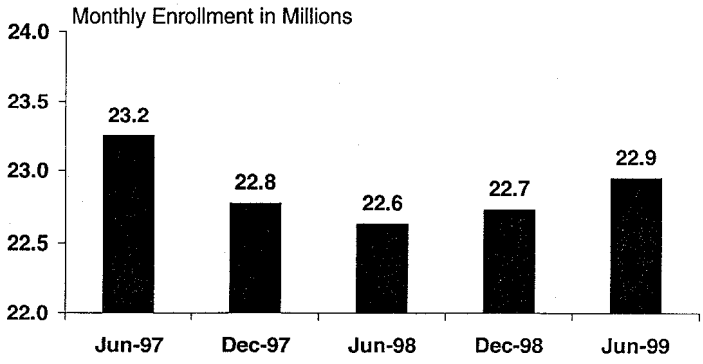
Figure 3

Total Medicaid Enrollment in 21 States



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

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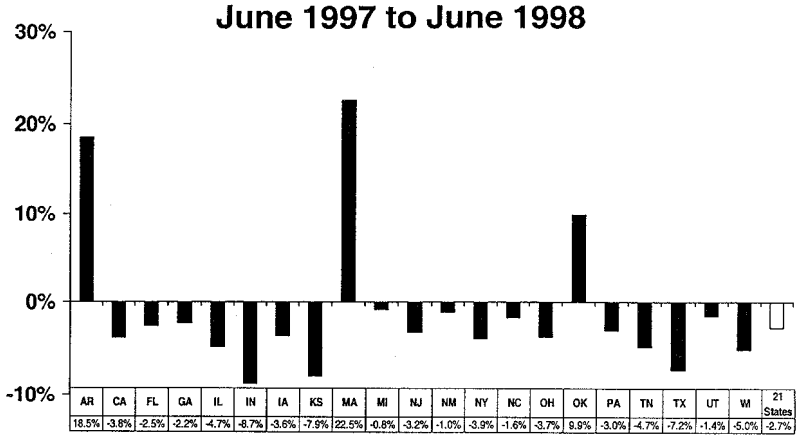
Figure 4

Total Medicaid Enrollment in 21 States: Percentage Change June 1997 to June 1998



SOURCE: Compiled by Health Management Associates from state Medicaid enrollment reports.

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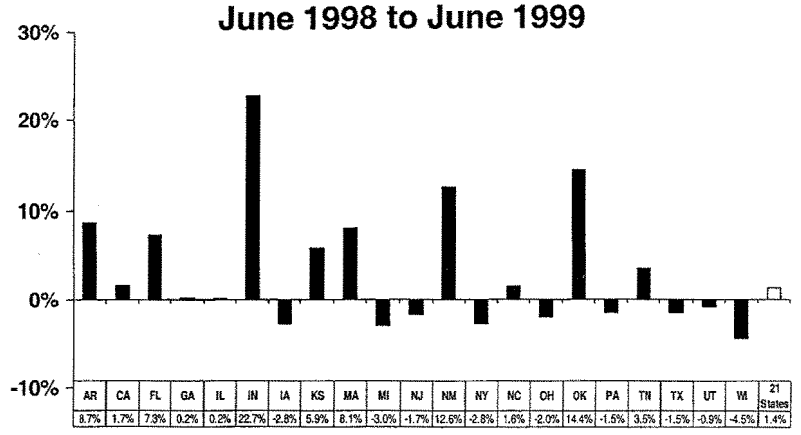
Figure 5

Total Medicaid Enrollment in 21 States: Percentage Change June 1998 to June 1999



SOURCE: Compiled by Health Management Associates from state Medicaid enrollment reports.

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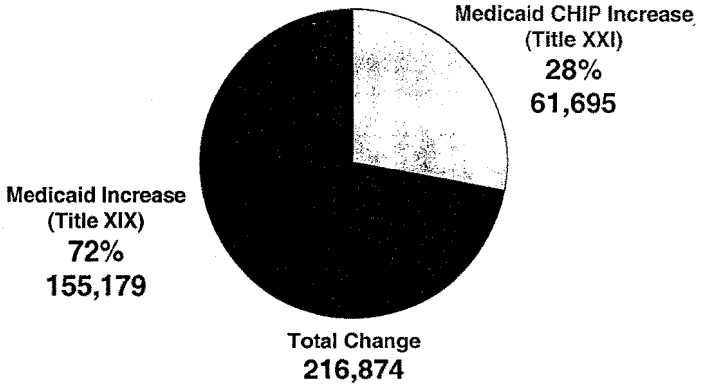
Figure 6

Net Increase in Medicaid Enrollment in 21 States December 1998 to June 1999



NOTE: Does not include enrollment in separate State CHIP programs.
SOURCE: Compiled by Health Management Associates from state Medicaid enrollment reports.

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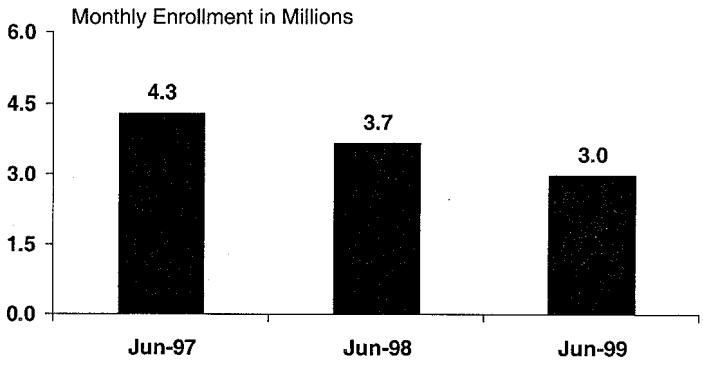
Figure 7

Medicaid Enrollees Receiving TANF Payments in 10 States



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

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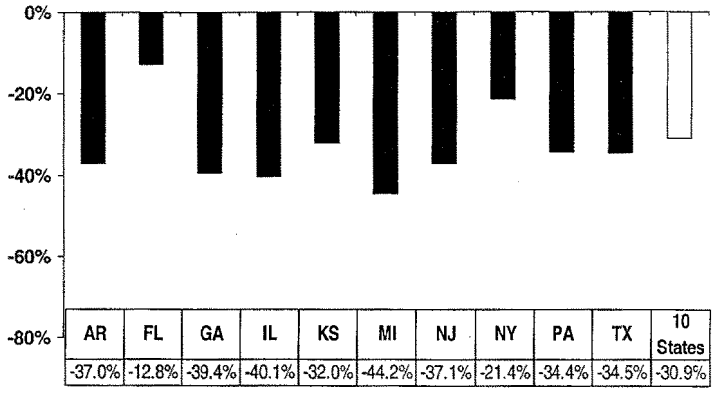
Figure 8

Medicaid Enrollees Receiving TANF Payments in in 10 States: Percentage Change June 1997 to June 1999



AR	FL	GA	IL	KS	MI	NJ	NY	PA	TX	10 States
-37.0%	-12.8%	-39.4%	-40.1%	-32.0%	-44.2%	-37.1%	-21.4%	-34.4%	-34.5%	-30.9%

SOURCE: Compiled by Health Management Associates from state Medicaid enrollment reports.

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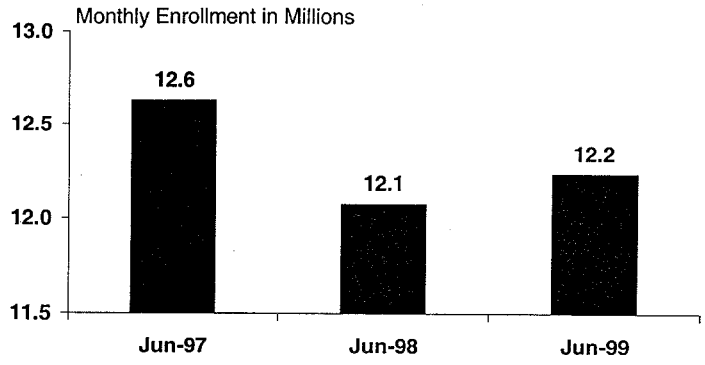
Figure 9

Families, Children & Pregnant Women: Medicaid Enrollment in 14 States



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

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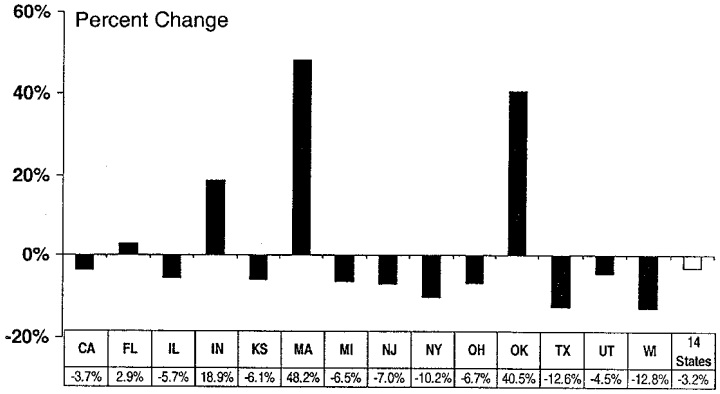
Figure 10

Families, Children, and Pregnant Women Enrolled in Medicaid in 14 States June 1997 to June 1999



CA	FL	IL	IN	KS	MA	MI	NJ	NY	OH	OK	TX	UT	WI	14 States
-3.7%	2.9%	-5.7%	18.9%	-6.1%	48.2%	-6.5%	-7.0%	-10.2%	-6.7%	40.5%	-12.6%	-4.5%	-12.8%	-3.2%

SOURCE: Compiled by Health Management Associates from state Medicaid enrollment reports.

