

VOL. XXI NO. 2

MARCH-JUNE 2000

## *Medicaid "Replacement Rates" Fail to Cover Many Eligible Families*

# Troubling Declines in Family Health Coverage After Welfare Reform

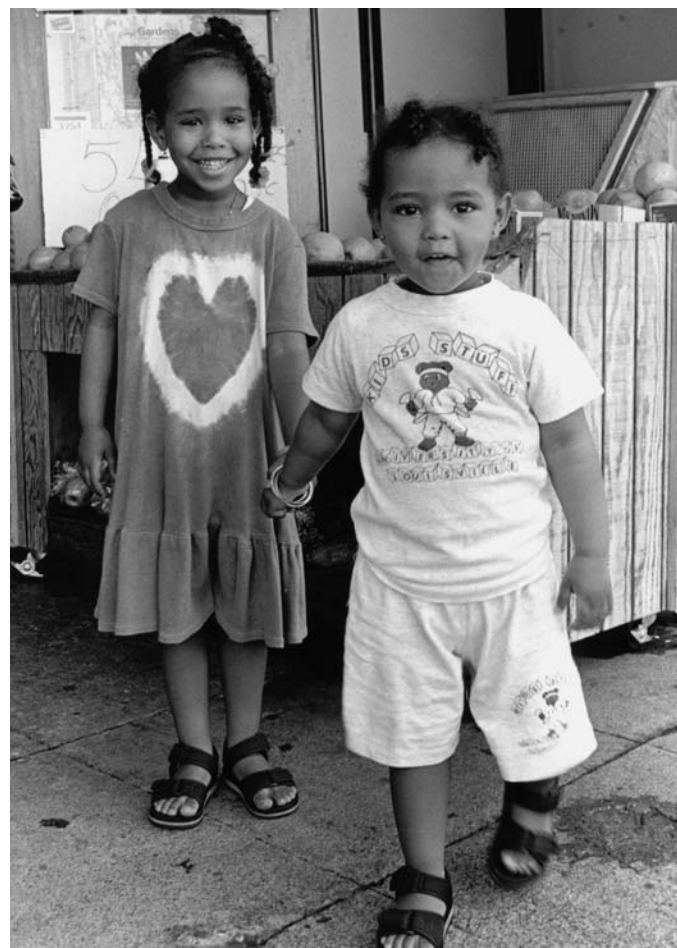
by Lucy Quacinella

One aspect of the fallout of welfare reform that has met with near universal concern is the loss of Medicaid coverage by families leaving welfare for work. The 1996 welfare law (the Personal Responsibility and Work Opportunities Reconciliation Act, or PRA) "delinked" Medicaid eligibility from cash aid, a major change from the previous practice under which AFDC eligibility carried with it automatic Medicaid coverage. However, it was expected that most families leaving TANF, the welfare reform replacement for AFDC, would remain eligible for Medicaid and would continue to receive it. It was also expected that families who chose not to go on TANF would still have access to Medicaid if they met all the eligibility requirements.

In an effort to ensure these results, Congress created a new "Section 1931" Medicaid category so that eligible families could get health insurance coverage without regard to whether they are on TANF cash aid.<sup>1</sup> In addition, the Family Support Act, the welfare reform initiative of the 1980s, guaranteed transitional Medicaid coverage for at least six and up to 12 months for certain families moving into the labor market from welfare. This "transitional" coverage is now also available to working families whose income is over the amount allowed by a state for families to receive Medicaid under Section 1931, with or without cash aid.

Things haven't quite worked out as intended. A number of national studies point to the lack of success of these efforts to ensure that low-income families get and keep health care coverage when they are not on welfare (see box on page 3). According to the General Accounting Office, for example, Medicaid declined by 7.4% nationally from 1995 to 1997.<sup>2</sup> A recent report found that Medicaid for low-income parents declined by 27% from 1996 to 1999 in the 15 states with the largest number of uninsured low-income adults.<sup>3</sup>

Many of the studies, like the GAO report, however, are based on data that the states report to the federal government in a way that



Kathy Sloane

may not be sensitive enough or timely enough to answer key local questions. More detailed local data, and/or examining state level data in different ways, might illuminate the problem from a different

D O U B L E I S S U E

<sup>1</sup> Section 1931 of the Social Security Act, 42 U.S.C. § 1396u-1. See Quacinella, "By Simplifying Medicaid Rules, States Could Cover More Families at Little Extra Cost," Youth Law News (Jan.-Feb. 1999).

<sup>2</sup> GAO, Medicaid Enrollment: Amid Declines, State Efforts to Ensure Coverage After Welfare Reform Vary, GAO/HEHS-99-163 (September 1999).

<sup>3</sup> Families USA, Go Directly to Work, Do Not collect Health Insurance: Low-Income Parents Lose Medicaid (June 2000).

## Recent Studies On Declines in Medicaid Family Coverage

*Go Directly to Work, Do Not Collect Health Insurance: Low-Income Parents Lose Medicaid*. Families USA (June 2000). Finding that Medicaid for low-income parents declined by 27% from 1996 to 1999 in the 15 states with the largest number of uninsured low-income adults. [www.familiesusa.org](http://www.familiesusa.org)

*Medicaid Enrollment in 21 States, June 1997 to June 1999*, Kaiser Commission on Medicaid and the Uninsured (April 2000). Finding varying declines depending on the state and time, based on data from the states. [www.kff.org](http://www.kff.org)

*How Welfare Reform and Economic Factors Affected Medicaid Participation: 1984-1996*, Urban Institute (February 2000). [www.urban.org](http://www.urban.org)

*Health Insurance Coverage After Welfare: Almost Half of Women and Close to One-Third of Children Are Uninsured One Year After Leaving Welfare*, Barret, B., and Holahan, J., Health Affairs (January/February 2000).

