Improving Coverage for Adults Through Medicaid and the State Children's Health Insurance Program

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Prepared by

Cindy Mann
Research Professor
Georgetown University
Institute for Health Care Research and Policy
Washington DC

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Prepared for

Covering Kids & Families
500 Taylor Street
Suite 202
Columbia, SC 29201
803.779.2607
info@coveringkids.org
www.coveringkids.org

By

Cindy Mann
Institute for Health Care Research and Policy
Georgetown University
Washington DC
crm32@georgetown.edu

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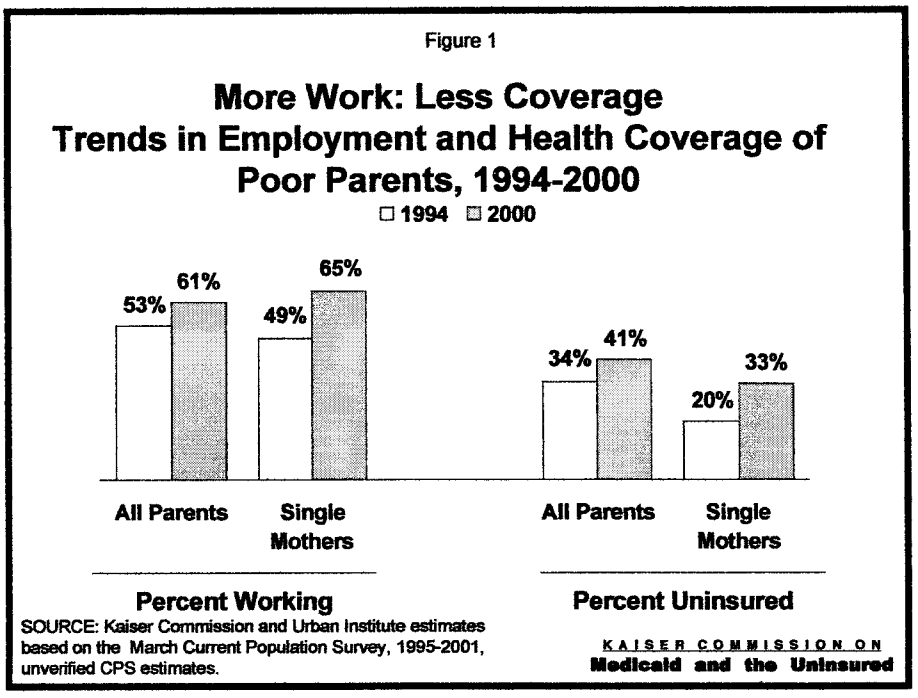
Introduction

Over the five years following the enactment of the State Children's Health Insurance Program (SCHIP), significant progress has been made extending eligibility for health care coverage in Medicaid and SCHIP to children in low-income families. States have also taken important steps to ease the enrollment process to help assure that eligible children are enrolled. Eligibility levels for children have expanded in every state, and simplified Medicaid and SCHIP enrollment procedures for children are now the norm in most states. As a result, after a decline in Medicaid enrollment following the 1996 federal welfare law, enrollment of children in Medicaid and SCHIP has been growing, and increased enrollment in public coverage programs has helped to lower the number of uninsured children.[1] More needs to be done to assure that all low-income children have coverage, but many of the policies needed to build toward this goal are now in place.

Coverage for low-income parents and other adults does not have as strong a foundation from which to build and, as a result, much more needs to be done to reduce uninsured rates among adults. In recent years, the portion of low-income parents and other adults who are uninsured has been growing. Ironically, as labor market participation among low-income adults has climbed, insurance coverage rates have fallen. For example, between 1994 and 2000, the portion of poor single mothers who were working rose from less than half (49%) to almost two-thirds (65%). During this same time period, the portion of poor single mothers who had no health insurance jumped from one-fifth to one-third (Figure 1, see page 2).

[1] According to U.S. Census Bureau data, between 1999 and 2000, the number of uninsured children fell largely as a result of publicly funded coverage. In the following year, between 2000 and 2001, as the economy soured the number of children lacking coverage held steady notwithstanding a drop in employer-sponsored coverage. Rising enrollment in Medicaid and SCHIP offset the drop in job-based coverage.

Figure 1



Three factors are responsible for this disturbing trend. First, while most of us receive health insurance coverage through our employer, low-wage workers are much less likely to have access to employer-based coverage. Only three out of ten poor, working parents had employer coverage in 2000. Second, Medicaid coverage is often not available to fill the gap. Medicaid eligibility levels for parents are below the poverty level in most states, and adults who are not living with children are typically not eligible at any income level. Third, even when parents or other adults are eligible for Medicaid they may not know they are eligible, or, if they do know, they may not be successful navigating the application or renewal process. The processes for enrolling and staying enrolled are often much more burdensome than the processes in place for children.

Part I of this report reviews why it is important to strengthen the system for adult coverage through public programs. Part II identifies how adults can be covered through Medicaid and SCHIP, and Part III follows with a description of some of the steps that can be taken to promote participation of eligible adults and families.

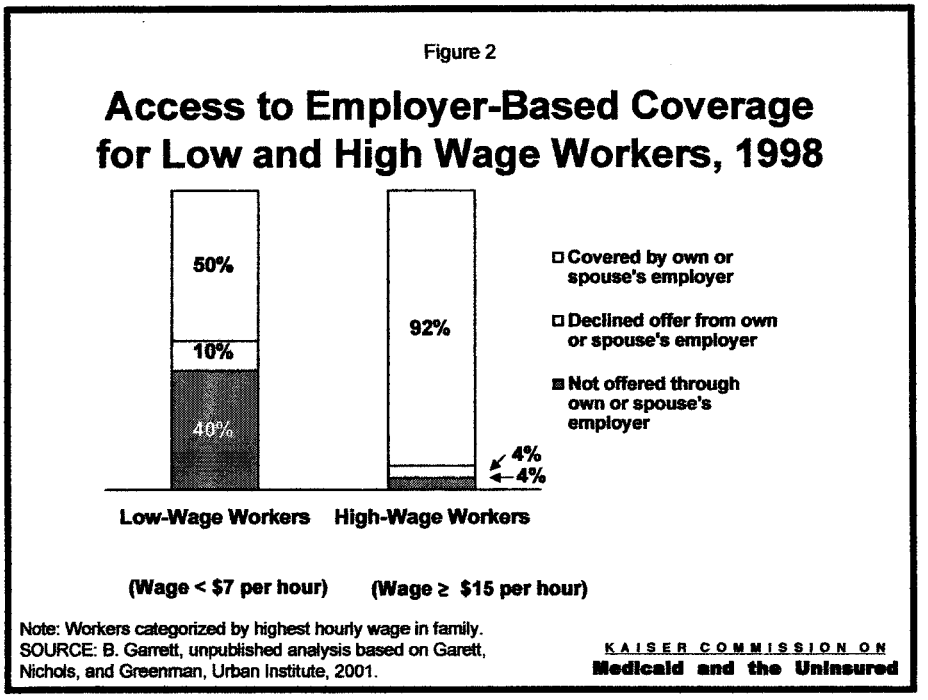
Part I. Why Cover Adults?