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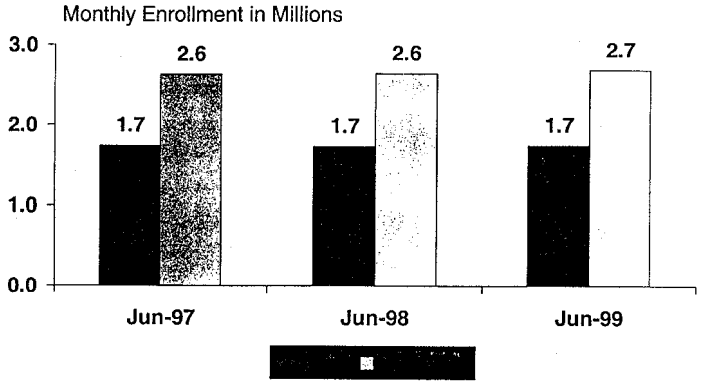
Medicaid and the Uninsured

Figure 11

Aged and Disabled Medicaid Enrollment in 9 States



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

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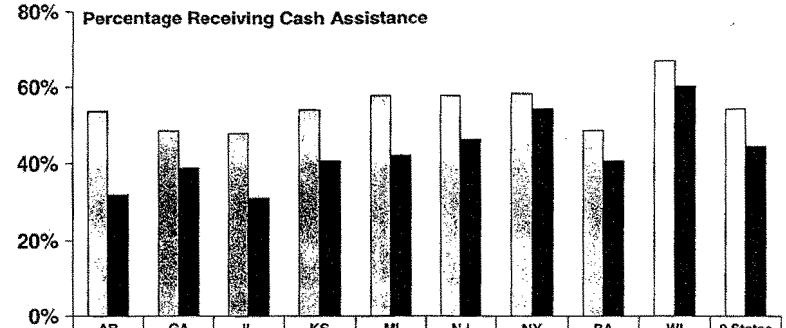
Figure 12

Medicaid Enrollee Composition in 9 States
Change from June 1997 to June 1999



	AR	GA	IL	KS	MI	NJ	NY	PA	WI	9 States
□ Jun-97	53.7%	48.4%	47.7%	53.9%	57.5%	57.5%	58.0%	48.4%	66.8%	54.2%
■ Jun-99	32.0%	38.8%	31.0%	40.8%	42.1%	46.1%	54.2%	40.7%	60.2%	44.3%

SOURCE: Compiled by Health Management Associates from state Medicaid enrollment reports.
NOTE: "Cash Assistance" includes those receiving both TANF and SSI.

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Figure 13

Conclusions and Future Challenges

This study has provided a snapshot of Medicaid enrollment in 21 states, identifying a recent reversal in 12 states of the Medicaid decline that began in 1995. Continuing challenges include:

- **Improving our understanding of the factors contributing to enrollment changes;**
- **Continuing the transition of Medicaid from a welfare-based program to a "health insurance" program;**
- **Developing strategies to obtain timely, reliable data to document changes in Medicaid enrollment at the national and state level;**
- **Rethinking data collection efforts in the context of current Medicaid policy and program operation needs.**

KAISER COMMISSION ON
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Chairman JOHNSON. Mr. Winstead.

STATEMENT OF DON WINSTEAD, WELFARE REFORM ADMINISTRATOR, FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES

Mr. WINSTEAD. Thank you, Madam Chair and Members of the Subcommittee. I appreciate the opportunity to provide you with information about Florida's welfare reform activities and issues related to health coverage for families leaving welfare. My name is Don Winstead, and I am the Welfare Reform Administrator with the Florida Department of Children and Families.

I would like to summarize the key points in my written testimony and expand on information that was presented at your field hearing on welfare reform in January in Riviera Beach, Florida.

First of all, I would like to mention some brief background information about our program in Florida to set the context for what we are finding with Medicaid coverage for children. Second, I would like to share with you information about what we are seeing in enrollment trends. Third, I would like to give you some information about some specific strategies we are using to try to increase enrollment; and, finally, share some recent actions that were adopted in the Florida legislature in the 2000 session that just completed on May 5.

If I can refer to the chart—and I believe there are copies of these charts in your folders—first of all, if we look overall at the decrease, if you look at the eight States in the country that collectively comprise about 60 percent of the Nation's caseload, Florida has had the largest caseload decrease. Our decrease has been 68 percent through the latest period reported, June, 1999; and I have attached material to my written testimony that shows that decrease has continued. When we focus on the families that are subject to the time limits and work requirements, the decrease is even greater.

Another indication of the transformation that we have seen in Florida is how we are using money, and I will just mention very briefly—it is a little hard to see on here, but you see this line here, in Federal fiscal year 1994, we were spending about 80 percent of our total expenditures in this area on welfare payments. Now that has dropped dramatically, and the thing that we are spending the bulk of our money on are things that support work—child care, case management, support services. We are investing in supporting work rather than merely paying for welfare payments, which is a significant transformation for our State.

I would like to focus on what we have seen in terms of the trends for children in our State, and this chart shows two trend lines. One is children receiving cash assistance, and that is this line. As you can see from when we implemented our welfare reform program, the number of children receiving cash assistance has declined from 376,000 down to 124,000, a significant decrease that mirrors the overall decrease that we have seen.

On Medicaid we did see a decrease from 1996 to 1998. It then bottomed out, and we have seen an increase since then so that today there are more children in Florida eligible for Medicaid than when we implemented our welfare reform program in the fall of 1996, in spite of the fact that we have led the country among large States in cash assistance caseload decrease.

I have also included some information about adults, and the adult story is a bit more complex because of all of the different coverage groups. But we are seeing with adults, as the cash assistance adults have declined dramatically, we have seen some decline in our transitional benefit and TANF-related enrollment of adults. But that decline has slowed, and I think it indicates to us that we are doing a more effective job of sharing information about transitional benefits although the pathways, if you will, for adults, there are fewer in our program than there are for children.

I would like to mention now two specific strategies that we have used relative to enrolling children. First is to try to do a better job of sharing information about transitional benefits. I believe in your folder is a copy of a brochure—and we actually use two brochures. One is called, Leaving Welfare for Work Isn't as Scary as It Seems. In that, prominent in what we try to share with people, is information about health coverage and the importance of that. We also share information about food stamps and the earned income tax credit, about other benefits for families that don't require you to be on welfare. Because we clearly want to underscore that you don't have to be on welfare in order to receive other benefits.

We have another version of the brochure that is designed for low-income families who are not recipients entitled, Have You Heard About Benefits for Working Families, again to make that same point.

The other strategy that I think has been an important part of what we have done is the simplified eligibility for children's health. This covers our Medicaid Program and our SCHIP. You can see it is a one-page, front-and-back form.

And it is significant that it comes with an envelope, and the significance of that is that you do not have to come to our office in order to become eligible or have eligibility for your children determined. You mail it in. There is a brochure that you can keep that explains the program. This is mailed in, and the entire process is done through the mail so that the person doesn't have to enter the office. This gives the family the choice. They can come to the office and be served at an outposted location or handle the transaction through the mail to get health coverage for children.

My final two points in terms of additional strategies, number one, the legislature just authorized, effective July 1, presumptive eligibility for children, so we will be implementing that Federal option. Second, we expanded eligibility for infants from 185 percent of the Federal poverty level to 200 percent of poverty in our Medicaid Program. So we believe that will also give us an additional tool.

I will be glad to answer any questions at the appropriate time.

[The prepared statement follows:]

Statement of Don Winstead, Welfare Reform Administrator, Florida Department of Children and Families

Madam Chairman and Members of the subcommittee, I appreciate the opportunity to provide you with information about Florida's welfare reform activities and issues related to health coverage for families leaving welfare. My name is Don Winstead and I am the Welfare Reform Administrator with the Florida Department of Children and Families.

In my testimony this morning, I would like to expand on information I presented at your field hearing on welfare reform on January 24, 2000 in Riviera Beach, Flor-

ida. In that testimony, I provided information regarding trends in the number of children receiving cash assistance in Florida compared with the number of children eligible for Medicaid. Today, I will provide some additional detail on those trends. I will also summarize some of the strategies that we think have been important in increasing Medicaid enrollment of children and provide information about further efforts we are planning, based on state law changes in the recently completed session of the Florida Legislature.

I would like to begin with some background on Florida's welfare reform implementation to put my comments on health coverage within the broader context of our program.

Background:

Florida implemented the Temporary Assistance for Needy Families Block Grant Program (TANF) in October 1996. Our program is called Work and Gain Economic-Self Sufficiency or "WAGES." Like many states, we have seen a significant decline in our cash assistance caseload. If you look at the eight largest states that collectively comprise about 60 percent of the nation's caseload, Florida's caseload decline has been the highest among these large states. From the latest information posted on the Administration for Children and Families web site, our decline from August 1996 through December 1999 was 68%. This decline includes both families who are subject to time limits and the work requirement and also the children in so-called "child-only" families, who are not subject to time limits.

When we take the "child-only" cases out of the calculation and focus on the families with an adult subject to the work activity requirements and the time limit, our overall caseload decline through March 2000 has been 79%. I have attached a caseload summary sheet showing some of the relevant data.

As our cash assistance caseload has continued to decline, we have experienced a significant shift in the emphasis of our program. Increasingly, we have focused more on the importance of transitional benefits and supports to families who have moved from welfare to work. To illustrate the scope of this change, I will refer to an attached chart showing a comparison between our FFY 1994 expenditures on the AFDC/ JOBS program and the budget for the comparable programs in the current state fiscal year. As you can see, in FFY 1994, about 80 percent of the federal and state funds we spent were on welfare payments. Today, welfare payments represent a much smaller proportion of our program budget and much more of our budget goes to activities that support work, such as child care and work activity supports. I should emphasize that the child care funds shown do not include the child care and development fund. I only included child care funds transferred from TANF or paid directly out of TANF.

As this background information suggests, our program has undergone a significant transformation since you passed the Personal Responsibility and Work Opportunity Reconciliation Act in 1996. As we focus on helping families move successfully from welfare to work, an important part of this transition relates to health coverage, particularly Medicaid.