*Implications for Family Planning of Post-Welfare Reform Insurance Trends*, The Guttmacher Report on Public Policy (December 1999). Census Bureau data show that between 1994 and 1998 the proportion of American women of reproductive age enrolled in Medicaid fell by 21%.

*Missed Opportunities: Declining Medicaid Enrollment Undermines the Nation's Progress in Insuring Low-Income Children*, Guyer, G., Broaddus, M. and Cochran, M., Center on Budget and Policy Priorities (October 21, 1999). Latest Census Bureau data shows children continue to lose coverage notwithstanding improved economy and child health expansions. [www.cbpp.org](http://www.cbpp.org)

*One Step Forward, One Step Back: Children's Health Coverage After CHIP and Welfare Reform*, Pulos, V., Families USA (October 1999). Report on declines in the 12 states with the largest number of uninsured children. [www.familiesusa.org](http://www.familiesusa.org)

*Families Who Left Welfare: Who Are They and How Are They Doing?*, Loprest, P., Urban Institute (1999). 53% of children in families surveyed who had stopped receiving welfare at some time between 1995 and 1997 lost Medicaid. [www.urban.gov](http://www.urban.gov)

*Medicaid Enrollment: Amid Declines, State Efforts to Ensure Coverage After Welfare Reform Vary*, GAO (September 1999). Finding 7.4% decline in Medicaid for nonelderly and nondisabled adults and children between 1995 and 1997. [www.gao.gov](http://www.gao.gov)

*On and Off Medicaid: Enrollment Patterns for California and Florida in 1995*, The Urban Institute (July 1999). In California, about half the children and about half the adults leaving AFDC left Medicaid as well. In Florida, about half the children and two-thirds of the adults leaving AFDC lost Medicaid. [www.urban.org](http://www.urban.org)

*Losing Health Insurance: The Unintended Consequences of Welfare Reform*, Families USA Foundation (May 1999). Two-thirds of low-income people lost Medicaid coverage and became uninsured as of 1997 due to welfare reform. [www.familiesusa.org](http://www.familiesusa.org)

*Participation in Welfare and Medicaid Enrollment*, Greenberg, M., for the Kaiser Family Foundation (September 1998). Drop in Medicaid enrollment through 1996 substantial. [www.kff.org](http://www.kff.org)

*Medicaid: Early Implications of Welfare Reform for Beneficiaries and States*, GAO (February 1998). Review of nine states' post-welfare reform Medicaid rules. [www.gao.gov](http://www.gao.gov)

(Continued on page 3)

(Continued from page 1)

angle. Input from advocates knowledgeable about the individual circumstances of particular Medicaid-eligible families also has the potential to clarify further the impact of the major state rule changes applied after welfare reform and how Medicaid consumers have been affected at various points in the process.

The Center on Budget and Policy Priorities (CBPP) has developed a model for determining "Medicaid replacement rates" that furthers the discussion about what is happening with health insurance coverage in the aftermath of welfare reform. It has also used the model in California to analyze the number and proportion of families with children covered by Medi-Cal during two critical phases related to welfare reform. The model is replicable, and CBPP is beginning to use it to analyze Medicaid data in other states as well. For each state, the final phase, which begins with full implementation of the Medicaid portion of a state's welfare reform, will be the most meaningful test. For California, that time started in about January 2000; final data for that period, however, were not available at the time this article was prepared. A follow-up report about Medi-Cal replacement rates will pick up where this one leaves off, in a future issue of *Youth Law News*. In the meantime, analyzing the first two phases — before welfare reform and during the transition — sets the stage for understanding the status of the Medi-Cal caseload after full implementation in this particular state, and we hope that an introduction to the "replacement rate" model will help with on-going analyses of state-specific trends throughout the nation.

### Medicaid "Replacement Rates": Measuring State Success in Enrolling Families in Medicaid as Welfare Caseloads Decline

The CBPP model examines the extent to which the *decline* in the number of Medi-Cal cases among families also receiving cash aid (referred to as "cash-assistance-based" Medi-Cal) is *offset* by an *increase* in Medi-Cal cases over the same period among low-income families *not* receiving cash aid ("non-cash-assistance-based" Medi-Cal — see box on page 4). If, for example, the cash-assistance-based caseload declined by 1,000 cases, and the non-cash-assistance-based caseload increased by the same number, the replacement rate would be 100%. If the latter category increased by only 100, the replacement rate would be 10%.

Using state data, CBPP determined the Medi-Cal replacement rates during the period between March of 1995, the peak of California's recession when both welfare and Medi-Cal caseloads were at historic highs, and December of 1999. During this 58-month period there have been two distinct phases in the replacement rate: March 1995 through December 1997 (Phase I) and January 1998 through December 1999 (Phase II). Tables 1 - 4, included at the end of this article, display the actual figures.