Publicly funded coverage for parents and other adults is important for a number of reasons.

- **Low-income working adults often do not have access to health insurance through their jobs.**

Making publicly funded coverage available is a high priority because so many low-income adults cannot obtain health insurance coverage through the workplace. Low-wage workers are much less likely than higher wage workers to have an offer of insurance. According to data from 1998, only half of workers earning less than $7 an hour had coverage offered by their employer or by their spouse's employer, compared to 96 percent of workers earning $15 an hour or more. In addition, about 10 percent of low-wage workers had an offer of coverage but did not take up that offer largely due to costs. As a result, in 1998 only 40 percent of workers earning less than $7 an hour had employer-based coverage either through their own jobs or their spouses' jobs compared to 92 percent of workers earning $15 an hour or more (Figure 2).

Figure 2



Studies of women leaving welfare show even lower rates of employer-based coverage although the rates of coverage rise as wage levels rise. Among women who had recently left welfare and who were surveyed in 1999, just 16 percent of those earning less than $7 an hour had employer-sponsored coverage. Only about a quarter (26 %) of the women earning between $7 and $10 had coverage through their jobs.[2] (On average, women leaving welfare earn $7.15 an hour[3]). In addition to earning low wages, many of the women leaving welfare are new workers, temporary workers, part-time workers, and workers employed by service firms – characteristics that increase the likelihood that job-based coverage will not be available.

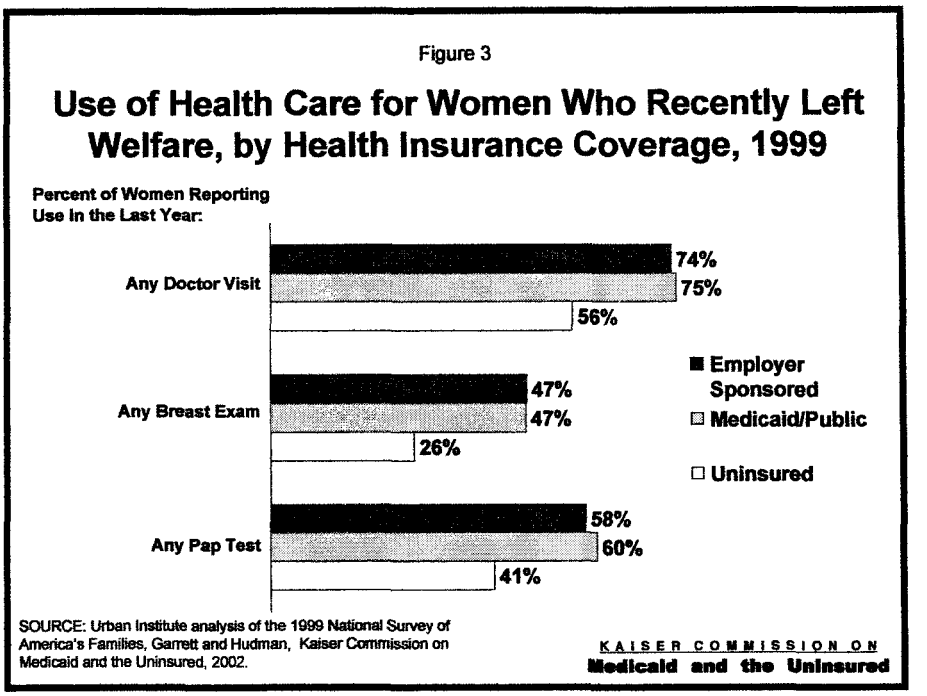
- **Health care coverage connects people to necessary health care.**

Most basic among the reasons to assure that health care coverage is available to low-income parents and other adults is the connection between health insurance and medical care. Research consistently shows that health care coverage improves access to health care, particularly for primary and preventive care. A study based on the 1999 National Survey of America's Families, for example, shows that women with coverage either through their employers or through Medicaid or another public program were much more likely than women without coverage to have had a doctor visit, a breast exam or a pap test within the past year (Figure 3, see page 5).

[2] Urban Institute analysis of the 1999 National Survey of America's Families, Garrett and Hudman, "Women Who Left Welfare: Health Care Coverage, Access, and Use of Health Services," Kaiser Commission on Medicaid and the Uninsured, 2002.

[3] Loprest, Pamela J. "How are Families that Left Welfare Doing? A Comparison of Early and Recent Welfare Leavers," The Urban Institute, 2001.

Figure 3



- **Health care coverage can help adults become employed and stay employed.**

One reason why a growing number of state policymakers and employers have been looking for ways to extend coverage to low-wage workers is that health insurance coverage has increasingly been recognized as an integral work support. Low-wage earners have little ability to pay for health care services without insurance and they are likely to forego routine health care services when they have no coverage. Coverage and access to care can help workers stay healthy and avoid absences that can threaten their jobs.[4] In addition, while uninsured low-wage earners may be able to receive emergency services, they are often saddled with debts they have difficulty paying if they do receive these services.

- **Coverage of parents promotes children's enrollment and utilization of services.**

Over the past few years, research has confirmed that family coverage makes a difference for children. In a report reviewing the research in this area, the Institute of Medicine has found that extending publicly supported health insurance to low-income

[4] Buchmueller, Thomas C. "The Business Case for Employer-Provided Health Benefits: A Review of the Relevant Literature," Health Care Foundation, 2000.

uninsured parents can boost enrollment among children. It also found that when parents are insured and using health care services their children are more likely to use health care services as well.[5]

[5] Institute of Medicine, "Care Without Coverage." See also Lambrew, J., "Health Insurance: A Family Affair," The Commonwealth Fund, May 2001; Ku and Broaddus, "The Importance of Family-Based Insurance Expansions: New Research Findings about State Health Forms," Center on Budget and Policy Priorities, September 5, 2000; Dubay, Kenney, "Covering Parents Through Medicaid and SCHIP: Potential Benefits to Low-Income Parents and Children," The Kaiser Commission on Medicaid and the Uninsured, October 24, 2001; Davidoff, Kenney, Dubay, Yemane, "Patterns of Child –Parent Insurance Coverage: Implications for Coverage Expansions," The Urban Institute, November 2001; Hanson, "Is Insurance for Children Enough? The Link Between Parents' and Children's Health Care Use Revisited," Inquiry 35, 1998.

Part II. Adult Coverage under Medicaid and SCHIP

A few states have extended publicly funded coverage to adults with state and local funds. However, in general, states have needed to rely on federal funding to cover part of the cost, and, therefore, they have looked to the Medicaid program, and more recently to SCHIP, for ways to extend coverage to low-income adults. This section of the report explains the basic federal rules that permit states to cover parents under Medicaid and some of the ways states have covered parents and other adults under Medicaid and SCHIP through waivers.