Medicaid Coverage for Children

There have been a number of national reports and news stories indicating that the decline in welfare caseloads has been accompanied by a decline in Medicaid enrollment of children. This has been an issue of concern in our state and there are a couple of points that I think are important to understand. Many of the national articles I have seen rely on data through 1997 or 1998. In Florida, we saw a decline in Medicaid enrollment after we implemented welfare reform, although the decline was not as great as the decline in cash assistance. However, since 1998 we have seen a change in this trend. Attached is a chart comparing trends in children receiving cash assistance with trends in children eligible for Medicaid. As you can see, the decline in Medicaid is less than the decline in cash assistance, but the number of eligible children did decline from 1996 to 1998. Since 1998, the decline in cash assistance has continued, but the the trend has been reversed in Medicaid and the number of children eligible for Medicaid has increased.

As a technical note, in April 1999 we had a change in the age categories within which the Medicaid agency in Florida reports their enrollment data. The caseload data prior to April 1999 reflects children 0 to 17 while the reports since April 1999 aggregate children age 0 to 18. I've estimated the number of 18 year-olds in months from April 1999 forward to show the most comparable data. Either way, the number has been increasing in Medicaid.

In Florida, there are more children eligible for Medicaid today than when we implemented welfare reform.

I have also attached information related to Medicaid enrollment of adults. Because adult enrollment includes a much broader group of people than our welfare reform program, I have also shown the number of adults receiving cash assistance compared with two categories of adults eligible for Medicaid. One category shows adults enrolled in AFDC/TANF and unemployed-parent Medicaid coverage groups and the other shows total Medicaid enrollment of non-elderly adults. We believe the decline in the TANF coverage group by only 4% in the past year while adults on cash assistance have declined 28% in the same time period, indicates that we are making significant progress in the area of transitional Medicaid.

Strategies for Medicaid Enrollment

I would like to highlight two specific strategies related to providing Medicaid coverage for eligible children and families.

One critical issue for families leaving welfare is to make sure they are informed about their potential eligibility for transitional benefits. This issue is not new with passage of the TANF legislation. Florida began expansion of Medicaid eligibility to non-welfare recipients in the mid 1980's and there has been substantial further expansion of coverage groups through both state and federal legislation since then. Transitional Medicaid and transitional child care were first authorized under the Family Support Act of 1988.

In spite of these expansions, the task of educating people that Medicaid eligibility is not tied to cash assistance is an ongoing challenge. We have worked with the Southern Institute on Children and Families to develop brochures make information on transitional benefits more accessible to families. Several other states, particularly North Carolina and Georgia were instrumental in the development of this material and we learned from their experience in adapting the content to Florida.

We continue to work to refine our notices and other marketing material to better inform families about benefits.

A second effort that has been critical to our enrollment of children in Medicaid has been the development of a simplified application process for our State Children's Health Insurance Program, Florida Kidcare.

Our simplified application form is used for enrolling children in Medicaid and for those who are not Medicaid eligible, the same form is used to enroll children under our Title XXI program. You will note that the application is one page and comes with an envelope. The envelope is important to our strategy to increase access to health coverage. Through the simplified application, families in Florida can apply for and have their children approved for Medicaid or other Kidcare coverage groups without the need to ever visit our eligibility office. The entire process can be done through the mail. If a family wants to come to one of our service centers and apply for Medicaid either by itself or in conjunction with an application for cash assistance or Food Stamps, they can do so. The choice of how to apply is up to the family.

The simplified application forms are widely available through child care centers, schools, community based organizations, county health clinics, hospitals, etc. The form is also available through the internet at floridakidcare.org.

Every mail-in application is screened for potential Medicaid eligibility. We believe this process has been an important part of increasing Medicaid enrollment for children and also in encouraging people to think of Medicaid as health insurance coverage rather than welfare.

Future Initiatives

Prior to concluding, I would like to mention several additional strategies for increasing health coverage for children as a result of recent legislation. The 2000 session of the Florida Legislature ended on May 5, 2000. They passed new Kidcare legislation and provided significant new state funding for expansion of health coverage for uninsured children. Medicaid eligibility for infants was expanded from 185% of the federal poverty level to 200% of the poverty level. The legislature also authorized the implementation of presumptive eligibility for children under the state option that was part of the Balanced Budget Act. We believe presumptive eligibility for children will provide us with an important tool to further expand access to health coverage.

In addition, major legislation was enacted to take the next step in welfare reform by merging the governance and operation of our workforce system and our TANF-funded work activities. A new public-private entity, Workforce Florida, Inc. will have jurisdiction over the Workforce Investment Act Programs, the Welfare to Work grant, TANF-related work activities and a number of other federal and state training and economic development programs. We believe this evolution in our implementation of workforce programs will enhance our ability to provide support for the remaining families who are receiving cash assistance and provide support for low

income working families who have already left welfare or who have not received welfare in the past.

We believe that efforts to strengthen working families and reduce the likelihood that they will need welfare in the future is one of the keys to further success in implementing welfare reform. I would be glad to answer any questions you might have.

[Attachment are being retained in the Committee files.]

Chairman JOHNSON. Ms. Gifford.

STATEMENT OF KATHLEEN GIFFORD, ASSISTANT SECRETARY, OFFICE OF MEDICAID POLICY AND PLANNING, INDIANA FAMILY AND SOCIAL SERVICES ADMINISTRATION

Ms. GIFFORD. Thank you, Madam Chair and Members of the Committee, for inviting me here to share Indiana's experience.

Indiana has achieved success in both welfare reform and access to health care. Since welfare reform began in Indiana, TANF caseloads have declined by almost 60 percent. In 1999, Indiana was cited first in the Nation in TANF job placements, but as we implemented welfare reform we saw declines in enrollments of families in Medicaid. We have dramatically reversed that downward trend.

As part of our effort to implement CHIP, Indiana launched a comprehensive outreach campaign. Enrollment of children in Hoosier Healthwise, which is Indiana's Medicaid and CHIP program for low-income families and children, has increased by almost 60 percent since the outreach campaign began in July, 1998, from 210,000 children to over 330,000 children. Over 100,000 of those children who were newly enrolled were without health insurance prior to joining Hoosier Healthwise, more than our original target of 91,000 derived from census data. Enrollments within the low-income families category of Medicaid also increased by over 40 percent during this same time period, with the rate of increase for parents actually exceeding the rate of increase for children in that category.

At the Indiana Family and Social Services Administration we attribute these enrollment successes primarily to three things: the commitment of our Governor Frank O'Bannon; second, to the teamwork within our very large agency; and, third, because we established strong and clear policies at the central office level that were then implemented locally through locally determined plans.

One key to a successful outreach effort is to make it a priority at the very highest level. Governor O'Bannon charged our agency with the responsibility of finding and enrolling every eligible child into Hoosier Healthwise. Even after we began to see Medicaid budget concerns on the horizon last December, due in part to the unexpected strong enrollments, the Governor stated that we should shout from the rooftops and that the strong enrollments were good news despite the budget implications. Governor O'Bannon continues to promote the enrollment of all eligible children in Hoosier Healthwise.

Clear policies were established at the central office level to destigmatize the Medicaid Program and simplify the enrollment process. We changed our marketing techniques to reposition Hoosier Healthwise as a health care program rather than a welfare

program. We developed a snazzier card. We advertised. We simplified the enrollment form. We eliminated unnecessary verification requirements, and we established a mail-in application unit.

Also, although Indiana's CHIP program combines a Medicaid expansion with a State-designed non-Medicaid Program, both parts are fully coordinated and virtually seamless to the consumer. Both are marketed as Hoosier Healthwise. Medicaid eligible children are enrolled in package A, and CHIP non-Medicaid eligible members are enrolled in package C. We believe that this design has greatly assisted us in our efforts to destigmatize Medicaid and simplify the enrollment process.

Our local implementation strategies included establishing over 500 community enrollment centers. Our county directors also collaborated with local partners to develop outreach plans specifically tailored to their communities.

Other significant community partners that collaborated with us at both the State and local levels included the Wishard Hispanic Health Project, the Indiana Minority Health Coalition and the Indiana Primary Health Care Association.

Finally, I would like to take this opportunity to bring an important Indiana concern to your attention. Indiana is one of only a few States that is likely to expend its entire 1998 CHIP allocation before it expires. Despite our enrollment successes and the fact that the census data obviously underestimated the number of uninsured children, we have now learned that our 2000 CHIP allocation will decline by 10 percent. We were also disturbed to hear that the Senate appropriations Committee voted last week to redirect almost $2 billion of unspent CHIP allocations for other purposes.

In light of the decrease in our 2000 CHIP allotment we are very hopeful that any unspent CHIP allocations can be used as they were originally intended, for reallocations to States like Indiana. We have enrolled many more children than we originally projected based on the census data. A decrease in funding at this time could be detrimental to our efforts.

That concludes my testimony. Thank you.

Chairman JOHNSON. Thank you very much.

[The prepared statement follows:]

Statement of Kathleen Gifford, Assistant Secretary, Office of Medicaid Policy and Planning, Indiana Family and Social Services Administration

Madame Chairman and Members of the Subcommittee:

Thank you for inviting me to speak to you today about the importance of health insurance in the post-welfare reform environment. The coordinated efforts of Congress, the Executive Branch and the states have brought critical attention and resources to the issue of ensuring the good health of our children and your efforts are greatly appreciated.