### Summary of Findings to Date

From March 1995 to December 1999, Medi-Cal enrollment in the "cash-assistance based" program declined overall by more than 1 million children and parents (1,079,157). This drop among those receiving cash-assistance-based Medi-Cal paralleled the decline in the welfare caseload, but enrollment in "non-cash-assistance-based" Medi-Cal rose by only 691,833. Thus, the replacement rate — the extent to which the decline in the cash-assistance-based category was offset by growth in the non-cash category — was only 64.1% (See Table 1). This means that 387,324 fewer individuals had coverage.

Such a low replacement rate is troubling in any case, but when the two phases under review are examined separately, the results point to even greater cause for concern. The overall replacement rate and corresponding declines would likely have been much worse

had the state not, during the Phase II portion of the period under review, imposed a moratorium on closing Medi-Cal cases while it prepared to “de-link” Medi-Cal from cash aid. The moratorium led to a better than 100% replacement rate during Phase II, and this pulled the overall replacement rate up to 64.1% from the dismal 7.4% of Phase I, as discussed more fully below.

*Phase I — Pre-Welfare Reform:* The period from March 1995 through December 1997 includes the time of peak welfare enrollment until the eve of implementation of welfare reform, called CalWORKS in California.<sup>4</sup> During these 34 months, the cash-assistance-based Medi-Cal caseload fell by more than half a million (510,091) while the non-cash-assistance-based caseload rose by only about 37,500 (37,535). This translates into a shockingly low replacement rate of only 7.4% (see Tables 1 and 3).

*Phase II — Transition to Welfare Reform:* The period from January 1998 through December 1999 reflects California’s transition to welfare reform. As the state prepared to de-link CalWORKS and Medi-Cal for families not on cash aid, it instructed counties to con-

<sup>4</sup> Although the federal welfare reform law was signed in August of 1996, states were permitted to phase it in; California did not implement its TANF program until January 1, 1998.

## “Non-Cash-Assistance-Based” Medi-Cal Categories

People not receiving cash aid may be eligible for health coverage under a number of separate Medi-Cal programs, including:

- Those eligible under court order in *Edwards v. Myers*,<sup>1</sup> requiring counties to continue Medi-Cal eligibility for a family leaving cash aid for at least one month while determining whether the family remains eligible in another category, unless there is proof of ineligibility.
- Section 1931, the post-welfare reform eligibility category for low-income families with dependent children, including those who are not on cash aid.
- Those eligible for Transitional Medi-Cal (TMC) because they have left welfare or Section 1931 Medi-Cal due to increased earnings or child support, after having been on Section 1931 Medi-Cal, with or without cash aid, for at least three of the previous six months.<sup>2</sup>
- The “percent of poverty” categories establishing eligibility for low-income pregnant women, infants, and children. In California, these beneficiaries include pregnant women and infants under a year old in families with incomes at or below 200% of the federal poverty level, children ages one to five at or below 133% of poverty, and children ages six to 18 at or below 100% of poverty.
- The Medically Needy program, a holdover under which families who could have qualified for AFDC but for excess income or resources, as well as families who chose not to apply for cash aid, could receive Medi-Cal by incurring a “share of cost” or “spending down.” This program now picks up where Section 1931 leaves off.

<sup>1</sup>167 Cal.App.3d 1070 (1985). The ruling is based on federal Medicaid law, which requires all states to have a similar redetermination procedure to ensure that eligible families do not lose health coverage. However, not all states do.

<sup>2</sup>The federal Transitional Medical Assistance (TMA) program provides coverage for at least six months with no income limit, and up to a year if income remains at or below 185% of poverty. 42 U.S.C. § 1396u-1. California has added a second year of TMC eligibility for parents as a state-only program. *Welf. & Inst. Code* § 14005.81.

tinue Medi-Cal coverage for all former welfare recipients until Medi-Cal could be changed to comply with the new Section 1931 eligibility category (see box on page 6 regarding HCFA letter to state Medicaid directors and follow-up Q’s & A’s).

As a consequence of the moratorium on Medi-Cal case closings, the replacement rate changed dramatically, from the low rate of 7.4% in Phase I to 117.7% in Phase II (Table 1).<sup>5</sup> Although the number of children and parents receiving cash-assistance-based Medi-Cal still fell by over half a million (550,052), the number covered by the non-cash-assistance-based program grew by more than that decline (647,261), since most families leaving cash assistance were not terminated from Medi-Cal during the moratorium.

In addition, during this period, California began implementing a new Medi-Cal category under the State Children’s Health Insurance Program (SCHIP) for teens ages 14 through 18 by expanding the income eligibility limit for them to 100% of the poverty level, up from about 70% of poverty. Adding this brand new group contributed to pushing the replacement rate over a “perfect score.” Finally, some of the growth in the replacement rate appears due to two other programs, the “200% of poverty” program for infants under 1 and for pregnant women and the “133% of poverty” program for children ages one through five. In each of these programs, enrollment increased by about 35% by the end of Phase II (see Tables 3 and 4) and coincided with implementation of a new outreach campaign under SCHIP. It is difficult to know, however, the extent to which the increase simply reflects a shift from other categories to these two. *Still, the “extra” cases in the pregnant women’s and younger children’s categories added during this period do suggest that caseloads can increase as a result of education and outreach when stability is provided in the Medi-Cal caseload for families leaving cash aid.*

## How Will Replacement Rates and Declines Look for 2000?

The next phase, which will reflect the status of Medi-Cal enrollments after full implementation of welfare reform, began in January 2000, but data will not be available for several months. California’s moratorium on Medi-Cal terminations was lifted at the end of 1999; this and other program developments will almost certainly have an impact on Medi-Cal caseload trends. In other states, where Section 1931 rules have been in place and fully implemented for a longer period than in California, the data needed for the final phase of a replacement rate analysis may already be available.