Medicaid eligibility rules (federal requirements and state options)

Medicaid is a program that covers people who fit within certain "categories" or "eligibility groups." There are five basic eligibility groups under Medicaid. As shown in Figure 4 (page 8), adults can qualify for Medicaid if they are elderly, disabled, pregnant or a parent living with his or her children.[6] Adults who do not fit any of these categories (e.g., adults without children or parents whose children are no longer living with them) do not qualify for Medicaid at least not unless the state has a waiver. Waivers are discussed below.

People who fit within one of these five basic eligibility groups can qualify for Medicaid, if their income and resources (assets) are below the eligibility levels in that state and they meet other eligibility criteria (for example, they must meet certain citizenship or immigration status rules). For each eligibility group, federal rules set *minimum* income and resource levels and allow states to expand coverage beyond these minimums.

The only eligibility group that does not have a uniform national minimum income level is parents.[7] The minimum eligibility levels for parents are based on standards a state had in place in its Aid to Families With Dependent Children (AFDC) program, the federal welfare program that was repealed in 1996.

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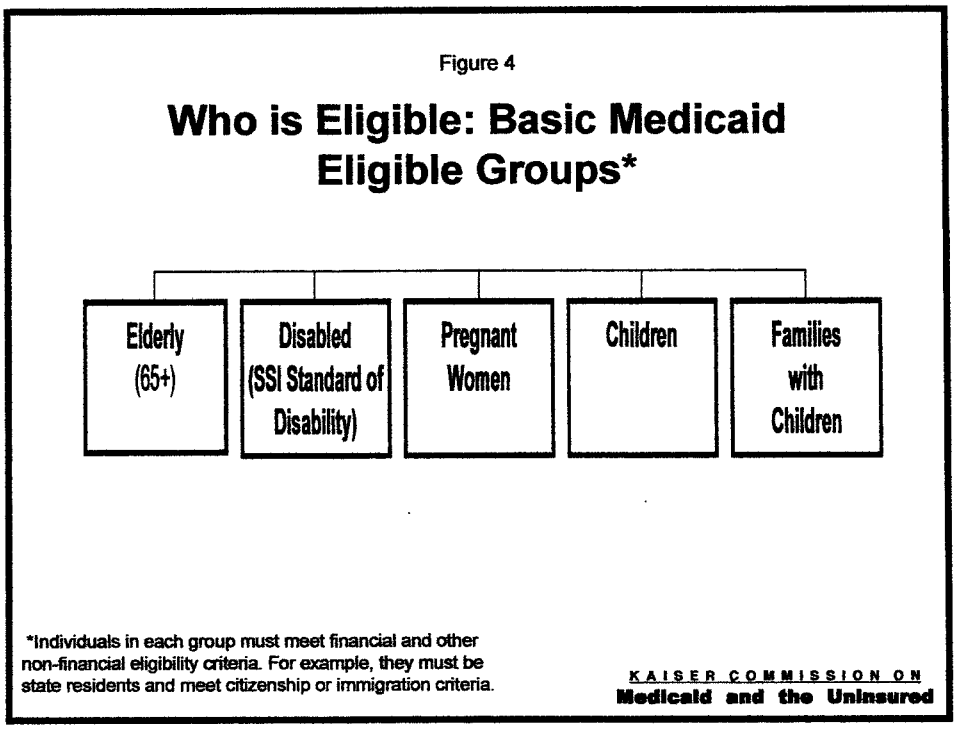
[6] In this context, the term "parent" includes parents as well as grandparents and other close relatives who are living with and primarily responsible for caring for a child. Step-parents are not included under federal Medicaid rules.

[7] The minimum income eligibility level for aged and disabled people is the SSI income level (in most states) and the minimum income eligibility level for pregnant women is 133% of the federal poverty line (this is the same minimum standard that applies to children under age six).

Figure 4



Before the AFDC program was repealed by the 1996 federal welfare law, parents were generally eligible for Medicaid if they were receiving cash assistance through AFDC. When AFDC was replaced by the Temporary Assistance to Needy Families (TANF) block grant, the eligibility link to cash assistance was severed. For the first time, parents—like children—could qualify for Medicaid based on their income not their status as welfare recipients, and states were given broad new flexibility to expand coverage to low-income working parents. The new eligibility category created by the 1996 welfare law is often referred to as the "delinking" provision or as "1931 eligibility," since it "delinked" Medicaid eligibility from eligibility for welfare and was established by section 1931 of the Social Security Act.

Section 1931 eligibility rules

- Section 1931 covers parents (and other "caretaker relatives," such as grandparents, aunts and uncles) and their children. *At a minimum*, states must cover single parent families and some two-parent families (if they meet certain rules relating to unemployment or disability). Under a federal regulation adopted in August 1998, states can drop restrictions on two-parent family coverage and

cover two-parent families to the same extent (e.g., at the same income levels) that they cover single-parent families.[8]

- The family's income and resources must be below state-established levels. *At a minimum*, states must cover families whose income and assets are below the AFDC eligibility standards that were in place in that state in July 1996.[9] Section 1931 rules allow states to increase those income standards to adjust for changes in costs (using the Consumer Price Index). Even more significant, states can disregard income and effectively increase the income eligibility standards to whatever level the state chooses. Similarly, states can liberalize the resource (asset) standard or drop the asset test entirely, as most states now do for children's eligibility.

Some parents have an additional route to Medicaid coverage under federal rules through Transitional Medical Assistance (TMA). TMA was first adopted in the 1980s when Medicaid eligibility for parents was linked to welfare. TMA allowed families with children to continue to receive Medicaid for up to 12 months if they were leaving welfare because of employment. Families could qualify for TMA for a shorter period of time if they became ineligible for welfare due to child support income. The goal was to assure that families who left welfare for a job or because of child support payments could keep their Medicaid coverage for at least a temporary period of time. When Medicaid for families was delinked from welfare in 1996, TMA was retained but changed to reflect the new delinking rules.

TMA eligibility rules

- TMA is an extension of coverage, not a separate category of coverage. To qualify for TMA, families must first have been covered under Medicaid under section 1931 for at least three out of the previous six months, and they must be losing their eligibility for Medicaid under section 1931 either because of earnings (a new job, higher earnings, etc.) or because of child support payments (new payments or higher payments).

[8] The regulation can be found at Vol. 63, No. 152 of the Federal Register, pages 42270-4.
[9] A state can drop its income standard to levels in effect as of May 1988.

- TMA coverage is limited to four months if eligibility is based on child support payments, and it is limited to six months, with a six-month extension (i.e., up to 12 months), if eligibility is based on earnings.[10] There is no income limit except for the second six-month period; to qualify for the six-month extension the family's income must be below 185 percent of the poverty line (gross income less child care expenses). Families also must submit income reporting forms to the Medicaid agency to maintain coverage for the full 12 months.