Indiana has achieved strong early successes in both welfare reform and access to health care. Former Governor and current Senator Evan Bayh initiated Indiana's welfare reforms during the summer of 1995 with a series of Aid to Families with Dependent Children (AFDC) waivers very similar to the federal legislation that followed in 1996. Governor Frank O'Bannon has continued this welfare reform effort and has seen the State of Indiana cited as first in the nation in Temporary Assistance for Needy Families (TANF) job placements and sixth in success in the workforce, the highest overall rating of any state. Indiana's success in welfare reform also has led to significant caseload declines, almost 60% since 1994. However, these caseload declines were accompanied by smaller declines in enrollment of families in Medicaid and Food Stamps. At O'Bannon's direction, the State of Indiana has dramatically reversed the downward trend in Medicaid enrollment and has begun an

effort to increase access and education regarding Food Stamps. In fact, Indiana was recently highlighted in a report of *Medicaid Enrollment in 21 States*, released by the Kaiser Commission on Medicaid and the Uninsured, as the state with the highest enrollment increases since 1998.[1] These enrollment increases were a result of the Governor's commitment to families and children; teamwork within the Indiana Family and Social Services Administration at the state and local levels; a strong central policy with local implementation; and Indiana's commitment to family-friendly services, prevention and, if necessary, early intervention.

MEDICAID OUTREACH IN INDIANAS6602

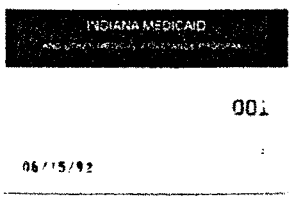
In the post welfare reform era, it became apparent that to encourage Medicaid enrollment the perception of the program would have to change from welfare to health care. Accessibility of enrollment sites and complexity of application procedures were also a concern. For these reasons, Indiana felt it was vitally important to develop and implement outreach as a key focal point in increasing Medicaid enrollments.

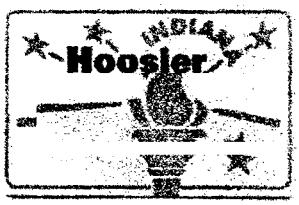
Governor Frank O'Bannon and the state legislature first expanded Medicaid eligibility to Indiana children in the summer of 1997. Later that year, Congress passed the Balanced Budget Act of 1997 and brought the nation's attention to the troubling issue of uninsured children among the poor and working poor in the U.S. In July of 1998, Indiana expanded Medicaid eligibility for a second time and was able to use the Children's Health Insurance Program (CHIP) funding for both expansions of eligibility. At the same time, O'Bannon issued a statewide directive that 91,000 uninsured children would be targeted in an aggressive outreach campaign over the next 18 months. The campaign encompassed three major components: de-stigmatize Medicaid and CHIP services; reach out to local communities to find all uninsured children who are eligible for Medicaid and CHIP; and simplify enrollment processes.

De-stigmatization of Medicaid

The de-stigmatization of Medicaid and CHIP was a priority for the State. Medicaid was to be converted from a "welfare program" to a program of health care coverage for persons in need of help in obtaining such coverage. In short, Medicaid was made to look as much like private coverage as possible. Several strategies addressed this priority:

- Medicaid and CHIP became known to the public as "Hoosier Healthwise," the name formerly used only for the Medicaid managed care program;
- Hoosier Healthwise was advertised with a friendly mascot, Dr. Whoosier, an owl that would appear in parades, on frisbees and sipper cups and in public appearances with Governor O'Bannon; and
- The customer's Medicaid card became a Hoosier Health Card, similar to that used by health plans across the state.





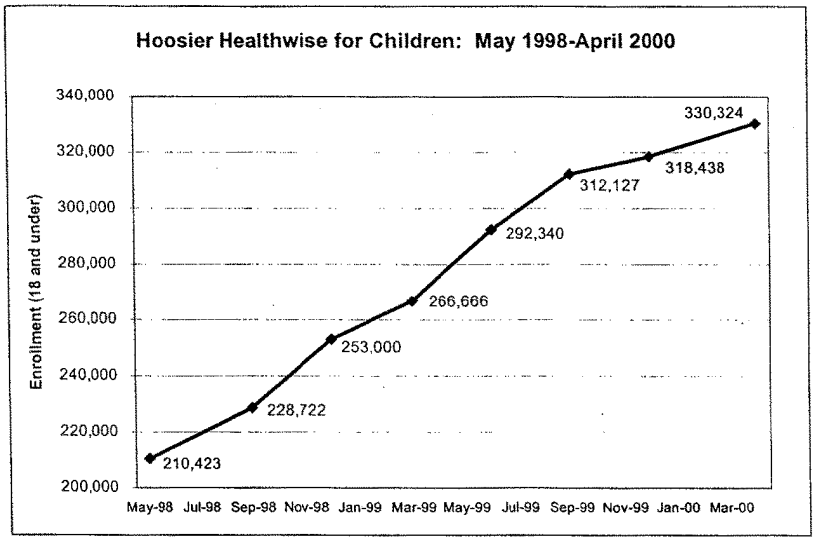
Outreach at the Local Level

Another vital element of increased enrollment is outreach into local communities. A key element to this outreach was extending outreach beyond state facilities and staff. Prior to 1998, a family had to visit a Local Office of Family and Children to apply for Hoosier Healthwise. An active effort was initiated to identify and recruit alternative locations for enrollment. Soon after the outreach campaign began, this effort had resulted in over 500 community enrollment centers that volunteered to accept Hoosier Healthwise applications across the state, including hospitals, health clinics, child care centers and social service providers. At the same time, new mail-in applications were available to families through a widely advertised toll-free number.

[1] Medicaid Enrollment in 21 States, The Kaiser Commission on Medicaid and the Uninsured, April 2000.

The Hoosier Healthwise enrollment process was significantly simplified to assist families, further de-stigmatize services, and encourage participation of local enrollment sites. A fairly complex automated eligibility process conducted in a Local Office of Family and Children became a single, double-sided sheet for children and pregnant women that could be completed in an enrollment center or mailed into the DFC. Income verifications were simplified and self-declaration was used more frequently. Although enrollment has been simplified and enrollment centers are handling part of the application process, the integrity of eligibility determination has been important to the State. The DFC received HCFA approval to evaluate the quality of the enrollment center application process to further improvement in this area.

The outreach effort also included specific strategies to increase enrollment among ethnic minorities. The DFC contracted with three statewide organizations—the Wishard Hispanic Health Project, Indiana Black Expo and Indiana Minority Health Coalition. Posters, brochures and applications were translated into Spanish to address the needs of the largest non-English speaking population in the state. Additionally, the Indiana Primary Healthcare Association participated in monthly meetings with the other statewide organizations to ensure services in the community were coordinated among all the partners. Outreach funds were provided directly to the 92 counties' Local Offices of Family and Children to implement the Governor's enrollment directive in a way that addressed the unique needs and interests of each local community. Communities used remarkable creativity in spreading the word about Hoosier Healthwise enrollment: appearing in parades, visiting local schools and health providers, and sponsoring special events. This local direction and coordination was vital to the State's success.



Results

The outreach campaign was, and continues to be, extremely successful. Indiana's enrollment of children in Hoosier Healthwise has increased by almost 60% since the outreach began in July of 1998, from 210,000 to over 330,000. Over 100,000 additional children without insurance were enrolled in Hoosier Healthwise, which eclipsed Governor O'Bannon's target of 91,000.

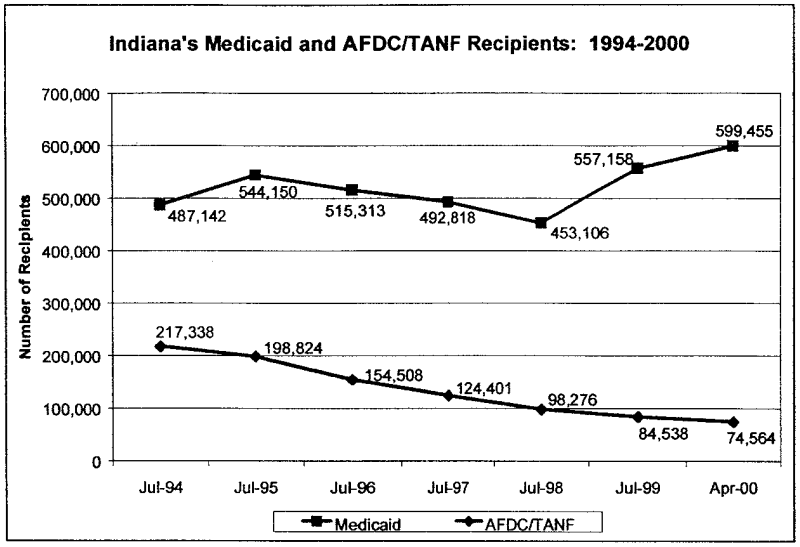
Data Concerns I would like to express Indiana's concerns with the data and methodologies used to measure the uninsured population and allocate federal resources to serve the uninsured. The increase in enrollment of over 100,000 uninsured children during the first eighteen months exceeded Governor O'Bannon's original expectations. This was due in part to the lack of precision of the Current Population Survey (CPS) data that provide the only state-level estimates of uninsured children by poverty level. The CPS data indicated a 35% drop in the number of children under 200% of poverty between the 1995 and 1998 three-year averages for the State of Indiana. This trend seems too extreme to reflect reality in any meaningful way, especially when compared to other economic indicators.

The Census Bureau's most recent estimate of uninsured children under 200% of poverty for Indiana is 123,000. However, the Census Bureau's large margin of error acknowledges the fact that their point estimates are questionable. Congress has appropriated more funds to enlarge the survey. Still, these point estimates currently are being used to determine the CHIP allotments for states. These seemingly inaccurate estimates compounded with the precipitous decline in the number of children under 200% of poverty in Indiana's CPS data have resulted in a projected 10% decrease in CHIP funding for the State in 2000. Since Indiana is enrolling many more children than the CPS data projected, a decrease in funding at this time could be quite detrimental to efforts to improve working families access to health care. Because of the current inaccuracy of the CPS data at the state level, we have commissioned a survey of 10,000 families in Indiana to generate our estimates. Preliminary results from the survey will be available in June 2000. We would appreciate any flexibility Congress could build into the allocation formula to adjust for situations such as these.