If a state’s Medicaid replacement rates were low before welfare reform and remain low afterward, action will clearly be needed to meet the challenges of this new era. In developing strategies for approaching such challenges, it will be important not to overlook structural problems that may have been preventing eligible individuals from getting and keeping Medicaid since well before the enactment of welfare reform. The following key questions may arise in the search for explanations.

## Decline in Number of People Eligible Not a Likely Explanation

In judging whether a dramatically low replacement rate is valid, one possible explanation is that many fewer families are eligible for Medicaid at the later time in the comparison, for any one of several reasons. Under close scrutiny, however, the several possible hypothetical scenarios about eligibility may be unconvincing, given circumstances in the state.

<sup>5</sup> It should be noted that implementation of the moratorium was not uniform throughout the state, and the strikingly high replacement rate during this phase may not characterize each of the state’s 58 counties.

One potential explanation for lower caseloads that immediately comes to mind is that, in today's strong economy, people are earning higher incomes and fewer remain within the income eligibility limits used for Medicaid by many states<sup>6</sup>. This would affect eligibility for new applicants, but only to the extent that low-wage workers are in fact benefitting from a state's boom, something that does not appear to be the case universally.<sup>7</sup> In any event, the relationship between an individual's income and a state's Medicaid income limits fails as an explanation for Medicaid declines among individuals who have been receiving Section 1931 Medicaid, with or without cash aid, because of the existence of Transitional Medicaid (TMA). TMA provides six months of coverage to families who have been receiving Medicaid under the main category for family coverage<sup>8</sup> for at least three of the last six months if increased income from work was the reason they left TANF or Medicaid. For the first six months of TMA, *there is no income limit at all*. During the next six months, coverage can continue if the family's income is at or below 185% of the federal poverty level, an amount significantly over the old AFDC recipient limits as well as the TANF recipient limits in most states.<sup>9</sup> Most people who left welfare and got jobs as state economies were crawling out of the recession in the mid-1990s were within these income limits, and given TMA's generous rules, not even the sizzling economy of 1999 and 2000 could defeat eligibility for so many former welfare or Section 1931 beneficiaries.<sup>10</sup>

Another possible explanation for low Medicaid replacement rates might be that people leaving cash aid are moving into jobs in which their employers provide private insurance coverage; after all, with unemployment rates at record lows, employers must compete for workers, and offering health coverage is a key mechanism for attracting and retaining employees. In reality, however, there has been a steady *increase* in the rate of uninsured workers in recent years, especially for employees of small businesses, which is where most former welfare recipients are likely to become employed and where lack of insurance coverage is most prevalent.<sup>11</sup> In California, a state benefitting considerably from the current economic boom, the most recently available data show that the increase in the number of uninsured residents is closely related to lost Medi-Cal coverage and the failure of the private market to make up the difference.<sup>12</sup>

<sup>6</sup> Many states set the income limit for their Section 1931 Medicaid programs below poverty. States have the option to change this by using income disregards and other "methodologies" to effectively increase the Medicaid income limit under their Section 1931 programs. See, Supporting Families in Transition: A Guide to Expanding Health Coverage in the Post-Welfare Reform World, HCFA, p. 7.

<sup>7</sup> For example, according to a recent report about California, where the economy is now among the strongest in history, average hourly wages for the bottom 70% of earners were lower in 1998 than in 1979, after adjusting for inflation. For the poorest 20% of California households, income fell by 19% between the 1970s and the 1990s. Will Work Pay? Job Creation in the New California Economy, California Budget Project, April 2000.

<sup>8</sup> This is the Section 1931 category today, with or without cash aid.

<sup>9</sup> Some states also provide a second year of transitional coverage under waivers or through state-only programs. In California, for example, Transitional Medi-Cal (TMC) is available to parents with income up to 185% of poverty under a state-only program. Welf. & Inst. C. § 14005.81 There are reporting requirements for the last six months of TMA; the President's budget proposal now pending in Congress would eliminate them.

<sup>10</sup> It is important to acknowledge that a strong economy in which more low-income families are working could indeed contribute to a low replacement rate, but for mathematical reasons rather than reasons related to eligibility. If fewer families are entering the "front end" of the system, which is likely when the economy is doing well, the number in the "decline group" would stay larger longer, requiring greater effort on the replacement side of the equation to keep pace. But even assuming that a strong economy would deflate the replacement rate somewhat, this factor alone would not likely account for huge drops in a state's Medicaid caseload.

<sup>11</sup> See, e.g., The State of Health Insurance in California, 1999, Regents of the University of California (January 2000) and earlier editions ([www.chpps.berkeley.edu/hipp/](http://www.chpps.berkeley.edu/hipp/)).

<sup>12</sup> E. Richard Brown, California's Growing Uninsured Population and Options to Expand Coverage, UCLA Center for Health Policy Research, UCLA School of Public Health, May 2000.

<sup>13</sup> Kaiser Family Foundation, Health Care Trends and Indicators in California and the United States (June 20, 2000) ([www.kff.org](http://www.kff.org)).