Waivers

In addition to the coverage options available under section 1931, states may also rely on waivers to extend coverage to low-income adults. Waivers can be granted by the Secretary of the U.S. Department of Health and Human Services (DHHS) to allow a state to use Medicaid or SCHIP funds in ways that otherwise would not be permitted under federal rules. [11] Waivers offer states alternate ways to expand and shape coverage, but they can also result in major changes in Medicaid and SCHIP coverage and financing that can be quite controversial.[12]

With respect to coverage of parents, waivers are not necessary to expand coverage (given the flexibility to expand coverage under section 1931) unless a state wants to change the benefit package, charge premiums or co-payments that would not be permitted by law, or impose an enrollment cap. Waivers are necessary if a state wants to cover adults without children (who are not elderly, disabled or pregnant). SCHIP waivers have also permitted states to use available SCHIP funds in Medicaid or in separate SCHIP programs to cover parents and pregnant women, and, more recently, childless adults as well. SCHIP offers states a higher federal matching rate than Medicaid and thereby lowers the state's cost of extending coverage to a new group of people.

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[10] Some states have waivers that extend TMA for longer periods of time.

[11] There are several sources of Medicaid waiver authority. The broadest authority is found in section 1115 of the Social Security Act which permits the Secretary of the U.S. Department of Health and Human Services to allow research and demonstration projects that "further the objectives" of the Medicaid program. Other more narrowly drawn provisions, allow HHS to grant waivers for states to provide home and community based services to people who would otherwise need institutional care or to require Medicaid beneficiaries to enroll in managed care.

[12] U.S. General Accounting Office, "Medicaid and SCHIP, Recent HHS Approvals of Demonstration Waiver Projects Raise Concerns," July 2002; Kaiser Commission on Medicaid and the Uninsured, "The New Medicaid and CHIP Waiver Initiatives," February 2002.

Some examples of how states have used Medicaid and SCHIP waivers include:

- Imposing co-payments or premiums for parents covered under a Medicaid expansion (Missouri, Rhode Island, Wisconsin).

- Altering the benefit package provided to adults, for example, to exclude hospital services (Utah) or to prioritize the services that will be provided based on available funds (Oregon).

- Extending Medicaid coverage to childless adults (District of Columbia, Maine, New York) and to noncustodial parents (Missouri).

- Using SCHIP funds to cover parents in Medicaid (Minnesota, Rhode Island Wisconsin) and in separate SCHIP programs (Arizona, New Jersey).

- Using SCHIP funds to cover childless adults in Medicaid or in separate SCHIP programs (Arizona, New Mexico).

- Making TMA available for longer than the 12-month TMA period (Connecticut, South Carolina).

- Imposing enrollment caps that allow enrollment freezes or waiting lists based on state budget constraints (Arizona, Oregon, Utah).

Waiver financing issues also can be quite important. In general, the federal government will not approve a Medicaid waiver that will cost the federal government any more than it would have spent without the waiver. This is referred to as "budget neutrality." In general, in order to satisfy federal budget neutrality policies, a state must identify savings or offsets if it is going to expand coverage in ways that would otherwise boost federal Medicaid costs. The cost of expanding coverage for childless adults through the recently approved Utah waiver, for example, is offset largely through new cost sharing and some benefit reductions for very low-income parents who were eligible for Medicaid prior to the

waiver. Maine's waiver achieves budget neutrality by redirecting disproportionate share hospital (DSH) funds to cover the federal cost of extending Medicaid eligibility to childless adults.

SCHIP waiver financing works differently. Since federal SCHIP funds are capped, states do not have to establish budget neutrality; they can use waivers to draw down SCHIP funds up to their state's SCHIP allotment. Arizona was able to use SCHIP funds to expand coverage for parents and refinance coverage for childless adults without having to reduce coverage to other populations. However, because SCHIP funds are capped nationwide, one state's waiver could affect other states' SCHIP funding. In general, states have three years to spend their SCHIP allotments and at the end of that period unspent funds are shifted (reallocated) to states that have fully spent their allotments. To the extent that states begin to rely on SCHIP waivers to finance or refinance coverage for other populations, less SCHIP funds will be available to states that may need those funds to cover children.[13]

State coverage choices

Table 1 (pages 14 and 15) and Figure 5 (page 13) show the income eligibility levels for parents in Medicaid and other publicly funded health coverage programs, by state, as of June 2001. The variation in eligibility levels across states is significant, from a low of 13 percent of the poverty level in Alabama to a high of 275 percent of the poverty line in Minnesota. Two separate calculations are provided in Table 1: the income eligibility standard for unemployed parents and the income eligibility standard for parents with earnings. The standard for employed parents considers the earnings disregards that some states allow, which have the effect of making parents with somewhat higher earnings eligible for Medicaid.

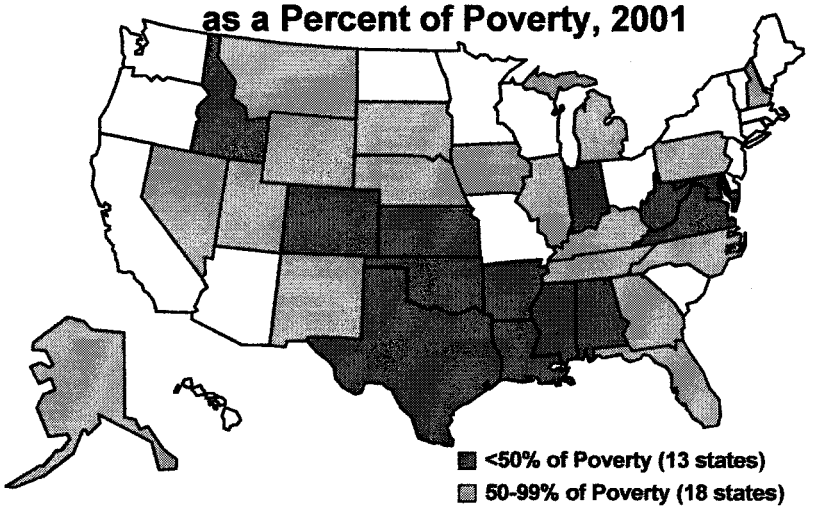
While many states still have income eligibility standards for parents that are well below the poverty level, considerable progress has been made in the past few years as states, including California, Connecticut, Maine, New York, and Ohio expanded coverage. Budget pressures, however, threaten that progress. Two states that expanded coverage to parents (Missouri and New Jersey) rolled back those expansions as a result of state budget pressures,

[13] Financing issues resulting from waivers add to other SCHIP financing issues that have prompted the Office of Management and Budget to project that close to 1 million children will lose SCHIP coverage between 2003-2007.

and another state (California) put its second expansion for parents on hold due to revenue shortfalls.

Figure 5

Medicaid Income Thresholds for Working Parents as a Percent of Poverty, 2001



■ <50% of Poverty (13 states)
▨ 50-99% of Poverty (18 states)
□ 100%+ of Poverty (20 states, including DC)

Note: Based on a family of three. Average wage for parents leaving welfare is $7.15/hour (Loprest, 2001).
SOURCE: Guyer, J., "Low-Income Parents' Access to Medicaid Five Years After Welfare Reform", KCMU, June 2002

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Table 2 (pages 16 and 17) shows the asset tests that states were using for parents as of June 2001. As of that date, 19 states had eliminated the asset test for all parents under Medicaid, compared to 44 states that had taken this step for children.