In addition, Indiana is one of only 13 states that have or are expected to have expended its 1998 CHIP allotment. There is debate regarding the prospect of re-allocating the unused funds. States with successful enrollment initiatives should not be penalized by delaying re-allocations until other states exhaust their allotments. The funds should be used by the states that are providing health coverage to children now to promote further expansions in enrollment across the country. The combined effect of inaccurate CPS figures and declining funds at just the time Indiana needs them would be hugely detrimental to Hoosier Healthwise.

ENROLLMENT OF LOW-INCOME FAMILIES

Between 1995 and 1998, Indiana observed declines in low-income families' enrollment in Medicaid, as did the nation. The steps we have taken to de-stigmatize the program, reach out to local communities and simplify enrollment also have had a dramatic effect on the enrollment of low-income families. In fact, the Low-Income Families (1931) category of Medicaid has increased by over 40% since May of 1998, when outreach began. And the rate of increase for parents actually exceeded the rate of increase for children in that category. Enrollment in Transitional Medicaid has quadrupled since the outreach began. It is apparent that fewer families were being served by Medicaid before 1998, perhaps due to complexity or stigma; however, family coverage has increased dramatically since steps to de-stigmatize the program and reach out to communities were taken. Most observers in Indiana feel that these de-stigmatization and outreach efforts were effective with parents who voluntarily withdrew from Medicaid when they left TANF, possibly because it was seen as another type of "welfare."



In 1998, the State also made many administrative changes to support the de-linking of Medicaid eligibility from TANF. Changes were made to the automated system to ensure that no family closed a Medicaid case without being informed that they remained eligible. Extensive training was conducted with local staff to ensure that families were told about the availability and importance of Transitional Medicaid Assistance and Hoosier Healthwise for Children. These efforts complemented the general outreach efforts that impacted children and families across the state.

Indiana shares the concern of the Health Care Financing Authority (HCFA) that families who are eligible for coverage must continue to receive it. And the State looks forward to receiving the results of the technical assistance visits conducted by HCFA last fall. However, the guidance that was issued in April does not take into account any specific state's circumstances or progress since the de-linking of Medicaid and TANF. States have not yet been informed of specific deficiencies found in the site visits. FSSA supports corrective action where necessary to remedy any inappropriate loss of Medicaid coverage; however, we believer that a "one-size-fits-all" reinstatement approach could cause confusion and extreme administrative burdens.

CURRENT INITIATIVES AND NEXT STEPS

As an increasing number of families enter the workplace, the role of supportive services including access to quality health care has become even more crucial. In addition to health care, Indiana has focused on a variety of supportive services for working families. As stated earlier, Indiana is committed to increasing the level of access and education regarding the availability of Food Stamps to low-income families; however, simplifying enrollment processes for Food Stamps may be more challenging due to the strong focus on eliminating any potential eligibility and payment errors.

Much of the innovation in supportive services for families is made possible by the flexibility of TANF block grant funds that support many services for working families up to 250% of poverty. Funds available for child care vouchers have increased from $17 million in 1992 to over $200 million in 2000. Governor O'Bannon's commitment to early childhood has allowed for increased funding for early intervention and prevention services for children at risk of developmental disabilities, abuse or neglect. Indiana has focused on the importance of non-custodial parents in children's lives with increased child support collections and Access and Visitation services that promote the emotional bond between non-custodial parents and their children. Also, through the Fathers and Families Initiative, Indiana continues to encourage and support locally driven fatherhood programs throughout the state through the provision of grants and technical assistance.

Indiana is committed to vigorous evaluation of welfare reform's effects on families and children. As part of the State Level Project on Child Outcomes funded by HHS in five states, Indiana is currently surveying Indiana's children in families affected by welfare reform to determine its effects. Past findings of Indiana's experimental welfare reform evaluation found that former clients were working at much higher levels; however, they were having trouble retaining employment and increasing the family's net income. As a result, the State implemented an Earned Income Credit for low-income working families, enhanced job retention services, and soon will implement an income disregard for TANF families in poverty.

The vast majority of these family services have been expanded through the use of TANF federal and Maintenance of Effort funds and have allowed the State of Indiana to provide a comprehensive set of supports for working families seeking economic self-sufficiency. As one of seven states selected by the National Governors' Association for their State Policy Academy, "Expanding Opportunities for Low-Income Families to Advance in the New Economy," Indiana is committed to a comprehensive approach to enhance the lives of Hoosier families. Indiana's success in promoting access to health care will be used as a model for improving access to all of the critical supports available to working families.

Indiana is investigating options for the possible expansion health coverage to the parents of children eligible for Hoosier Healthwise. A committee of stakeholders (businesses, labor and health care providers) has been appointed to look into a wide variety of approaches.

We, in Indiana, are proud of our successful efforts to provide coverage to children and working families. We greatly appreciate the support provided to us in these efforts by Congress and the Department of Health and Human Services and look forward to working with you to assure the best in health care for every American. Thank you again for this opportunity to speak with you today.

Chairman JOHNSON. Dr. Mitchell.

STATEMENT OF LYNN MITCHELL, M.D., M.P.H., MEDICAID DIRECTOR, OKLAHOMA HEALTH CARE AUTHORITY

Dr. MITCHELL. It is my privilege to be here today. My name is Lynn Mitchell. I am the Medicaid Director of the Oklahoma Health Care Authority, the designated State Medicaid agency in Oklahoma. My testimony today reflects Oklahoma's experience and views.

The Oklahoma Medicaid Program serves over 400,000 recipients, approximately 12 percent of the State's population, including 260,000 children and 150,000 adults. The current annual budget is $1.7 billion. Since the Authority's creation in 1994, we have focused our efforts on achieving efficiencies through care and benefit management and on improving health care quality, access to care, and availability and use of preventive services. By State legislative action effective December, 1997, Oklahoma extended eligibility to children and pregnant women with family income up to 185 percent of the Federal poverty level.

We also initiated an aggressive and highly successful outreach program. The State was aided financially in its efforts to extend benefits to uninsured children by your enactment of Title XXI, the SCHIP program, for which we are very grateful.

From July, 1997, through March this year, Oklahoma's total Medicaid enrollment grew from 282,000 to 404,000 individuals, a 43-percent increase. During this same time period as TANF rolls steadily declined, the Medicaid enrollment for low-income children grew from 176,000 to 296,000 people, a 68-percent increase.

I am here to talk briefly about how we increased access and reduced barriers to quality Medicaid health care for low-income families, especially those families who are moving forward from welfare or cash assistance programs.

In addition to expanding the income eligibility standards, Oklahoma made significant changes in the requirements and in the manner in which eligibility determinations are made, changes that are supportive of working families. The agency reduced the Medicaid eligibility application from 17 pages to 2 pages. The face-to-face interview and the asset test were eliminated. The automatic case determination at 6 months was changed to a 6-month redetermination process. Income declaration was instituted rather than income verification and documentation. Medicaid applications were made accessible through Department of Human Services county offices, county health departments, WIC offices, public libraries, school systems, day-care facilities and through the mail by calling a toll-free number.

Perhaps most importantly, the agency had to overcome the negative stigmatism of Medicaid, welfare, and cash assistance. The program was designed to emphasize personal responsibility and destigmatize the negative stereotypes of government assistance. This resulted in the creation of the managed health care insurance program called SoonerCare.

An integral part of the agency's success and the aspect of our program we are very proud is of Oklahoma's outreach initiative. We recognized the need to develop a comprehensive outreach campaign to spread the word of available health care to eligible individuals. The task was enormous, too enormous for one State agency to undertake alone. Therefore, the Oklahoma Health Care Authority developed a strong partnership with other closely related State and Federal agencies.

Our partners included the Oklahoma Department of Human Services, the Oklahoma State Department of Health, the Oklahoma Commission on Children and Youth, the Oklahoma State Department of Agriculture, the Oklahoma State Department of Education, and the Social Security Administration. The objective was to effectively communicate the newly expanded health care service to eligible populations and to reduce the number of uninsured children in Oklahoma through establishing mechanisms of health care delivery.

We also focused on enhancing and supporting local and community-based outreach initiatives. Increased access to primary health care services that would result in a healthier Oklahoma population was the common goal.

The Department of Human Services created county-by-county outreach plans developed by specialized DHS outreach workers. These approaches included increased office hours, attendance at special events, public school coordination through the free and reduced lunch program and day-care coordination. The Oklahoma State Department of Health reached individuals through the WIC, Immunization and SoonerStart Early Intervention programs.

Additional outreach partnerships included collaboration with the Head Start program, the Oklahoma Institute for Child Advocacy in the implementation of The Oklahoma Covering Kids Initiative and through the Oklahoma Commission on Children and Youth in two rural pilot communities to demonstrate grassroots outreach strategies.

On behalf of the State of Oklahoma, we are very proud of the efficiency and effectiveness of our Medicaid Program. It is very humbling that we are becoming recognized as a State that is moving in a positive direction. We are appreciative of the Federal support to provide and improve health care coverage to Oklahoma's working families.

Thank you for your time and this opportunity.

[The prapered statement follows:]

Statement of Lynn Mitchell, M.D., M.P.H., Medicaid Director, Oklahoma Health Care Authority

Madam Chairman, committee members, it is my privilege to be here today. My name is Dr. Lynn Mitchell. I am the Medicaid Director of the Oklahoma Health Care Authority, the designated state Medicaid agency in Oklahoma. It is my privilege to also serve on the Executive Committee of the National Association of State Medicaid Directors. My testimony today reflects Oklahoma experiences and views. I am proud to say we are among the leading states setting the standard for state Medicaid programs that provide health insurance coverage to low-income, working families.