Harry Cutting

Nationally, only 61% of employers provide workers with health insurance benefits.<sup>13</sup>

There are several other narrower potential explanations, but none of these could account for the huge decline in caseloads either. Some may wonder whether individuals whose "cash-based" Medicaid was not replaced by a "family-based non-cash assistance" Medicaid category may have moved into yet another category, such as the Medically Needy program for the Aged, Blind and Disabled (ABD-MN). This category has in fact been increasing in recent years in many states. Given the age range of the family cash aid population, however — children under 18 and their parents or other caregivers — it is safe to say that such movement would not account for more than a tiny fraction of cases.

Could a significant portion of the decline be immigrants and their family members who were frightened away from public benefits as a result of welfare reform or other factors related to their status? Some studies conclude that the participation of even eligible immigrants in public benefits programs dropped after welfare reform. Even in the highest immigration states, however, huge declines in Medicaid could not be explained by this factor alone, because there were simply not that many immigrants on Medicaid to begin with.

Some ask whether the declines simply reflect families' antipathy to any program, like Medicaid, that is associated with welfare, especially after welfare reform. Declines of the magnitude being identified in some states now, however, seem hard to attribute to the stigma of welfare, either before or after welfare reform. Moreover, the stigma attached to cash aid does not seem to carry over completely to Medicaid. Two recent studies demonstrate that families value Medicaid for the health care coverage and access to health

<sup>14</sup> Medicaid and Children: Overcoming Barriers to Enrollment, Findings from A National Survey, The Kaiser Commission on Medicaid and the Uninsured (January 2000); Speaking Out ... What Beneficiaries Say About the Medi-Cal Program, Medi-Cal Policy Institute (March 2000).

## Highlights of HCFA Letter to State Medicaid Directors and Q's & A's

[excerpt from summary prepared by the Center on Budget and Policy Priorities and National Center for Youth Law]

In an April 7th letter to state Medicaid directors with accompanying questions and answers and a June 8 Set #1 Q's & A's, the Health Care Financing Administration (HCFA) addressed three topics related to the low Medicaid replacement rates discussed in the companion article: (1) steps states must take to identify individuals and families whose Medicaid benefits were improperly terminated and reinstate them to coverage; (2) federal requirements for redetermining Medicaid eligibility; and (3) federal rules regarding states' computerized eligibility systems. Some of the key points addressed in each of these three areas include the following:

### 1. Reinstatement Requirement

- All states must evaluate whether they have terminated anyone from Medicaid improperly since their TANF plans went into effect and, if so, they must reinstate the Medicaid benefits. If a state decides it does not need to make any reinstatements, it must provide its HCFA regional office with information on the review it undertook to reach this conclusion.
- Those improperly terminated include families whose Medicaid was cut off due to computer error or without a "proper redetermination of eligibility." For example, the letter notes that families who left TANF due to earnings should have been evaluated for ongoing Medicaid eligibility, including not only under Transitional Medicaid (TMA) but also under other Medicaid eligibility categories, such as section 1931. In addition, states that did not implement a section 1931 coverage category until some time after beginning their TANF programs must review Medicaid/TANF terminations that occurred before the section 1931 category was operational.
- Once families or children have been reinstated to coverage, states must conduct a determination of their ongoing eligibility. This requirement assures that families will not have benefits restored only to be cut off again a short time later if they in fact are eligible for Medicaid. HCFA notes that federal financial participation (FFP) will be available for a period of up to 120 days to allow states adequate time to review ongoing eligibility.
- HCFA notes that it may not always be clear or easy for a state to determine whether a particular individual was terminated properly. Therefore, states that identify problems in policy or practice that led to improper terminations may broadly reinstate coverage without making a specific finding that an individual termination was improper.
- HCFA indicates that states have the option of paying medical bills incurred by families between the time of Medicaid termination and their reinstatement to coverage, and that FFP will be available for such payments (including payments to providers or direct payments to individuals for out-of-pocket costs).
- HCFA notes that in some states individuals applying for Medicaid and TANF may have been improperly denied Medicaid. While HCFA is not requiring states to identify and enroll these applicants, it encourages them to do so.

### 2. Review of Federal Requirements for Redetermination

- The letter restates the longstanding Medicaid policy on redeterminations that "individuals must not be terminated from Medicaid unless the State has affirmatively explored and exhausted all possible avenues to eligibility." Individuals in all Medicaid categories are entitled to redeterminations, regardless of whether they have been receiving cash aid. This includes families on Section 1931 Medicaid without TANF, children in federal poverty level programs, families losing TMA, and others. "All possible avenues" includes disability and pregnancy, among others.
- In addition, the letter reiterates that states must conduct "ex parte" reviews of ongoing eligibility for Medicaid. In doing so, they must make "all reasonable efforts to obtain relevant information from Medicaid files and other sources (subject to confidentiality requirements)." The HCFA letter elaborates on the circumstances under which states should be using information from other programs to conduct ex parte reviews: any information that the government relies on in determining eligibility for other benefits, such as TANF, food stamps, or SSI, should, to the extent that the programs require regular redeterminations of eligibility and prompt reporting of changed circumstances, be considered accurate for purposes of Medicaid eligibility. HCFA also notes that other sources of potential information for ex parte reviews include wage and payment information, information from SSA, and state child care or child support files.
 

(Note: An "ex parte" review is one in which a state uses information already available to it to evaluate ongoing eligibility. A state may not require additional information from a Medicaid beneficiary unless the information is not otherwise available and is necessary to determine ongoing eligibility.)
- At redetermination, states may not require families to provide information that is not relevant to their ongoing eligibility, or information that they provided at the point of initial application and that is not subject to change, such as family members' social security numbers and dates of birth.