With respect to coverage of parents in two-parent families, as of June 2001, eight states — Arkansas, Kentucky (for applicants), Louisiana, New Hampshire, North Dakota, Tennessee, Utah and West Virginia — still limited their coverage under Medicaid primarily to parents in single-parent households.[14]

[14] Guyer, Jocelyn. "Low-Income Parents' Access to Medicaid Five Years After Welfare Reform," The Kaiser Commission on Medicaid and the Uninsured, June 2002.

Table 1
Income Threshold for Parents Applying for Medicaid
(Based on a Family of Three as of June 2001)

State	Income threshold for unemployed parents			Income threshold for employed parents	
	Monthly Dollar ($) Amount	Annual Dollar ($) Amount	As a percent (%) of poverty line	Monthly Dollar ($) Amount	Annual Dollar ($) Amount
US Median	**$544**	**$6,528**	**45%**	**$836**	**$10,032**
AL	$164	$1,968	13%	$254	$3,048
AK	$1,118	$13,416	73%	$1,208	$14,496
AZ *+	$1,219	$14,630	100%	$1,309	$15,710
AR	$204	$2,448	17%	$255	$3,060
CA	$1,219	$14,630	100%	$1,309	$15,710
CO	$421	$5,052	35%	$511	$6,132
CT	$1,829	$21,945	150%	$1,919	$23,025
DE	$1,219	$14,630	100%	$1,491	$17,892
DC	$2,438	$29,260	200%	$2,438	$29,256
FL	$303	$3,636	25%	$806	$9,672
GA	$424	$5,088	35%	$756	$9,072
HI *	$1,403	$16,830	100%	$1,403	$16,830
ID	$317	$3,804	26%	$407	$4,884
IL+	$377	$4,524	31%	$686	$8,232
IN	$288	$3,456	24%	$378	$4,536
IA	$426	$5,112	35%	$1,065	$12,780
KS	$403	$4,836	33%	$493	$5,916
KY	$526	$6,312	43%	$909	$10,908
LA	$174	$2,088	14%	$264	$3,168
ME	$1,829	$21,945	150%	$1,919	$23,025
MD	$418	$5,016	34%	$523	$6,276
MA	$1,621	$19,458	133%	$1,621	$19,458
MI	$459	$5,508	38%	$774	$9,288
MN *	$3,353	$40,233	275%	$3,353	$40,233
MS	$368	$4,416	30%	$458	$5,496
MO+	$1,219	$14,630	100%	$1,309	$15,710
MT	$478	$5,736	39%	$836	$10,032
NE	$535	$6,420	44%	$669	$8,028
NV	$348	$4,176	29%	$1,097	$13,164
NH	$600	$7,200	49%	$750	$9,000
NJ *+	$2,438	$29,260	200%	$2,438	$29,260
NM	$389	$4,668	32%	$704	$8,448
NY *	$1,621	$19,458	133%	$1,621	$19,458
NC	$544	$6,528	45%	$750	$9,000
ND	$488	$5,856	40%	$1,336	$16,032
OH	$1,219	$14,630	100%	$1,219	$14,630
OK	$471	$5,652	39%	$591	$7,092
OR *	$1,219	$14,630	100%	$1,219	$14,630

Table 1 Continued

State	Income threshold for unemployed parents			Income threshold for employed parents	
	Monthly Dollar ($) Amount	Annual Dollar ($) Amount	As a percent (%) of poverty line	Monthly Dollar ($) Amount	Annual Dollar ($) Amount
PA	$403	$4,836	33%	$677	$8,124
RI *	$2,255	$27,066	185%	$2,345	$28,146
SC	$610	$7,315	50%	$1,219	$14,630
SD	$796	$9,552	65%	$796	$9,552
TN*+	$840	$10,080	69%	$990	$11,880
TX	$275	$3,300	23%	$395	$4,740
UT+	$583	$6,996	48%	$673	$8,076
VT *	$2,255	$27,066	185%	$2,345	$28,146
VA	$291	$3,492	24%	$381	$4,572
WA	$2,438	$29,260	200%	$2,438	$29,260
WV	$253	$3,036	21%	$343	$4,116
WI *	$2,255	$27,066	185%	$2,255	$27,066
WY	$590	$7,080	48%	$790	$9,480

Notes: (1) These tables take earnings disregards into account when determining income thresholds for working parents. In some cases, these disregards may be time limited. States may also use additional disregards in determining eligibility. (2) States marked with (*) have expanded coverage for parents under an 1115 waiver using Medicaid and/or SCHIP funds, while Washington State has used state funds to expand coverage for parents. Some states, such as Arizona, California, and New York have secured waivers to expand coverage beyond the levels shown in this table, but have not yet implemented their expansions. (3) Three states marked with a (+)—Tennessee, New Jersey and Missouri rolled back their expansion in 2002 due to state budget constraints. Two other states marked with a (+)—Illinois and Arizona—implemented parent eligibility expansions in October 2002.

SOURCE: J. Guyer, Kaiser Commission on Medicaid and the Uninsured, "Low-Income Parents' Access to Medicaid Five Years After Welfare Reform," June 2002.

Table 2
Asset Test for Parents as of June, 2001

State	Asset Limit		Treatment of First Vehicle
AL	$2,000		Disregard one vehicle
AK	$1,000		Disregard one vehicle
AZ *		No Test	--
AR	$1,000		Disregard one vehicle
CA	$3,150		Disregard fair market value of up to $4,650
CO	$2,000		Disregard one vehicle
CT		No Test	--
DE		No Test	--
DC		No Test	--
FL	$2,000		
GA	$1,000		
HI	$3,250		
ID	$1,000		
IL	$1,000		
IN	$2,000 applicants;		Disregard equity value of one vehicle up to $5,000
IA	$5,000 for adult recipients		Disregard equity value of one vehicle up to $3,959
KS *	$2,000	No Test	--
KY	$1,000		Disregard one vehicle
LA	$2,000		Disregard equity value of one vehicle up to $10,000
ME	$2,000		Disregard one vehicle
MD			Disregard one vehicle
MA	$3,000	No Test	--
MI	$6,000		Disregard one vehicle
MN †			--
MS		No Test	--

Table 2 Continued

State	Asset Limit		Treatment of First Vehicle
MO	$3,000	No Test	--
MT	$6,000		Disregard one vehicle
NE	$2,000		Disregard one vehicle
NV	$1,000		Disregard one vehicle
NH			Disregard one vehicle
NJ		No Test	--
NM	$5,550	No Test	--
NY *†	$3,000		Disregard one vehicle; second car limit up to $2,000
NC			Disregard one vehicle
ND *		No Test	--
OH		No Test	--
OK	$2,000	No Test	--
OR			Disregard equity value of one vehicle up to $10,000
PA		No Test	--
RI		No Test	--
SC	$2,000	No Test	--
SD	$2,000		Disregard one vehicle
TN			Disregard equity value of one vehicle up to $4,650
UT	$3,025		Disregard equity value of one vehicle up to $1,500
VT †	$3,000		Disregard equity value of one vehicle
VA	$1,000		Disregard equity value of one vehicle up to $1,500
WA (state funded pgm.)	$1,000		Disregard equity value of one vehicle up to $5,000
WV	$1,000		Disregard equity value of one vehicle up to $1,500
WI *†		No Test	--

Notes: States marked with (*) have eliminated their asset test since June of 2001. States marked with (+) have eliminated the asset test for higher income but not lower income parents. **Source:** J. Guyer, Kaiser Commission on Medicaid and the Uninsured, "Low-Income Parents Access to Medicaid Five Years After Welfare Reform," June 2002.