The Oklahoma Medicaid program serves over 400,000 recipients (approximately 12% of the State's population), including 260,000 children and 150,000 adults. The current annual budget is $1.7 billion. Since the Authority's creation in 1994, we have focused our efforts on achieving efficiencies through care and benefit manage-

ment and on improving health care quality, access to care, and availability and use of preventive services. By state legislative action effective December 1997, Oklahoma extended eligibility to children and pregnant women with family income up to 185% of the Federal Poverty Level. We also initiated an aggressive and highly successful outreach program. The State was aided financially in its efforts to extend benefits to uninsured children by your enactment of Title XXI, the State Children's Health Insurance Program, for which we are very grateful.

From July 1997 through March this year, Oklahoma's total Medicaid enrollment grew from 282,000 to 404,000 individuals, a 43 percent increase. During this same time period as TANF rolls steadily declined, the Medicaid enrollment for low-income children grew from 176,000 to 296,000 people, a 68 percent increase.

I am here to talk briefly about how we increased access and reduced barriers to quality Medicaid health care for low-income families especially those families who are moving forward from welfare or cash assistance programs. In addition to expanding the income eligibility standards, Oklahoma made significant changes in the requirements and in the manner in which eligibility determinations are made that are supportive of working families. The agency reduced the Medicaid eligibility application from 17 pages to 2 pages (one-page front and back). The application process time was reduced from 45 days to 20 days. The face-to-face interview and the asset test were eliminated. The automatic case termination at six months was changed to a six-month re-determination process. Income declaration was instituted rather than income verification and documentation. Medicaid applications were made accessible through Department of Human Services (DHS) county offices, county health departments, WIC offices, public libraries, school systems, day care facilities and through the mail by calling a toll-free telephone number.

Perhaps most importantly, the agency had to overcome the negative stigmatism of Medicaid, welfare and cash assistance participants and programs. The program was designed to emphasize personal responsibility and de-stigmatize the negative stereotypes of government assistance. This resulted in the creation of the managed health care insurance program called SoonerCare.

An integral part of the agency's success and the aspect of our program we are very proud of is Oklahoma's outreach initiative. To begin, Oklahoma had a large uninsured population. We recognized the need to develop a comprehensive outreach campaign to spread the word of available health care to eligible individuals. The task was enormous, too enormous for one state agency to undertake alone. Therefore, the Oklahoma Health Care Authority developed a strong partnership with other closely related state agencies. Each agency committed resources and programs to the outreach effort. Responsibilities were outlined through a series of outreach task force meetings. Prior experiences with outreach were shared in order to focus on the most effective communication mechanisms.

Our state agency partners included the Oklahoma Department of Human Services, the Oklahoma State Department of Health, the Oklahoma Commission on Children and Youth, the Oklahoma State Department of Agriculture and the Oklahoma State Department of Education. The objective was to effectively communicate the newly expanded health care service to eligible populations and to reduce the number of uninsured children in Oklahoma through established mechanisms of health care delivery. We also focused on enhancing and supporting local, community based outreach initiatives. Increased access to primary health care services that would result in a healthier Oklahoma population was the common goal.

The Department of Human Services created county-by-county outreach plans developed by 47 specialized DHS outreach workers. They included innovative approaches to meet the community needs. These approaches included increased office hours, attendance at special events, community development and awareness including speaking engagements, public school coordination through the free and reduced lunch program and day care coordination. The Oklahoma State Department of Health reached individuals through the WIC, Immunization and SoonerStart Early Intervention programs. Additional outreach partnerships included collaboration with the Head Start program, the Oklahoma Institute for Child Advocacy in the implementation of "The Oklahoma Covering Kids Initiative" and through the Oklahoma Commission on Children and Youth in two rural pilot communities to demonstrate "grassroots" outreach strategies.

The Oklahoma Health Care Authority has designed, developed and produced fact sheets, flyers, posters, postcards, public service announcements for newspapers, radio and television as well as advertisements in movie theaters.

In addition, we are designated by HCFA as a Pilot Outreach Site for its Native American population. We are also investigating additional outreach mechanisms such as outdoor and mass transit promotions.

The Oklahoma Health Care Authority is also focused on considerations for the long-term Medicaid program to ensure local communities have adequate support and local outreach initiatives are working in concert with each other. This will reduce duplication of effort, maximize lessons learned and develop ongoing dialogue and information sharing. We will continue to seek ways to track and measure our health care program's outreach mechanisms and their effectiveness.

On behalf of the State of Oklahoma, we are very proud of the efficiency and effectiveness of our Medicaid program. In a recent *Kaiser Commission Study on Medicaid and the Uninsured*, Oklahoma was identified as being one of just a few states that have experienced constant, positive enrollment growth during the past two years. It is very humbling that we are becoming nationally recognized as a state that is moving in a positive direction. We are appreciative of the federal and state support to provide and improve health coverage to Oklahoma's working families.

Thank you for this time and opportunity.

Chairman JOHNSON. I thank the panel very much for your testimony. Actually, your success is quite spectacular; and the common elements of focusing on the target population, systemic outreach efforts, collaborations, local folks involved makes a lot of sense.

Also, they are not things that the Federal Government can do. If you don't do it, we cannot do it. I commend you on that.

I am wondering how difficult it has been to create seamlessness between Medicaid and CHIP and how difficult the simplification process has been. I appreciate your bringing the application that Florida uses, Mr. Winstead.

First of all, I am sorry my friend Pete Stark is not here, because it is quite interesting how simple this application is. Actually, it is adults, children, name, address and Social Security number and a little household information on the back. You really have simplified at a level that we in Congress have certainly not been able to do.

It is going to be very hard to integrate these programs, and also the complexity of doing this nationwide is very hard. If you can talk about what are some of the—what were some of the things that were easy about the administrative reforms that other States could do actually quite rapidly and what are the things that are hard and are there any things that we need to change the law, recognizing the shoals that plague that process.

Mr. WINSTEAD. If I may, first of all, I think it was very difficult in a lot of ways to accomplish some of the things that we have. But what we have discovered is some of the programs are Medicaid are mind-numbing in their complexity. Our attitude is that we need to manage the complexity and not delegate it to the families that we serve. We are trying to build processes to try to make some of that complexity invisible to the families. I think that the application that we use for Medicaid and our CHIP program was a big step in that direction.

One of the things that we found and I am sure others have found is that one of the real barriers is the stigma associated with Medicaid and the association that has built up over the years between Medicaid and welfare. That is why we market our program as Florida Kid Care. And Medicaid for children is just one of the components of Florida Kid Care, but other marketing efforts do not use the word Medicaid, and we have tried very much to create the message that this is not welfare, this is health coverage and tried to make that distinction.

I think the other thing that I would just like to mention, because I have not heard any mention of it this morning, which I think is an important part of the discussion, is the Food Stamp Program and where that fits in all of this. Many of the same families that we are trying to reach through our health coverage efforts also may have coverage for food stamps, and the fact that many low-income working families don't have to be eligible for welfare to also receive assistance from the Food Stamp Program is I think an important part of the mix, but also part of the complexity and the problem because under Federal regulations the Food Stamp Program does require office visits, face-to-face contacts with people. So figuring out ways to make that benefit accessible so that people don't have to go through multiple processes is I think an ongoing challenge.

Chairman JOHNSON. I would certainly hope—particularly those States that have succeeded in simplifying the health care application and the operation of that system and better integrating it, and I think it would be very helpful if you would get together and make your recommendations as to how we can simplify and integrate food stamps.

The real issue is the change in guidelines and the tradeoffs involved, and I think the more that comes from the people who are on the frontline, the better that Congress can deal with it. It should not be something that the interest groups that are in this for different reasons primarily drive.

So I think your recommendations in that area if you work together would be a very powerful lever to help us get going in the next session. Everybody knows that needs to be done. Everyone dreads the cutouts. There is also a lot of recognition that we must complete this move from a cash benefit to a work benefit national policy, and that was the goal of food stamps, and we really have to, in a sense, regularize everything and integrate everything. I would urge you to move on. You have done wonderful work in simplifying Medicaid and integrating it with CHIP. Is it fair to say that all of you have succeeded in integrating?

Ms. GIFFORD. I think our program was designed to make it all part of Hoosier Healthwise so that the families would not necessarily know which one they were applying for.

Chairman JOHNSON. Is that true, Dr. Mitchell?

Dr. MITCHELL. SoonerCare is a seamless program where CHIP tied onto our own State eligibility expansion, and they just happen to coincide at almost the same time.

Chairman JOHNSON. Would you put on the record the name of your program and the seamlessness and the income guidelines, how much you have expanded this, so we have that clear information.

Ms. GIFFORD. Hoosier Healthwise, we expanded Medicaid eligibility up to 150 percent of the Federal poverty level across the board for all age categories of children using the CHIP dollars.

Our second expansion, using the CHIP dollars that began a few months ago, goes to 200 percent of the Federal poverty level, again an expansion of Hoosier Healthwise but a non-Medicaid expansion.

Dr. MITCHELL. Our program is called SoonerCare, and our expansion was 285 percent of the Federal poverty level for children through age 17 and pregnant women.

Chairman JOHNSON. Dr. Smith?

Mr. SMITH. Well, it is my observation, looking around the country, since I am no longer running the program, that many States are working very hard to integrate their CHIP programs and their Medicaid Programs.

If you were to look at Badger Care in Wisconsin or look at New Mexico's program or MI Child in Michigan, all of these programs have names which are not Medicaid. They are designed in many cases to make it as seamless as possible so that in many cases, in Indiana or Wisconsin, if a child's eligibility transfers from CHIP to Medicaid, it is transparent to the child. It is an accounting procedure in terms of how the cost of program is charged, but it doesn't affect the health care for the child.

Mr. WINSTEAD. Our program is Florida Kid Care. We cover children up to 200 percent of the poverty level. For infants, Medicaid is up to 200 percent, effective July 1. Then for the younger children, 133 percent is Medicaid, and between 133 and 200 is our Title XXI program. And then for the older children, up to 100 percent is Medicaid, and above 100 percent is our Title XXI program. But all children are covered up to 200 percent of poverty.