### 3. Computerized eligibility systems

- The letter, along with the accompanying Q's & A's and the Set #1 Q's & A's of June 8, reiterate that states must expeditiously correct any computer problems that result in erroneous Medicaid denials or terminations.
- In the event that a state still has work to do on its computer system, it must adopt an effective back-up system to assure that erroneous denials and terminations do not occur. For example, such a state might adopt a policy of having supervisors review all TANF case closures before any Medicaid termination could proceed.

The April 7, 2000 HCFA letter with Q's & A's is posted at <http://www.hcfa.gov/medicaid/smd40700.htm>. The June 8 Set #1 Q's & A's is posted at <http://www.hcfa.gov/medicaid/q%26a40700.htm>.

services it provides.<sup>14</sup> The studies also show that families' concerns about the program are mainly over the crushing paperwork requirements and the demeaning treatment from overworked eligibility staff in welfare offices, where most families have had to go to apply in person for Medicaid coverage.<sup>15</sup>

Finally, a more technical question may be raised. Could dramatically low replacement rates after full implementation of welfare reform be explained by individuals returning to cash aid, and getting their Medicaid back in the "cash assistance" category, rather than being counted in the "non-cash assistance" Medicaid group? The methodology used in determining the replacement rate precludes this possibility, as those "recycling" back onto cash-aid-linked Medicaid would not be included in the "decline" group. The size of the decline group is the number of those who became disconnected from cash-based Medicaid at both ends of the system: the "front end" — by not applying for welfare in the first place — and the "back" end — by leaving cash aid.

### Flaws in a State's Medicaid Retention System

As noted earlier, it was assumed in the welfare reform debate that, as welfare rolls declined, families taking a job instead of welfare would receive Medicaid benefits. In fact, the availability of these benefits was widely recognized as a prerequisite for people to be able to participate in the low-wage labor market. As a growing number of reports indicate, however, Medicaid coverage without cash assistance does not measure up to expectations, both before welfare reform and after full implementation.

What accounts for the fact that so few families seem to be keeping their Medicaid benefits as cash aid caseloads drop, even though most are likely to remain eligible? A "ground-level" perspective on the way families actually experience the cash aid and Medicaid pro-

<sup>15</sup> Eligibility workers in Los Angeles County, for example, average over 500 Medi-Cal cases per worker.



Cheryl A. Ertel

grams suggests that the rules and procedures used by a state may be a very big part of the problem.

A major issue identified in some states involves computer systems for closing cash aid cases, as noted in HCFA's April 7, 2000 letter to state Medicaid directors and June 8, 2000 Q's & A's (see page 6). In Pennsylvania, Maryland, Florida and Washington, Medicaid cases were summarily closed at the time the cash aid case was closed, without a review to "redetermine" whether Medicaid eligibility existed for the family under some other category, without cash aid. This violates federal law. Litigation and

## HCFA Letter Also Targets Children Who Lost SSI-Linked Medicaid Due to Welfare Reform

HCFA's April 7 letter and the June 8 Set #1 questions and answers also addresses the situation of children with disabilities who remain eligible for coverage under Section 4913 of the Medicaid statute. This is the eligibility category that was established by the Balanced Budget Act of 1997 for those receiving children's SSI benefits on August 22, 1996, the date the welfare law was signed by President Clinton. Some of these children lost their SSI due to the new law's tightening of the definition of childhood disability.<sup>1</sup> Because this loss of SSI meant loss of the "welfare" link to Medicaid, these children have been at risk of losing Medicaid altogether. *Section 4913 continues Medicaid eligibility for any child who was on SSI as of August 22, 1996 and who still meets the old, more generous test for disability for children but who loses SSI cash benefits because they do not meet the more restrictive SSI disability test for children imposed by welfare reform.*

HCFA is requiring states to review the Social Security Administration's (SSA) list of children who were on SSI on August 22, 1996, who should be covered under the Section 4913 category, to determine whether they are currently enrolled in Medicaid. Any child from the list who is not on Medicaid now, but who meets the

old SSI disability test for children, must be *reinstated* to Medicaid. This is so even for those former child SSI beneficiaries who have "aged out" of the children's SSI category.

For previous children's SSI recipients who *are* on Medicaid, HCFA is requiring states to ensure that they are enrolled under Section 4913 rather than under some alternative Medicaid eligibility category. Being enrolled in the "right" eligibility category is important because it may involve important protections, such as *the right to remain outside of Medicaid managed care plans.*

HCFA is offering to assist states by making the SSA's list of affected children available for matches. States are required to match the SSA list against their Medicaid lists for the children and to report the results to their HCFA regional offices.

*The April 7, 2000 HCFA letter with Q's & A's is posted at <http://www.hcfa.gov/medicaid/smd40700.htm>. The June 8 Set #1 Q's & A's is posted at <http://www.hcfa.gov/medicaid/q%26a40700.htm>.*

<sup>1</sup> See Bussiere, "Children's Disability Benefits Threatened Under Guise of 'Welfare Reform,'" *Youth Law News* (Sept.-Oct. 1996).



Marilyn Nolt

negotiation in these and other states have led to improvements in redetermination practices.

Three other different but related procedural roadblocks in the Medicaid “retention” procedures used in some states also contribute to low Medicaid replacement rates and fuel the declines.