Part III. Promoting Participation of Eligible Adults

Over the past several years, there has been a growing recognition that progress toward coverage goals requires more than eligibility expansions. Policies and procedures to assure that those who are eligible for public coverage programs are enrolled and are able to stay enrolled as long as they remain eligible are also needed. The importance of taking affirmative steps to remove barriers to enrollment and retention was brought home by reports in the mid 1990's showing that close to half of the low-income children who were uninsured were eligible for Medicaid but not enrolled. Enrollment barriers and limited information about eligibility have been consistently identified by families as reasons why Medicaid eligible children were not enrolled in the program.

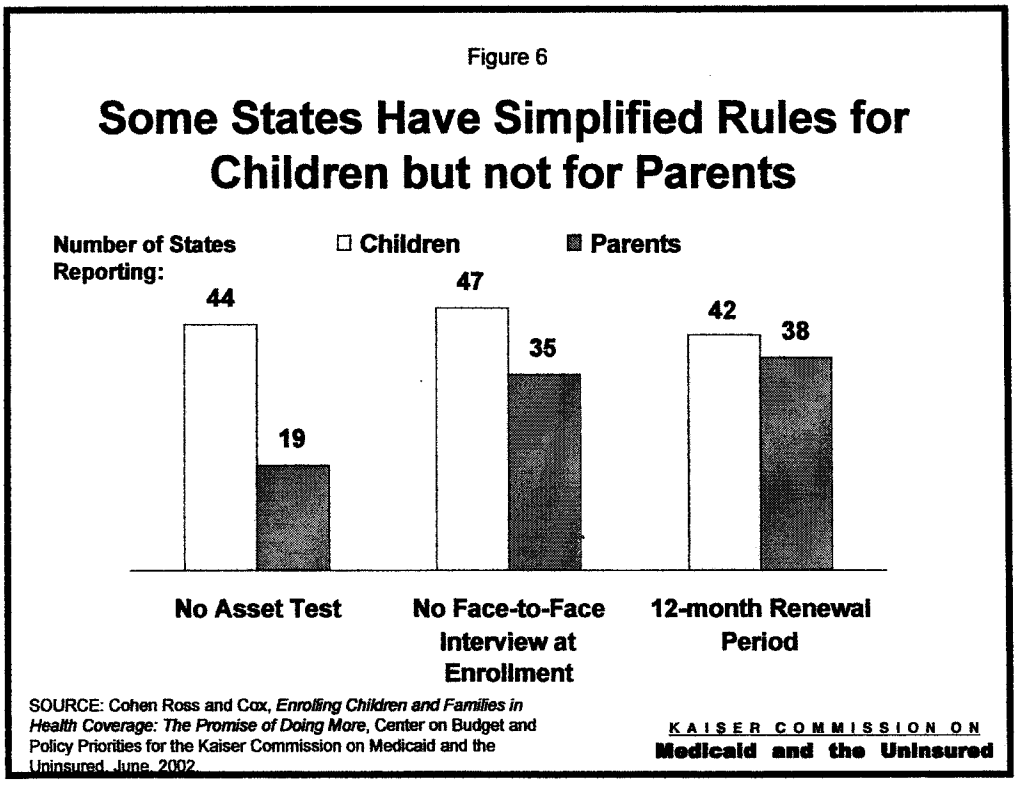
After SCHIP was adopted, states, the federal government and others engaged in efforts to cover children focused on easing enrollment barriers for eligible children in both Medicaid and SCHIP. Applications were shortened and simplified; families were permitted to apply for their children through the mail, through phone hotlines, or through outstation sites; the documentation required from families was streamlined; and retention procedures were reviewed and, in many cases, improved. Some states revised their notices to make them less bureaucratic and more welcoming, and others linked program eligibility systems to avoid having to ask families for information already available through other programs (such as the food stamp or school lunch programs). As barriers fell, enrollment grew. Moreover, the time for processing applications dropped in many states, as did administrative costs.[15]

Some states, particularly those that expanded eligibility for low-income parents, carried over many of the improvements adopted for children to family coverage. However, in other states, procedures that have been abandoned with respect to children remain in place when children apply along with their families. For example, while almost all states (47) had dropped the in-person application interview requirement for children as of June 2002, only 35 states had done so for families (Figure 6, page 19). When simplification steps are taken only with respect to children, not only do parents and other adults not benefit from these improvements, but the poorest children are often disadvantaged as well. In most states, the

[15] Mann, Cindy, et al. "Enrolling Children in Medicaid: If You Build it Right, They Will Come," Kaiser Commission on Medicaid and the Uninsured, May 2002. Smith, Vernon K., et al., Health Management Associates, "Eliminating the Asset Test for Families: A Review of State Experiences," for the Kaiser Commission on Medicaid and the Uninsured, April 2001.

poorest families are eligible for family coverage, and the children as well as the parents in those families can get caught in the paperwork maze when families must navigate difficult Medicaid application and renewal processes.[16]

Figure 6



Simplifying enrollment and retention for adults

Virtually all of the steps states have taken to improve participation rates in Medicaid among eligible children can be taken to facilitate enrollment of eligible parents and other adults. As shown in Table 3 (page 20) federal law permits states broad flexibility to simplify enrollment procedures for parents.

Similarly, states can take steps to improve their renewal procedures, as many have been doing for children. Table 4 (page 21) shows the steps that many states have taken for children and identifies whether, under federal law, those steps are also available for parents.

[16] Cohen Ross, Donna and Cox, Laura. Center on Budget and Policy Priorities, "Enrolling Children and Families in Health Coverage: The Promise of Doing More," for the Kaiser Commission on Medicaid and the Uninsured, June 2002.

Table 3
Promoting Participation: Simplifying the Enrollment Process

Simplified Application Procedures	Allowed Under Federal Medicaid?	
	For Children	For Parents
Short, simplified applications	Yes	Yes
Mail-in applications; no in-person interview	Yes	Yes
Eliminate questions about assets	Yes	Yes
Eliminate questions about paternity and whereabouts of absent parent	Yes*	Yes*
Reduce verification requirements	Yes**	Yes**

Notes

***Questions about paternity and whereabouts of an absent parent:**

For children: Questions can be dropped completely from a child-only application. If questions are included, the application must explain that the questions are optional. In a family application, the form should make it clear that answers to questions about paternity and the whereabouts of an absent parent or the failure to answer these questions will not affect children's eligibility.