Chairman JOHNSON. Thank you.

Mr. Cardin.

Mr. CARDIN. Thank you, Madam Chair.

I would like to thank our witnesses. I am particularly impressed by the brochure from Florida. I think it does really put in terms that people can understand what is available for someone who is leaving welfare and is going to work. Although I might disagree about one aspect. It isn't as scary as it seems. I think it is kind of scary on health coverage today. The children have much better rules than the parent do. Too many adults are not covered by insurance and are not eligible to be covered by insurance, and the transitional Medicaid is complicated, and we certainly have not done a very good job on that.

Then you look at the eligibility, 32 States have eligibility that if the parent is at minimum wage doesn't even qualify for Medicaid which the States could be doing a better job there. The States do have significant surpluses. There is an opportunity to expand, and yet there has been a reluctance by the States to do something to help us I think in welfare reform by making it easier and less scary for people to go to work.

The question I have for you, though, is: We have one welfare director and three people in the Medicaid Program. What is the relationship in the States between the welfare director and the Medicaid director and maybe also the budget director about trying to put together strategies that really require the cooperation of all three of the levels of administration?

If we are going to make welfare reform work, we have to have a close connection with Medicaid. The more you succeed, the larger the Medicaid budget is going to be. Success is measured by greater State expenditure, which doesn't always get the budget director very happy about that policy. I am curious about what is the relationship in your various States.

Ms. GIFFORD. I think you have put your finger on a crucial element of a successful outreach campaign, having that kind of cooperation.

Obviously, we had to work very closely together; and the whole process of designing our CHIP program brought together interagency, interdivisional representatives and people from all around the community. Absolutely, that has been I think very important to our success in Indiana, that cooperation.

We have been confronted in Indiana, because of our success in enrollment, with budget issues. I now have budget issues, and I kind of held my breath a few months ago communicating those issues, wondering what the reaction would be. And I think that is the true measure of how dedicated the policy leaders in Indiana are that they said, OK, we have budget issues but at least it is for a good thing. I continue to have support for expansion as far as enrollment despite my budget issues, but those are very critical issues that many Medicaid directors have to worry about.

Mr. WINSTEAD. In Florida—and I think my colleague from Indiana made an important point earlier about the executive direction and the leadership from the top. And I think in our State Governor Bush has certainly made a priority, health coverage for children. Every Tuesday afternoon the head of our agency, the head of the Medicaid agency and the head of health meet on Health and Human Services issues. We work very closely together, and the budget that was just passed by the legislature that the Governor will sign includes over $80 million appropriated to create over a hundred thousand new slots for additional enrollment of children in health coverage. So it just needs to be a priority, and the folks involved need to work closely together.

Mr. CARDIN. Ms. Gifford, let me at least get a response from you. There is some information here in your State that the individual who was not receiving cash assistance under TANF but was receiving Medicaid, that the clock, 5-year clock was still tolling for that individual even though the person wasn't receiving benefits under the TANF law. Was that ever the case and was it corrected?

Ms. GIFFORD. I am not sure that I can answer that question, but I can provide that information when I get back to Indiana.

[The information follows:]

INDIANA FAMILY AND SOCIAL
SERVICES ADMINISTRATION
INDIANAPOLIS, IN 46707–7083
July 7, 2000

Honorable Benjamin J. Cardin
House Committee on Ways and Means
1106 Longworth House Office Building
Washington, DC 20515

Dear Congressman Cardin:

I am happy to be able to provide a response to the question that you posed during my testimony on May 16, 2000 regarding the application of federal time limit policies in the Temporary Assistance for Needy Families (TANF) Program.

First of all, it is important to explain that Indiana has been operating a welfare reform demonstration project since June 1995. Under the terms and conditions of this demonstration, the state applies a 24-month time limit to a portion of our TANF cash assistance adults. The State's time limit does not apply to children.

Another provision of the State's Demonstration Project allows a family to be considered a cash assistance recipient even though the family's income is greater than

the traditional income limits of the program and would otherwise be ineligible for assistance. The State's traditional program limits eligible for assistance. The State's traditional program limits eligibility to approximately 24% of the Federal Guidelines. The welfare reform provision allows a family to be considered a receipient even though the family does not received a TANF cash assistance provided their income remains below 100% of the Federal Poverty Guidelines. These families are referred to as "zero grant" recipients. The advantage of this provision is to provide their income remains below 100% of the Federal Poverty Guidelines. These families are referred to as "zero grant" recipients. The advantage of this provision is to provide a family additional support once the parent becomes employed making the transition to work less threatening. "Zero grant" families receive the full array of employment support services, categorical eligibility for Medicaid, child support services at no cost and priority for child care support services. Once a family's income exceeds 100% of the Federal Poverty Guidelines as a result of new or increased earnings, that family becomes elgibile for Transitional Medicaid benefits.

The terms and conditions approved by the Administration of Children and Families of the Department of Health and Human Services establish that a month during which a family has status as a zero grant family is a month of assistance for the purposes of the State's 24 month limit. As a component of the State's demonstration, this provision will remain in effect until March 31, 2001 when federal approval for the demonstration expires. Upon expiration fo the demonstration, the State will bring its TANF Program in full compliance with all applicable requirements of the TANF Block Grant.

I appreciate your interest in Indiana's policies and hope that this resolves the questions you have regarding this issue. If you have additional questions regarding Indians' TANF policies, please feel free to contact Char Burkett-Sims, Assistant Deputy Director of the Family Resources Bureau. She can be reached by telephone at 317–232–4903 or at her e-mail address cburkett-sims@fssa.state.in.us

Sincerely,

KATHLEEN GIFFORD,
Assistant Secretary

Mr. CARDIN. I appreciate that.

Dr. Smith, do you want to respond on your State's relationship?

Mr. SMITH. Not speaking for Michigan but looking around the country, what I have seen is that many States have discovered that Medicaid is one of the biggest supporters of welfare reform that there is. If the objective is to get people off of welfare and get them into jobs and have them keep those jobs on a sustained basis, then the health coverage is one of the strongest supports that can be there. And so I think there is increasing interest and in a number of States there is explicit interest in working together so that these two programs work in concert and support each other.

Mr. CARDIN. Dr. Mitchell?

Dr. MITCHELL. In Oklahoma as well we have a very good working relationship with our Department of Human Services who continues to be our eligibility determination agent in Oklahoma and has one particular outreach worker assigned over all of the programs so that we don't let anyone drop through any cracks, and that has been key in maintaining our numbers.

Our Governor has been very supportive of our eligibility expansion that took place in December, 1997. At the current time, however, his focus and the budget office focus has turned to paying for those individuals that we have in place and in the program currently, and the focus that is very much on the forefront right now is paying our providers a more appropriate reimbursement for the services that they are providing to our Medicaid patients.

Chairman JOHNSON. Thank you.

Mr. Watkins.

Mr. WATKINS. Let me say thanks to the panel. I was very impressed also with the Kid Care form. I think it is a very nice brochure. I am always trying to figure out how to raise money in this good job. I hope that you get a good response.

Let me say to the panel I have learned a lot today; and, Dr. Mitchell, it is great having you here. I hope your time allows you to come by my office so we can visit some more.

Let me state here I understand in Oklahoma we have about $110 million of TANF money that we are getting people off of welfare and all. I want to visit with you in more detail about that. Does Oklahoma spend all of its CHIP funds?

Dr. MITCHELL. We have not currently spent all of our CHIP funds, no, sir.

Mr. WATKINS. What percent do you have left?

Dr. MITCHELL. I brought that with me. I will pull it out.

Mr. WATKINS. How have you used those funds?

Dr. MITCHELL. The outreach funds primarily have been used for our outreach workers. There were some systems changes that were implemented. Primarily, we have used those for the outreach workers that have been the key and the integral part to making sure that we keep those rolls up and offer the health insurance benefit to all those that are eligible.

Mr. WATKINS. You have indicated that you have eliminated the asset eligibility.

Dr. MITCHELL. Yes, sir.

Mr. WATKINS. Can you elaborate what you have done on that?

Dr. MITCHELL. Probably somebody who has been in the Medicaid business longer can speak to that, but in the past, where assets played into the determination of eligibility, that has been eliminated. So if someone perhaps was given a piece of land and that in the past might keep someone ineligible for Medicaid because of that asset, that piece is no longer in the determination process.

Mr. WATKINS. You can be land poor, so to speak, with a lot of land, but if you don't have a lot of income, you have eligibility?

Dr. MITCHELL. That is correct.

Mr. WATKINS. I notice that you have your form down to two pages?

Dr. MITCHELL. Yes. We think that has made a substantial difference.

Mr. WATKINS. I wish my friend Pete Stark was here to hear that. I would like him to hear that Oklahoma did. Most of those people in California are from Oklahoma originally from the Dust Bowl days.

Chairman JOHNSON. They lost their common sense, huh?

Mr. WATKINS. That is correct.

Dr. MITCHELL. One was in the Ponca City area, and I believe the other was in the Garfield, I think, area.

Mr. WATKINS. Two of the richest areas of the State.

Dr. MITCHELL. That actually was a competitive bid, and we encouraged communities across the State to apply for that bid. We stayed clear of it, and those were the two counties that were awarded those pilot projects.

Mr. WATKINS. You have two pilots that have been done on a competitive bid?

Dr. MITCHELL. Yes, sir.

Mr. WATKINS. That is interesting. How is that?

Dr. MITCHELL. There were some outreach funds shared with the Oklahoma Commission on Children and Youth who did the administrative function of the pilot project, and through our Office of State Finance those bids were let and awarded to two communities that bid to show that they could be innovative in trying to attract individuals into the Medicaid Program.

Mr. WATKINS. Does it stand to reason if they were two of the wealthiest communities in the State that they could probably bid for it more than the poverty areas?