**(1) Redeterminations for Those Losing Medicaid Without Having Received Cash Aid**

Some states have generally followed federal Medicaid rules on redeterminations for people leaving cash aid. California, for example, has been extending Medi-Cal eligibility for most families leaving cash aid while determining if they remain eligible on another basis.<sup>16</sup> But the federal rules also require a redetermination for people who lose *non-cash-assistance-based* Medicaid eligibility (see box on page 4), and this is not being done in many states.

In many states a family who receives Section 1931 Medicaid without TANF cash aid or TMA does not get a review when it loses eligibility on that basis to determine whether any of the family members remain eligible for Medicaid under any of the other non-cash-based categories. The same is true of children on any of the Medic-

aid “federal poverty level” programs. Consider, for example, a five-year-old receiving coverage under the “133% of poverty” program. The current practice in many states is to end coverage on the child’s sixth birthday, even though the child would still be eligible if the family’s income were at or below 100% of poverty, which is the income limit for the next age group.<sup>17</sup> *During good economic times, when fewer families access Medi-Cal by going onto cash assistance in the first place, the absence of redetermination procedures for “non-cash family-based” coverage groups is likely to increase in importance as a factor leading to low replacement rates and corresponding large declines in Medicaid coverage.*

**(2) Welfare Monthly Income Reports As the Trigger for Continuing Medicaid Coverage**

Families receiving cash aid in most states are required to submit a form to the welfare department at the end of every month, reporting, among other things, whether or not they received income from sources other than public assistance. Many families leaving cash aid are terminated, not for excess income, but for “failure to cooperate” because they do not send in the welfare reporting form. Thus, for

<sup>16</sup> See, *Edwards v. Myers*, 167 Cal.App.3d 1070 (1985). California, however, fails to include disability among the potential categories for on-going eligibility. As confirmed in HCFA’s April 7, 2000 letter and June 8, 2000 Q & A, this is inconsistent with federal law. The failure to include disability among the alternative bases of Medicaid eligibility is being challenged in *LaFrenz v. Bonta*, San Francisco County Superior Court, No. 311196 (filed April 3, 2000).

<sup>17</sup> Pending legislation in California would change the current practice and implement the federal rule: see, SB 87 (Escutia), [www.asm.ca.gov](http://www.asm.ca.gov).

many families, not sending in the welfare report is simply a convenient way to convey that they do not wish to continue on welfare. However, most families choosing this way of exiting welfare likely do not realize that the welfare reporting form is the ticket in many states to keeping Medicaid when leaving cash aid, much less that Medicaid can continue even without cash aid or when parents work.<sup>18</sup> While federal law requires the state to attempt to collect the information needed to decide whether Medicaid eligibility should end along with cash aid, and to continue coverage unless there is proof that an individual is no longer eligible for Medicaid on any basis, this does not always happen. (The HCFA letter to state Medicaid directors and follow-up Q's & A's summarized in the box on page 6 reaffirms this obligation.)

**(3) Quarterly Status Reports**

Another critical factor concerns Medicaid retention policies for individuals who are determined to be eligible for coverage after losing cash aid. California, for example, has been requiring Medi-Cal beneficiaries who are not receiving cash aid to submit a "quarterly status report" (QSR) every three months, along with documentation, such as copies of pay stubs, child care expenses, and other items affecting eligibility.<sup>19</sup> Documentation is required even if a family has no change to report.<sup>20</sup> Many families simply fail to keep up with this paperwork and lose coverage within three to six months. One study found, for example, that in 1995, half of the children and half of the adults in California who left AFDC lost Medi-Cal as well. This was so even though, immediately after leaving cash aid, almost 80% of the adults kept their Medicaid for at time as part of the Edwards "redetermination" group. *Nearly half of the drop off occurred in the third month off cash aid, which is the time of the first quarterly status report.*<sup>21</sup>

**Conclusion**

Understanding where a state's family-based Medicaid caseload has been, with and without the link to cash aid, is a critical part of determining where the program is headed and assessing the scope and magnitude of a state's problems in providing health insurance for eligible families who are not on welfare. Such a review may also provide some indication of what does and does not promote Medicaid retention.

A key starting point is, of course, an analysis of what happens to Medicaid when cash aid ends, both before and after welfare reform. The concept of Medicaid replacement rates can help with that analysis, for periods for which there is sufficient data spanning the key junctures in the transition to welfare reform.

But focus on the broader picture is also essential. Even generally good technical procedures for redetermination at the time welfare ends will not help families keep their Medicaid if other aspects of a state's retention policies, such as periodic status reporting or the failure to give redeterminations to people with disabilities leaving TANF, families leaving TMA or Section 1931 Medicaid without cash aid, or children "aging out" of a "poverty level" category undermine retention at the same time. State responses to HCFA's most recent instructions on assessing their Medicaid caseloads in the world after welfare reform, reinstating families improperly cut off, and



Harry Cutting

improving on-going redetermination procedures will clearly be important. But advocates, social workers, providers, insurance companies and policy-makers will also need to ask what happens to families after the first few months of redetermination or reinstatement.

Once children or parents lose Medicaid coverage and disappear from the system, it is far more difficult and expensive to find them and reinstate benefits. Moreover, the impact on the family of the break in coverage can be devastating, physically as well as financially. Every effort must be made to promote retention not only at the point in time at which families leave cash aid, but also throughout the year. In some states, analyzing the drop-off in Medicaid caseloads based only on changes made as a result of welfare reform could mean missing the most significant factors contributing to low replacement rates and corresponding declines.