For parents: Parents must cooperate in establishing paternity and obtaining medical support from an absent parent if they are to be covered under Medicaid. However it is sufficient to simply ask whether the parent will agree to cooperate and assign support rights and then to pursue medical support, as appropriate, at a later time.

****Verification requirements (i.e., requirements that families supply documents to verify eligibility)**

For children and for parents: The only documentation that families must provide under federal law is proof of immigration status for applicants who are not U.S. citizens. Documentation is not required for citizens or for family members who are not applying for Medicaid for themselves.

Source: Centers for Medicare and Medicaid Services, "Continuing the Progress: Enrolling and Retaining Low-Income Families and Children in Health Care Coverage," Chapter I (http://www.cms.gov/schip/outreach/progress.pdf).

Table 4
Promoting Participating: Simplifying the Renewal Process

Simplified Renewal Procedures	Allowed Under Federal Medicaid?	
	For Children	For Parents
Short renewal forms and pre-printed renewal forms	Yes	Yes
Mail-in renewal forms; no in-person interview	Yes	Yes
Reduce verification requirements	Yes*	Yes*
12-month eligibility review periods	Yes	Yes
Continuous eligibility	Yes	No, but**

Notes

***Verification requirements at the point of renewal:**

For children and parents: The only documentation that families must provide is proof of immigration status if the family members who are renewing eligibility are immigrants and their status might have changed since the last review.

****Continuous eligibility:**

For parents: The continuous eligibility option is not explicitly available. However, states can disregard changes in assets and income that occur between renewals.

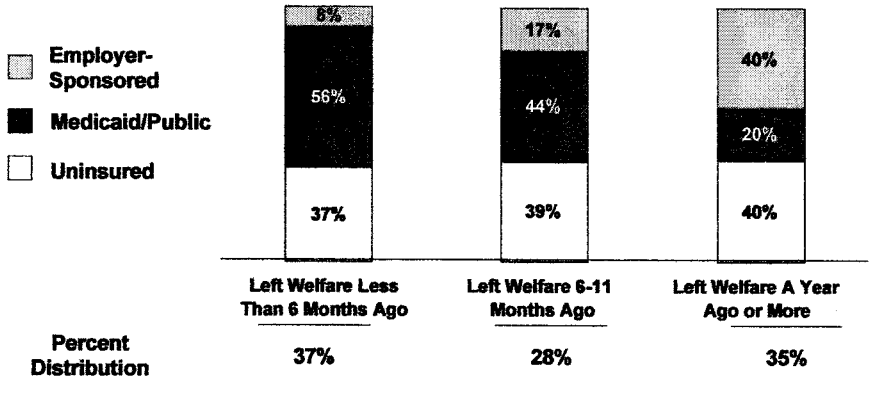
Source: Centers for Medicare and Medicaid Services, "Continuing the Progress: Enrolling and Retaining Low-Income Families and Children in Health Care Coverage," Chapter II (http://www.cms.gov/schip/outreach/progress.pdf).

Assuring that "delinking" is working properly

An area that deserves special attention with respect to family coverage under Medicaid is the process by which the state and the local offices administering Medicaid have delinked Medicaid and TANF eligibility. After the federal welfare law that created TANF was enacted in 1996 and eligibility for Medicaid and welfare was delinked, families moving in and out of the welfare system were not always properly considered for Medicaid eligibility. Partly as a result, eligible parents and children lost Medicaid coverage. For example, an analysis conducted by the Urban Institute showed that in 1999, 37 percent of the women who left welfare for a job were uninsured within the six-month period following their TANF exit. Most if not all of these uninsured women were eligible for TMA (Figure 7).

Figure 7

Health Insurance Coverage of Women Who Recently Left Welfare, by Months Since Leaving Welfare, 1999



SOURCE: Urban Institute analysis of the 1999 National Survey of America's Families, Garrett and Hudman, Kaiser Commission on Medicaid and the Uninsured, 2002.

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Although many states took action between 1998 and 2000 to correct the problems that led to the drop off in enrollment among eligible families, some states may not have fully addressed all of their problems and may still be losing families, or at least the parents in those families, who are eligible for Medicaid.[17] (For a more detailed discussion of the issues

[17] Burke, Courtney E. and Abbey, Craig W. "Managing Medicaid Take-Up," Rockefeller Institute, August 2002.

relating to delinking, please see an earlier *Covering Kids* publication, "The Ins and Outs of Delinking: Promoting Enrollment of Children Who are Moving In and Out of the TANF System," March 1999, and various HHS clarifications in the delinking rules.[18]) When states did examine their systems, they most often found that the problems fell into one of three areas:

- Computer systems had not been sufficiently updated to reflect the new Medicaid eligibility rules. As a result, unless a worker "overrode" the system, families who were eligible for Medicaid might not be evaluated properly for Medicaid if TANF was denied or terminated.

- Many states also found that they needed to improve staff training. When welfare and Medicaid were linked, for the most part, Medicaid just came along with welfare. Now that the two programs have been delinked, agency staff needs to understand the family Medicaid eligibility rules, particularly in states where the eligibility determination system is not fully automated and updated.

- Applicants and beneficiaries also need clear, accessible information about eligibility for Medicaid, and they need, in particular, to understand that they may be eligible for Medicaid even if they are not receiving welfare.

A special $500 million fund was created by the 1996 welfare law to help states with the cost of computer system changes, staff training and outreach to families.[19] As of March 2002, most states still had some funds available for this purpose and other related activities (see Table 5, page 24).

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[18] CMS, "Continuing the Progress: Enrolling and Retaining Low-Income Families and Children in Health Care Coverage," http://cms.hhs.gov/schip/outreach/progress.pd; HCFA, "Supporting Families in Transition: A Guide to Expanding Health Coverage in the Post Welfare Reform World," http://cms.hhs.gov/medicaid/welfareref/welfare.asp; See also Welfare Reform and Medicaid "State Medicaid Director" letters, http://cms.hhs.gov/medicaid/welfareref/smdltrs.asp and related materials, on delinking http://cms.hhs.gov/medicaid/welfareref/default.asp.

[19] For an explanation of how these funds can be used, see, Notice in the Federal Register, May 14, 1997 (Vol. 62, No. 93, pages 26545-26550) and "Congress Lifted the Sunset on the '500 Million Fund,'" Center on Budget and Policy Priorities, December 1999.