Dr. MITCHELL. They did not have to put up the funds. The bid process came from using the Federal funds. What they did was have to submit their proposal to be awarded the bid.

Mr. WATKINS. Maybe I am a little slow on this. I want to look into this more.

I feel very strongly about the welfare-to-work program. I think that reform has been working. We have probably 50 percent plus more of our welfare recipients off. That definitely—as we all know, we are trying to prevent them from falling through the cracks on the Medicaid Program and the health effort there—and we should.

I know that you have done a good job. Let me just ask the question here—and, again, I do this from a very sensitive type feeling. I want to get people on. I think it is good that we are having this effort. But do any of you have—on a long-term basis are you coordinating and meeting and working so that they will go off one of these days?

I think it is fine and dandy, but welfare —and welfare has a stigma. It has a stigma such that my mother would not allow us to go welfare. I worked three part-time jobs because she said that is what we are going to do.

Now Medicaid, we want Medicaid. We have to have it, I agree there, but we don't want it to be a way of life. I think just giving them everything does not let them face responsibility or face reality. Do we have anything in the long term? Short term, let's get them on. I hope we have a way to exit this program, helping them on that. Are you meeting with any agency that gets you there?

Mr. WINSTEAD. If I may——

Mr. WATKINS. Are you meeting with an agency? If I can get a yes or no there.

Mr. WINSTEAD. Yes, sir. And if I may say, the key thing that we are trying to accomplish in Florida is get families off of welfare and move to work. You are going to make more money on welfare.

Number two, children that grow up in families that have more money and who have working parents are going to do better than children who grow up on welfare, which is another way of saying long-term, chronic poverty. We have integrated our welfare reform efforts within our overall work force efforts, so within our work force activities we have a whole series of constant interactions with employers, with businesses, with economic development interests in Florida looking at incidence of health coverage, how it is pro-

vided by employers, which I think strategically is where we need to head, is more integration with the work force.

Mr. WATKINS. Ms. Mitchell, what are we doing in Oklahoma in that area?

Dr. MITCHELL. I don't know the answer to that, sir.

Mr. WATKINS. If you don't know the answer, I am worried. Because I think you have to be right in the middle of any strategy or any effort. Maybe that is one thing that we can visit about. I think we are doing wrong if we don't get them on Medicaid when we are getting them off, but I think we are also doing a disservice if we don't exit this program, try to get them gainful employment and work, because that is a way of life. It can become a way of life, and we will try to help move them off that.

I am here and I want to say from my personal standpoint I am thankful to this day for my mother and for her attitude. Because she didn't take the easy way. And I think we have got to say, hey, let's help them, but let's make sure that we provide a way because that is how in life later on they are going to be able to stand on their own two feet. If not, they are going to bring their children into the same situation.

Thank you for the job you do. I appreciate that very, very much; and it is a great track record on helping people get off welfare and get on Medicaid. I know I am very proud of Oklahoma, Dr. Mitchell, and all of you for what you are doing.

Madam Chair, thank you.

Chairman JOHNSON. I thank the panelists for their comments.

Dr. Mitchell, I would just say to my colleague Mr. Watkins' comments about the higher income areas getting the outreach grants, over and over again I am really struck with the problem that the poor rural regions have in competing in education. They don't have the grant writers.

I have one first selectman in my district who has one administrative person. That is her town government. So when I get her more rural road money, everybody rejoices. When they see that the Federal application is a stack like this, she calls me and says, I don't know why you bothered. I have schools in my district that don't have a school lunch program because they can't handle the administrative costs.

It would be interesting to look back and see, was the application from the poor rural counties, was it lesser quality for reasons that they couldn't afford to hire a consultant or they didn't have a grant writer on staff? Because it is a different problem to outreach in a very poor area than it is to outreach to poor people in a higher income region. And Connecticut has a lot of that. It is—because of the general well-being, it is not hard to find the bottom with welfare, it is hard to find the transition. It is not that the other grants are not useful, but I would urge you to just note that.

Mr. WATKINS. Madam Chair, you are right. I think a lot in the lower income they have to use what money they have for the higher percentage of the people so they don't have different things to deal with. I am sitting on this Committee for a reason, and I am sure interested in my area, which has always been noted as the lowest income area in the State, Madam Chair, and the highest rate of welfare and poverty. You well know that.

One of the things that I have dedicated my entire public life is to try to lift these people out of poverty—they are my loved ones, my people throughout the area—and turn some of those counties into economic growth area, and I am proud that we have done some of that. But it has been a passion working on that. We have to make sure that we have a strategy.

I will be happy to work with you. We will do whatever we can to assist, but we have to make sure that we don't overlook these areas until we get that done.

Chairman JOHNSON. And your accomplishments have been spectacular.

We thank the States and Dr. Smith for bringing a broader perspective. We appreciate your help in evaluating this problem and determining what to do. Thank you.

[Whereupon, at 12:35 p.m., the hearing was adjourned.]

[A submission for the record follows:]

Community Legal Services, Inc., Philadelphia, PA

MEDICAID PROTECTIONS FOR FAMILIES LEAVING WELFARE

Much has been written about the problem of losing tens of thousands of families from the Medicaid program when parents move from welfare to work. Here are some legislative suggestions for Congress to address the problem of Medicaid retention. These recommendations grow out of Community Legal Services'[1] considerable experience in addressing this problem, both within the state of Pennsylvania and nationally.

1. Require use of eligibility information given in the Food Stamp program.

Surprisingly large numbers of families participate in the food stamp program but do not receive Medicaid benefits. Given the rigor of establishing food stamp eligibility, states should be required to use existing eligibility information (income, alienage, household composition, etc.) often in the same agency's files to make a Medicaid determination without a new application and face to face interview.

2. Establish presumptive eligibility based on participation in the School Lunch Program or the WIC program.

The Urban Institute has documented that 48.5% of uninsured children are in the School Lunch Program and another 19.0% are in the WIC program. Both these programs are means tested (free school lunch is set at 130% of the federal poverty level, 185% for reduced price lunches; WIC requires participants to be below 185% of FPL). While these maximums do not exactly correspond to Medicaid eligibility levels in most states, most families are not right at the eligibility cutoff level. Legislation could mandate that those in the programs would be automatically eligible for, say 60 days, while a Medicaid application was initiated. Temporary eligibility would be actuated merely by checking a box on the relevant school lunch/WIC form.

3. Require all states to afford families mail or telephone redeterminations.

Now that the Medicaid caseload has so many working families, it is time to afford those families an option that fits with their work schedule. In many communities, people have transportation barriers to overcome or are still reluctant to be seen at welfare offices; eliminating the need to travel to a welfare office will serve to destigmatize the program.

4. Require written withdrawals from Medicaid.

We have seen compelling data that suggests that a great number of Medicaid families lose eligibility based on an oral "withdrawal" of benefits. Many of the oral withdrawals are misunderstandings or worse; it would be a simple protection to require those families who do want to refuse Medicaid to do so in writing.

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[1] Community Legal Services, Inc. of Philadelphia is a non-profit, public interest legal aid firm representing low income people. CLS has given a higher priority to safeguarding and reinstating Medicaid eligibility for Pennsylvania's and the nation's poor. This paper was prepared by Richard P. Weishaupt (215.981.3773) and Jonathan M. Stein (215.981.3742).

5. Coordinate Medicaid with the CHIP program.

Although some level of coordination is now in the CHIP statute, much could be done to bring these two programs closer together. For example, at the time of termination of Medicaid, not only should the statute require consideration of other Medicaid eligibility routes but the statute should require that all terminees be evaluated for the CHIP program prior to termination. (This would involve amending § 1925(a)(3)(C).) Similarly, all rejected Medicaid applicants should be considered for the CHIP program, without further application.

6. Use IEVS to do ex parte redeterminations and verifications.

Current law requires all states to have an Income Eligibility Verification System and to do ex parte redeterminations (where the agency looks to its own data sources to determine alternative Medicaid eligibility). These systems allow states to computer check the accuracy of information provided by applicants and recipients, using benefits data from federal agencies such as SSA, and, more importantly, wage data collected from the state's Unemployment Compensation system. Moreover, HCFA has told states that they must do redeterminations of eligibility without requiring a face to face interview when a family loses Medicaid eligibility under one provision but might qualify under another. (For example, a welfare recipient who gets a job and is no longer eligible for cash assistance will almost always qualify for 6 months of TMA benefits.) However, this HCFA directive is not as helpful as it might be because states insist on wage documentation from busy families. States are reluctant to use the data contained in IEVS because, although reliable, it is usually 3–6 months old.

A simple statutory revision could allow or require states to use this IEVS data rather than insist on paystub documentation, which, in a significant number of cases, is not available.

Use of IEVS data could also obviate the need for quarterly reporting now required under the TMA program authorized under § 1925 of the Act.

7. Mandate computer matches and reinstatement of SSI child disability terminees who have not been afforded the protection of § 4913 of the Balanced Budget Act.

There has been disturbing evidence that states like Georgia, Louisiana and Kentucky failed to implement § 4913 that insured the protecting between 50–100,000 former SSI children onto Medicaid. The problem has been compounded by HHS/HCFA failing to obtain a computer match between SSI terminees and the Medicaid enrolled to monitor national compliance and to order reinstatement of children who were not reinstated. A computer match and reinstatement could be done in 30 days and is essential to insure uniform implementation of this three year old law intended to insure access to health care for children who, although not meeting a more strict SSI standard, still need health care.

8. Extend coverage for those losing eligibility due to child support to make it coterminous to TMA.

Currently families who receive child support that makes them otherwise ineligible for Medicaid, receive an extra four months of coverage. We suggest making this identical with the coverage afforded under § 1925, i.e., 6 months plus an additional 6 months if income is less than 185% of FPL. This will simplify the program, encourage child support and insure more families.