**Table 1: Tracking the "Replacement Rate"**

	Phase I Mar 1995– Dec 1997	Phase II Jan 1998– Dec 1999	Overall Mar 1995– Dec 1999
Decline in Family-Based, Cash Assistance MediCal	-510,091	-550,052	-1,079,157
Increase in Family-Based, Non-Cash Assistance MediCal	37,535	647,261	691,833
Replacement Rate*	7.4%	117.7%	64.1%

\* Represents the growth in the number of enrollees in the family-based, non-cash assistance group as a proportion of the decline in the number of enrollees in the family-based, cash assistance group.

Source: CBPP calculations based on data provided by the California Department of Health and Human Services.

<sup>18</sup> See, e.g., Medicaid and Children: Overcoming Barriers to Enrollment, Findings from A National Survey, *The Kaiser Commission on Medicaid and the Uninsured* (January 2000), p. 7.

<sup>19</sup> Federal law, in contrast, only requires annual reporting.

<sup>20</sup> Governor Gray Davis has announced his intention to drop the QSR requirement entirely as of January 1, 2001. Families would still be required to report changes within ten days.

<sup>21</sup> On and Off Medicaid: Enrollment Patterns for California and Florida in 1995, *The Urban Institute* (July 1999), pp. 11 and 14

**Table 2: Disaggregating the Family-Based, Medi-Cal Enrollment Decrease Between March 1995 and December 1999**

Family-Based Medi-Cal	March 1995	December 1999	Change in Enrollment Mar 1995-Dec 1999	Average Monthly Change in Enrollment
<b>Family-Based Cash Assistance</b>	<b>2,708,932</b>	<b>1,629,775</b>	<b>-1,079,157</b>	<b>-18,933</b>
<b>Family-Based, Non-Cash Assistance</b>	<b>843,919</b>	<b>1,535,752</b>	<b>691,833</b>	<b>12,137</b>
<i>Medically Needy</i>	441,037	331,296	-109,741	-1,925
<i>Edwards</i>	205,703	302,987	97,284	1,707
200% Program for Pregnant Women and Infants	75,842	120,490	44,648	783
133% (1-5 year olds)	69,570	122,488	52,918	928
100% (6-18 year olds)	12,652	98,887	86,235	1,513
1931 Non-Cash	0	526,625	526,625	9,239
Transitional Medi-Cal	39,115	32,979	-6,136	-108
<b>Total Family-Based Medi-Cal</b>	<b>3,552,851</b>	<b>3,165,527</b>	<b>-387,324</b>	<b>-6,795</b>

Source: CBPP calculations based on data provided by the California Department of Health and Human Services.

**Table 3: Disaggregating the Family-Based, Medi-Cal Enrollment Decrease During Phase I**

Family-Based Medi-Cal	Mar-95	Dec-97	Change in Enrollment Mar 1995-Dec 1997	Average Monthly Change in Enrollment
<b>Family-Based Cash Assistance</b>	<b>2,708,932</b>	<b>2,198,841</b>	<b>-510,091</b>	<b>-15,457</b>
<b>Family-Based, Non-Cash Assistance</b>	<b>843,919</b>	<b>881,454</b>	<b>37,535</b>	<b>1,137</b>
<i>Medically Needy</i>	441,037	425,462	-15,575	-472
<i>Edwards</i>	205,703	155,883	-49,820	-1,510
200% Program for Pregnant Women and Infants	75,842	89,501	13,659	414
133% (1-5 year olds)	69,570	89,907	20,337	616
100% (6-18 year olds)	12,652	35,803	23,151	702
1931 Non-Cash	0	0	0	0
Transitional Medi-Cal	39,115	84,898	45,783	1,387
<b>Total Family-Based Medi-Cal</b>	<b>3,552,851</b>	<b>3,080,295</b>	<b>-472,556</b>	<b>-14,320</b>

Source: CBPP calculations based on data provided by the California Department of Health and Human Services.

**Table 4: Disaggregating the Family-Based, Medi-Cal Enrollment Increase During Phase II**

Family-Based Medi-Cal	Jan-98	Dec-99	Change in Enrollment 1998-December 1999	Average Monthly Change in Enrollment
<b>Family-Based Cash Assistance</b>	<b>2,179,827</b>	<b>1,629,775</b>	<b>-550,052</b>	<b>-28,950</b>
<b>Family-Based, Non-Cash Assistance</b>	<b>888,491</b>	<b>1,535,752</b>	<b>647,261</b>	<b>34,066</b>
<i>Medically Needy</i>	439,196	331,296	-107,900	-5,679
<i>Edwards</i>	152,537	302,987	150,450	7,918
200% Program for Pregnant Women and Infants	89,472	120,490	31,018	1,633
133% (1-5 year olds)	90,099	122,488	32,389	1,705
100% (6-18 year olds)	36,738	98,887	62,149	3,271
1931 Non-Cash	1	526,625	526,624	27,717
Transitional Medi-Cal	80,448	32,979	-47,469	-2,498
<b>Total Family-Based Medi-Cal</b>	<b>3,068,318</b>	<b>3,165,527</b>	<b>97,209</b>	<b>5,116</b>

Source: CBPP calculations based on data provided by the California Department of Health and Human Services.