Table 5
Medicaid "Delinking" Funds as of June 2002

State	Total Allocation	Amount Spent Through 6/30/02	Balance Remaining Through 6/30/02	Percent Spent Through 6/30/02	Percent Remaining Through 6/30/02
Alabama	6,504,897	$3,476,577	$3,028,320	53.45%	46.55%
Alaska	3,039,335	$704,975	$2,334,360	23.20%	76.80%
Amer. Samoa		$0	$0	0.00%	0.00%
Arizona	7,961,603	$1,812,948	$6,148,656	22.77%	77.23%
Arkansas	5,095,513	$2,241,910	$2,853,603	44.00%	56.00%
California	83,719,457	$63,899,115	$19,820,343	76.33%	23.67%
Colorado	5,166,316	$2,094,897	$3,071,419	40.55%	59.45%
Connecticut	5,756,737	$3,101,694	$2,655,043	53.88%	46.12%
Delaware	2,801,757	$530,634	$2,271,123	18.94%	81.06%
Dist. Of Col.	3,259,072	$1,421,750	$1,837,322	43.62%	56.38%
Florida	22,262,238	$14,641,163	$7,621,076	65.77%	34.23%
Georgia	11,591,548	$11,201,746	$389,802	96.64%	3.36%
Guam	270,439	$0	$270,439	0.00%	100.00%
Hawaii	3,435,742	$0	$3,435,742	0.00%	100.00%
Idaho	3,288,535	$3,202,897	$85,638	97.40%	2.60%
Illinois	19,363,893	$14,636,112	$4,727,782	75.58%	24.42%
Indiana	7,545,162	$7,328,442	$216,721	97.13%	2.87%
Iowa	4,782,362	$4,755,890	$26,473	99.45%	0.55%
Kansas	4,496,386	$4,361,911	$134,475	97.01%	2.99%
Kentucky	7,269,014	$2,494,295	$4,774,720	34.31%	65.69%
Louisiana	9,029,185	$9,029,185	$0	100.00%	0.00%
Maine	3,569,238	$3,569,238	$0	100.00%	0.00%
Maryland	7,595,943	$6,830,322	$765,622	89.92%	10.08%
Massachusetts	9,463,490	$9,623,388	($159,898)	101.69%	-1.69%
Michigan	15,975,444	$12,746,530	$3,228,914	79.79%	20.21%
Minnesota	7,708,769	$7,708,775	$0	100.00%	0.00%
Mississippi	6,617,604	$1,646,729	$4,970,875	24.88%	75.12%
Missouri	8,561,965	$8,561,962	$3	100.00%	0.00%
Montana	2,764,134	$596,256	$2,167,879	21.57%	78.43%
Nebraska	3,308,247	$2,123,375	$1,184,872	64.18%	35.82%
Nevada	3,258,808	$3,258,808	$0	100.00%	0.00%
New Hampshire	2,875,952	$2,875,955	($3)	100.00%	0.00%
New Jersey	11,012,253	$11,012,253	$0	100.00%	0.00%
New Mexico	4,860,333	$2,271,475	$2,588,858	46.73%	53.27%
New York	37,034,555	$15,487,100	$21,547,456	41.82%	58.18%
North Carolina	11,550,703	$2,490,837	$9,059,867	21.56%	78.44%
North Dakota	2,537,922	$2,537,922	$0	100.00%	0.00%
Ohio	16,909,160	$13,589,406	$3,319,754	80.37%	19.63%
Oklahoma	5,938,082	$3,801,855	$2,136,228	64.02%	35.98%
Oregon	5,740,656	$4,715,243	$1,025,413	82.14%	17.86%
Pennsylvania	17,553,338	$14,495,365	$3,057,974	82.58%	17.42%
Puerto Rico	8,325,084	$0	$8,325,084	0.00%	100.00%
Rhode Island	3,459,771	$1,199,181	$2,260,591	34.66%	65.34%
South Carolina	6,221,783	$6,348,762	($126,979)	102.04%	-2.04%
South Dakota	2,642,597	$2,642,601	($4)	100.00%	0.00%
Tennessee	9,250,889	$9,250,889	$0	100.00%	0.00%
Texas	27,523,805	$1,640,744	$25,883,061	5.96%	94.04%
Utah	4,006,172	$1,723,893	$2,282,279	43.03%	56.97%
Vermont	2,891,672	$1,882,410	$1,009,263	65.10%	34.90%
Virgin Islands	308,045	$0	$308,045	0.00%	100.00%
Virginia	8,531,522	$2,264,077	$6,267,445	26.54%	73.46%
Washington	10,443,170	$10,438,169	$5,001	99.95%	0.05%
West Virginia	5,420,593	$1,914,343	$3,506,250	35.32%	64.68%
Wisconsin	7,023,766	$6,305,184	$718,583	89.77%	10.23%
Wyoming	2,475,344	$225,515	$2,249,829	9.11%	90.89%
	500,000,000	$326,714,694	$173,285,312	65.34%	34.66%

Source: Medicaid and Medicare Services

Checklist

When reviewing state and local policies and procedures that could affect eligible parents' and other adults' participation in Medicaid, the following questions might help identify areas that need attention.

√ Are the enrollment procedures for parents/adults as simple as they are for children?

√ What are the renewal procedures for families/adults? Are they as simple as the procedures in place for children?

√ What are the local welfare offices' policies and procedures when TANF is denied or terminated? (It is important to look at procedures as well as policies.) Are policies being followed consistently across the state?

√ What are the policies and procedures for assuring that families are evaluated for TMA? Do verification requirements or other procedural requirements make it difficult for eligible families moving into the workforce to maintain their coverage?

√ What is the procedure for evaluating ongoing Medicaid eligibility when TMA ends? Some family members, particularly the children, will continue to be eligible, and federal law requires that ongoing eligibility be evaluated before TMA is terminated.[20]

√ What notices are given to families/adults about ongoing eligibility and what they might need to do to retain their eligibility?

[20] See letter to state Medicaid Directors from the Health Care Financing Administration, April 7, 2000; http:/lcms.hhs./gov/Medicaid/welfareref/smdltrs.asp.

√ What information is available to staff and in the community about family/adult coverage?

√ What data are available to help identify problems and successes? For example, it may help to keep track of:

- The number of parents receiving Medicaid who are not receiving TANF. If this number is very low, this may mean that Medicaid delinking rules are not being implemented properly. Are there variations across the state that might show were the procedures are and are not working well.

- The number of families receiving TMA. Is the number smaller than the number of families that have left TANF due to earnings? Do studies on "welfare leavers" in the state provide useful information as to whether families eligible for TMA are enrolled in coverage?

Conclusion

The progress that has been made extending coverage to children and assuring that eligible children are enrolled in Medicaid and SCHIP shows the importance of taking many of the very same steps for low-income adults. The specific changes that will be needed in any given state will vary depending on the rules, procedures and systems in that state. Nonetheless, in general, a blueprint for success has emerged based on the experience in states that have moved aggressively to cover low-income children.

We know the strategies that seem to work and that simplification and coordination will boost participation among eligible children and families. Ohio's experience is instructive. In 2000, Ohio adopted a modest expansion in eligibility for parents and pregnant women, developed a simplified family-based application for Medicaid, streamlined the verification requirements for children and families and addressed many of their TANF delinking problems. The result is shown in Figure 8 (see below) — enrollment among children, families and pregnant women jumped, partly because more people were eligible but mostly because barriers were reduced to encourage eligible people to enroll at higher rates.

The challenge now is to continue the progress that has been made with respect to children and to carry over successful strategies to parents and other adults.

Figure 8